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UMI
DEMOGRAPHIC AND PROFESSIONAL CHARACTERISTICS
OF CHILD-ORIENTED PSYCHIATRISTS, PSYCHOLOGISTS,
AND CLINICAL SOCIAL WORKERS WITH
REGARD TO THEIR ETHICAL BELIEFS

by

Kathleen Rishel Allen

A Dissertation Submitted to the Faculty of the
DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

In Partial Fulfillment of the Requirements
For the Degree of
DOCTOR OF PHILOSOPHY

In the Graduate College
THE UNIVERSITY OF ARIZONA

1998
As members of the Final Examination Committee, we certify that we have read the dissertation prepared by Kathleen Rishel Allen entitled "Demographic and Professional Characteristics of Child-Oriented Psychiatrists, Psychologists, and Clinical Social Workers With Regard to Their Ethical Beliefs" and recommend that it be accepted as fulfilling the dissertation requirement for the Degree of Doctor of Philosophy.

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SIGNED

[Signature]
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This dissertation is dedicated to my son, Yusef Omowale.
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ABSTRACT

This study was designed to extend the research on ethical beliefs to child-oriented mental health practitioners. The purpose of the study was to identify the beliefs and practices of psychiatrists, psychologists, and social workers regarding confidentiality, competence, and multiple relationships, and to determine whether ethical beliefs vary by profession, gender, or other demographic and professional characteristics.

A two-part questionnaire was mailed to 3000 child-oriented psychiatrists, psychologists, and social workers regarding their ethical beliefs in the areas of competence, confidentiality, and multiple relationships. A total of 1029 responses were obtained. Part One of the questionnaire addressed demographic and professional information, and Part Two contained 43 behavior description stems. Respondents were asked to indicate the degree to which they felt each behavior was ethical, using a Likert-like scale.

Significant (p < .001) differences were obtained between the three professional groups in their beliefs regarding multiple relationships, competence, and the total ethical belief rating. Psychiatrists were the least conservative/most accepting in their ethical belief ratings, social workers were the most conservative/least accepting and psychologists tended to fall in the middle on each measure. In addition, female practitioners endorsed a significantly (p < .001) more conservative viewpoint than did male practitioners in multiple relationships, competence, and total ethical behavior ratings. Although respondents were most in agreement in their respective beliefs about
confidentiality, a significant ($p < .05$) difference was found for gender, with females being more conservative/less accepting than males.

In the area of multiple relationships, psychiatrists indicated a greater willingness to engage in relationships such as treating the child of a close friend, and entering into business or social relationships with current or former clients, than either social workers or psychologists. Additionally, respondents as a group were more likely to rate as acceptable breaking confidentiality when working with children than when working with adolescents ($p < .001$). This study points to the differences, as well as areas of general agreement, in the ethical beliefs of psychiatrists, psychologists, and social workers.
CHAPTER ONE

INTRODUCTION

In recent years concern has grown about the ethical practices and professional behavior of mental health providers (Haas, Malouf, & Mayerson, 1986). Of particular concern has been various reports of sexual misconduct between providers and their clients (e.g., Pope, 1990c.). In response, professional associations have reviewed and revised their ethics codes, and researchers have explored various aspects of ethics, including ethics training (e.g., Baldick, 1980; Gawthrop & Uhlemann, 1992; Handelsman, 1986a, 1986b), ethical beliefs and practices (e.g., Bernard & Jara, 1986; Bernard, Murphy & Little, 1987; Borys, 1988; Gartrell, Herman, Olarte, Feldstein, & Localia, 1986; Pope, Tabachnick, & Keith-Spiegel, 1987), ethical decision making (e.g., Haas, Malouf, & Mayerson, 1988; Kimmel, 1991) and knowledge of law and ethics codes (e.g., Beck & Ogloff, 1995; Swoboda, Elwork, Sales, & Levine, 1978).

Practitioners have also been asked to identify specific incidents in their practice that they found to be ethically troubling (Pope & Vetter, 1992), and complaints to professional organizations have been reviewed and categorized with regard to the types of unprofessional practices in which these providers have engaged (e.g., APA, 1993b, 1994, 1995; APA Ethics Committee, 1988; Berliner, 1989; Hall & Hare-Mustin, 1983).

The professions of psychiatry, psychology, and social work have each formalized a code of ethics, adopted by the membership of their respective associations (American Psychiatric Association, 1993; American Psychological Association, 1992b, National Association of Social Workers, 1996). As the provision of mental health services is
interdisciplinary practitioners in each of these respective professions frequently interact with one another. While there are many overlapping areas among the ethics codes of the American Psychiatric Association (APA), the American Psychological Association (APA), and the National Association of Social Workers (NASW)—such as confidentiality and the prohibition of sexual relations with a current client—there are also many areas that do not overlap. Comparative research on ethical practices and beliefs amongst these three professional groups has been limited. For example, Crenshaw and Lichtenberg (1993) found differences among these groups in the practice of informing clients on the limits of confidentiality and forewarning them about mandatory reporting laws. Other studies found a significant gender difference (e.g., Borys, 1988) and a significant difference between psychodynamically oriented therapists and all other groups (e.g., Borys, 1988; Conte, Plutchik, Picard, & Karasu, 1989) with respect to multiple relationships and other ethical issues. Borys (1988) also found significant differences between the three professional groups in multiple relationships in regards to incidental involvements and social/financial involvements.

Research in the area of ethical practices has typically focused on clinicians that work primarily with adults. Although much of this research applies to child mental health services, practitioners who work with children and adolescents find that there are also important differences in the application of some ethical standards (e.g., Rae, Worchel, & Brunnquell, 1995). For example, under some conditions ethical and legal requirements may be in conflict when providing services to children (e.g., Koocher & Keith-Spiegel, 1990; Myers, 1982; Shields & Johnson, 1992). In addition, unlike the vast majority of
mental health services provided adults, the ability of children to make competent
decisions needs to be considered (e.g., Grisso & Vierling, 1978; Kaser-Boyd, Adelman,
& Taylor, 1985; Melton, Koocher, & Saks, 1983). Child clinicians also find that in some
instances the interests of parents and children may conflict (e.g., Plotkin, 1981; Rodham,
1973), and it is unclear at times whether confidentiality lies with the parent or with the
child/adolescent client (e.g., Arambula, DeKraai, & Sales, 1993; Gustafson &
McNamara, 1987; Morris, 1993).

Rae and Worchel (1991) surveyed a sample (n = 169) of psychologists who were
members of the Society of Pediatric Psychologists about their ethical beliefs and
behaviors. They compared the responses they obtained from the child-oriented
psychologists to those obtained in a similar study that surveyed primarily adult-oriented
psychologists (Pope et al., 1987). Rae and Worchel found that pediatric psychologists
were more likely than their adult-oriented counterparts to break confidentiality to report
that a client was suicidal or to report child abuse. These results suggest that studies that
have focused on adult-oriented practitioners may not be representative of clinicians that
work with children and adolescents.

In a survey of randomly selected members and fellows of the American
Psychological Association, which solicited examples of ethical dilemmas they faced in
their work, confidentiality and dual relationships were the two areas most often cited as
problematic—accounting for 35% of the total number of incidents (Pope & Vetter, 1992).
Another 3% of the reported incidents involved issues of competence.
Purpose of the Present Study

There is a paucity of recent literature that compares the ethical attitudes and beliefs of psychologists, psychiatrists, and social workers. Of those studies that have been performed, none have focused on child mental health services. The present study examined the relationship of various demographic and professional characteristics of child-oriented psychiatrists, psychologists, and social workers with regard to their ethical beliefs in the areas of confidentiality, competence, and multiple relationships. The characteristics of interest included: profession, gender, formal ethics training, therapeutic orientation, primary work setting, age, year of terminal degree, and years of practice.

The objectives of this investigation were: (1) to identify the beliefs and practices of psychiatrists, psychologists, and social workers regarding confidentiality, competence, and multiple relationships; (2) to determine whether ethical beliefs vary by profession, gender, formal ethics training, therapeutic orientation, primary work setting, age, year of terminal degree, and years of practice; (3) to determine if beliefs about specific professional practices vary by profession or by gender; and (4) to determine if ethical beliefs about certain behaviors vary based on the age of the client.

Research Questions

Based on the limited research comparing ethical beliefs and practices across professions, the following research questions will be addressed:

1. Is there a significant difference ($p < .05$) between the ratings of psychiatrists, psychologists, and social workers regarding their ethical beliefs concerning various statements about the provision of child mental health services?
2. Is there a significant difference ($p < .05$) in ratings of ethical statements based on clinicians' demographic (age and gender) and professional (formal ethics training, therapeutic orientation, primary work setting, years of practice, and year of terminal degree) characteristics?

3. Do beliefs about specific professional practices vary by profession?

4. Do beliefs about specific professional practices vary by gender?

5. Do beliefs about specific practices vary by the age of the client (e.g., child or adolescent)?

Because of the limited research in the area of comparative ethical beliefs, these questions are exploratory. No alternative hypotheses can be made at this time.
CHAPTER TWO
REVIEW OF THE LITERATURE

This chapter will review the literature related to ethics and codes of ethics, graduate training in ethical practices and research on ethics across the professions of psychology, psychiatry, and social work. The development of ethics codes in each profession will be discussed, as will be the methods employed by each profession to teach its members ethical practices. Research related to confidentiality, multiple relationships, and competence will be reviewed.

Ethics and Codes of Ethics

Ethics has been defined as "the rules or standards governing the conduct of a person or the members of a profession" (Soukhanov et al., 1992, p. 630). Consistent with this definition is the fact that each society also develops a broad system of ethical beliefs in order to guide the behavior of its citizens, not only to safeguard values and establish social order, but for the very survival of the culture (Midgley, 1991). Rules or standards that govern the members of a profession must therefore coincide with the values of the society in which the profession is found (Redlich & Mollica, 1976).

From a sociological perspective, the adoption of a code of ethics by a profession, as well as the active self-regulation regarding the codes, is part of what defines the group as a profession (Veatch, 1989). Professional codes of ethics are living documents that evolve out of the experience and knowledge of the group. They are affected by changes within the profession (e.g., development of new treatments), legal and statutory influences (e.g., child abuse reporting laws) and changing values within the larger society.
(e.g., consumer rights movement) (Ballantine, 1979; Canter, Bennett, Jones, & Nagy, 1994). Ethical codes provide guidance and structure for the members of a profession, are useful in the adjudication of grievances, sensitize members to moral issues, present to the public evidence of professional ideals, and set ground rules for the interaction among different groups of professionals (Beyerstein, 1993; Clouser, 1975; Watson, 1985; Yelaja, 1982). Rather than being a set of rules for the governance of every professional action, ethical codes provide a foundation for members of the profession to consult with when making decisions related to the practice of their particular profession (Bennett, 1994; Canter et al., 1994).

**Theoretical Views Regarding Ethics and Ethical Decision-Making**

**Ethical Theories**

Theoretical views regarding ethics have emerged from the study of philosophy and the focus on such constructs as "duty," "virtue," "obligation," and "right and wrong." These theories seek to develop a system of thought to justify moral principles and, in turn, guide members of society in moral decision making. In order to resolve moral dilemmas, it is often not sufficient for the professional to rely solely on ethics codes, which may be too narrow or too broad. This is where fundamental moral principles and ethical theories need to be considered (Beauchamp & Childress, 1983; Hare, 1981).

Two overarching theoretical systems have dominated ethical theory: "deontological" theories that focus on the act itself as being right or wrong, and "teleological" theories that focus on ends and goals (McLeish, 1993; Pojman, 1990). Deontological theorists, such as Immanuel Kant, argue that there are certain principles
that must be followed without exception and without regard for the consequences.

Teleological theorists, such as Jeremy Bentham and John Stuart Mill, argue that such a strict adherence to principles could actually result in an immoral act, such as when adherence to the principle of truth-telling leads to the death of an innocent person (Abelson & Nielsen, 1967).

Ethical relativists, such as Ruth Benedict, argue that there are in fact no universal moral principles, but that what is ethical is dependent on the cultural context of the act (Pojman, 1990). Values are relative to the common norm, or what is commonly accepted within the culture.

Another perspective, proposed by W. D. Ross (1930) and elaborated by Beauchamp and Childress (1983), proposes that moral principles be considered as prima facie valid. An ethical principle, therefore, would be considered binding unless it conflicts with another ethically binding principle. To determine one's actual duty in a given situation one would have to examine the weight of each conflicting prima facie ethical principle (Ross, 1930).

**Ethical Decision Making**

Richard Hare (1981) distinguishes between two levels of moral reasoning, the “intuitive” level and the “critical-evaluative” level. The intuitive level is in use in our daily lives as we instinctively respond to situations as they arise. The basis for this intuitive level of decision making is formed in our normal upbringing and refined at the critical-evaluative level as we develop and modify those principles in which we believe. For the professional, ethical codes become part of the intuitive level. According to Hare
(1981), these ingrained principles are not only necessary time-savers, but can keep us from engaging in “special case” decision making.

A moral dilemma arises when different moral principles can be called upon by opposing sides of a certain course of action. When faced with a moral dilemma, moral intuition is insufficient. To come to a decision, one must move to the critical-evaluative level of moral reasoning (Hare, 1981; Kitchener, 1984b). The critical-evaluative level is composed of three hierarchical tiers: “rules,” “principles,” and “ethical theories” (Beauchamp & Childress, 1983).

When intuition fails to provide a satisfactory answer to a course of action, the first alternative action that would be available to a psychiatrist, psychologist, or social worker would be reviewing the ethical code or rules of his/her profession. By reviewing relevant sections of the ethics code, as well as reading relevant cases to which the code has been applied, the mental health practitioner may obtain the needed answers associated with the particular dilemma under consideration (Koocher & Keith-Spiegel, 1990). When a review of the ethical code, however, fails to provide an adequate answer, one may refer to the more fundamental moral principles that serve as the foundation for ethics codes (Beauchamp & Childress, 1983). For example, W. D. Ross (1930), a deontologist held that there are several prima facie principles or duties, which are not absolute but which are always morally relevant. These principles are “autonomy,” “nonmaleficence,” “beneficence,” “fidelity,” and “justice.”

The principle of autonomy guides judgments about how to treat other autonomous persons, or those who are self-governing and self-directing, and able to set a voluntary
The principle of beneficence requires positive steps to prevent or remove harm or promote good. It is considered a violation of professional duties to fail to act in order to benefit others when in a position to do so (Beauchamp & Childress, 1983). As in nonmaleficence, competence is central to the principle of beneficence. A moral dilemma can arise when the principle of beneficence comes into conflict with the principle of autonomy, such as when involuntary commitment of a patient is being considered (Kitchener, 1984b).

The principle of fidelity involves promise keeping, truthfulness, and loyalty, which are central to the development of trust. Fidelity is involved in many professional and client relationships, such as confidentiality, the duty not to neglect or abandon a patient, and the right to informed consent (Beauchamp & Childress, 1983; Kitchener, 1984b; Ross, 1930).

Fairness and the establishment of harmony between one’s rights and the rights of others are concepts central to the principle of justice. Each person should be treated
equally unless a strong argument can be made for differential treatment (Pojman, 1990). Whether mental health resources should be allocated based on the justice of need or the justice of merit is an issue of growing concern for mental health workers as government support for services has become less available (Kitchener, 1984b).

The third tier in the critical-evaluative stage of decision making is moral theory (Hare, 1981). A moral theory attempts to explain why we place more weight on one principle than another when they conflict (Beyerstein, 1993). The type of moral or ethical theory to which one subscribes (e.g., deontological, utilitarian, relativist) largely determines how one evaluates the ethical principles when they come into conflict.

**Ethics vs. Law**

Legal standards bearing on mental health practice, although having similarities to ethical principles, have several differences. Criminal and civil legislation, as well as administrative procedures and malpractice case law, are all sources of legal standards that impact on mental health practitioners. Such laws or judicial rulings are roughly divided into regulatory aspects of the business (e.g., licensure and certification, malpractice law), and the rights of clients/patients (e.g., civil commitment statutes). Enforcement is through state licensing boards, civil courts and criminal courts that apply the law to all practitioners rather than by ethics committees of professional associations, whose jurisdiction is limited to only members of the association (Haas & Malouf, 1995; Pope & Vasquez, 1991; Sales, 1983).

Ethics codes are only concerned with the problems that arise in the behavior(s) of a member of a professional association. In the mental health professions, such
professional ethics codes are a means by which patients and clients are protected versus being placed at risk (Keith-Spiegel & Koocher, 1985; Pope & Vasquez, 1991). What is ethical and what is legal, however, may coincide at times. For example, such behaviors as fraudulent third-party billing or sexual relations with a client may result in a professional not only being sanctioned legally but also by his or her professional association. On the other hand, certain behaviors that might be considered unethical when engaged in by a mental health professional, such as publishing a scholarly journal article that contains plagiarized sections, or misrepresenting background and training information on an application for hospital privileges, may not be against the law but may cause an ethics committee to find the practitioner in violation of her or his association's code of ethics. Additionally, certain behaviors that involve legal sanctions, such as not renewing one's license to practice psychology, may be of little or no concern to an ethics committee (Keith-Spiegel & Koocher, 1985; Pope & Vasquez, 1991) but are of concern to a regulatory board.

Some mental health practitioners may also feel that certain laws are contrary to what they believe is in the best interest of their client or patient and, therefore, willfully break both the law and their professional association's ethics code (Ansell & Ross, 1990; Kalichman, 1993; Kalichman & Brosig, 1993). For example, in a national survey of psychologists, Pope and Bajt (1988) found that 57% of those responding had intentionally violated the law and/or an ethical standard. Of particular note were those laws mandating a breach of confidentiality, such as in the case of child abuse reporting laws, when such actions could negatively impact the therapeutic relationship.
Consistent with this point, the ethics codes of both the American Psychological Association (APA) and the American Psychiatric Association (APA) make reference to the relationship of the practitioner to the law. For example, the APA indicates that when there is a conflict between ethical responsibilities and the law, psychologists are to make their commitment to the ethics code known and attempt to resolve the conflict in a responsible manner (American Psychological Association, 1992b). With respect to psychiatrists, the Principles of Medical Ethics (American Medical Association, 1994a), which forms the basis of the ethics code of the APA, mandates respect of the law and also a responsibility to work to change laws that are not in the best interests of patients. In the annotations for psychiatry, it is noted that certain illegal activities, such as protesting social injustice, may not be considered unethical (American Psychiatric Association, 1993). The Code of Ethics of the National Association of Social Workers (NASW, 1996) suggests that when social workers' ethical obligations conflict with laws the social worker should make an effort to resolve the conflict in a manner consistent with the ethics code, seeking "proper consultation" if necessary.

**The Writing of Ethics Codes: A History in the United States**

Concern with the ethical practices of various trades and professions in the United States can be traced to the early 1900's. King (1922) attributed the interest in the writing of ethics codes in the business community to changes in the nature of business brought about by modern transportation and the need to restore good faith among buyers and sellers. This development appeared to parallel the increasing establishment of various professions and businesses and the declining reliance on the use of the unwritten code of
honor. Written codes defined standards, educated members of a professional group or trade, and increased the standing of the respective group or trade association on the part of the public (Hobbs, 1948).

It was during this time that diverse groups adopted codes of ethics. Heermance (1924), for example, published a book containing 165 different codes of ethics. Some of these latter codes were revisions of earlier codes, such as the American Bar Association's "Canons of Professional Ethics" (adopted in 1908) and The American Medical Association's "Principles of Medical Ethics" (adopted in 1912). There were also new codes like those adopted in 1920 by the Laundryowners National Association and the Associated Knit Underwear Manufacturers of America (adopted in 1923). It was estimated that between 1890 and 1919 over 200 business and professional groups adopted codes of ethics (Levy, 1974). This movement continued to be strong through the 1920's with, for example, the International Association of Rotary Clubs campaigning for a written code for each business and profession, and offering a model code for businesses to follow (Gundaker, 1922).

Landis (cited in Hobbs, 1948) conducted a study in the 1920's of hundreds of ethical codes and determined they were of four basic types: "a collection of specific rules of conduct...: a collection of two kinds of articles – specific rules of conduct and general principles which set no standard...: a collection solely of principles which set no standards...: one which consists of general principles, constantly applied to particular situations by the rulings of a practice committee." (p. 80). He concluded that most codes
were "formulations of vague idealism" rather than sets of specific rules with corollary control mechanisms and, therefore, ineffective for group control.

**Psychiatry**

As physicians, psychiatrists have been bound by the ethics code of the American Medical Association (AMA). Psychiatry did not have its own code until 1973, and the code adopted then was in the form of annotations to the AMA's "Principles of Medical Ethics" (ApA. 1973). Contemporary principles of medical ethics have their base in the Oath of Hippocrates. The Oath is part of the Hippocratic Collection, a library of writings by various authors from the fifth and fourth centuries B.C. For reasons not yet understood by modern scholars, a large portion of the Greek medical literature was named for Hippocrates, the most prestigious physician of the era when medicine first separated itself from superstition. The Oath Of Hippocrates (or "Hippocratic Oath") is generally considered by historians to have been written one or two centuries after the death of Hippocrates by a physician or group of physicians in the Pythagorean religious cult (Blomquist, 1978; Levine, 1971). Medical knowledge was considered by these latter practitioners to be both sacred and secret, and members of the Pythagorean cult pledged to teach their sons and the sons of their teacher, but to keep the art secret from all others. Professional clauses in the Oath include the duty to do no harm, confidentiality, prohibition of sexual misconduct, and admonitions against practicing outside one's competence (Katz, 1981; Levine, 1971; Veatch, 1989). Between the 10th and 12th centuries, the pagan version of the Oath was Christianized and became the basis for
European medical ethics (Blomquist, 1978). Other cultures have also written modified versions of the Oath to accommodate their respective religious beliefs (Goodfield, 1973).

Much of the first code adopted by the AMA was taken directly from Thomas Percival's, "Medical Ethics, or A Code of Institutes and Precepts Adapted to the Professional Conduct of Physicians and Surgeons," written in 1794 and published in 1803 (Leake, 1927/1975). Percival's purpose in writing the code was to reduce controversy among attending physicians at an English hospital following a disputed death, by establishing a professional etiquette and system of professional regulation (Berlant, 1978; Moore, 1978; Musto, 1981). It was also Percival who introduced the term "medical ethics" into the medical lexicon. Although he originally entitled his work "Medical Jurisprudence," he was persuaded to change the title, marking the beginning of a confusion between etiquette (the primary concern of his treatise), and ethics (Leake, 1927/1975).

Percival's code was divided into four sections, three concerned with professional conduct relative to hospitals or other medical charities, private or general practice, and apothecaries, and a fourth section concerned professional duties requiring a knowledge of law. Under this code, the medical profession had concrete rules to follow rather than the abstract principles of the Greek tradition (Leake, 1927/1975). Percival's code was similar to that of Hippocrates in its paternalism, protectionism, and secrecy (Newton, 1977; Veatch, 1989).

When the American Medical Association was founded in 1946, the primary motivation of its founder, Nathan Smith Davis, was to improve the standards of
professional training and morality. The medical profession at the time was only one of several unregulated groups competing for the business of curing disease. In 1847, the licensing of physicians had been discontinued and quackery, for example, in the form of “mail-order” medicine, was rampant. To establish itself as preeminent in the role of healing, the medical profession needed to set itself apart from the various forms of quackery prevalent at that time, through a strong organization which could regulate itself (Chapman, 1979; Leake, 1927/1975; Moore, 1978). At the first meeting of the medical group in 1847, the Code of Ethics of the American Medical Association (AMA, 1948) was adopted, stating clearly it was based on the work of Percival (Leake, 1927/1975). The code stressed the need for secrecy, the physician’s high moral obligation, etiquette between physicians as well as in their interactions with the public, the qualifications of a physician, and a section on the obligations of patients to their physicians (AMA, 1848; Musto, 1981). In an effort to separate the medical profession from the rival methods of healing, the code specifically prohibited practices associated with quackery, such as advertising and dispensing “secret nostrums.” Physicians were encouraged to send their prescriptions to druggists who did not sell “quack or secret medicines,” and were prohibited from consulting with anyone not considered a “regular practitioner” (AMA, 1848). This latter prohibition, the “exclusive dogma” clause, caused problems for those physicians wishing to work with homeopathic practitioners (Leake, 1927/1975).

In 1903, the governing body of AMA, the House of Delegates, adopted a revised code that eliminated the “exclusive” clause and changed the name to Principles of Medical Ethics of the American Medical Association (AMA, 1911; Leake, 1927/1975).
Major revisions were made in the code in 1912 and 1947, and in 1955 a revision was submitted to the House of Delegates in an attempt to distinguish ethics from etiquette. Complaints had been made about the large amount of space (16 pages) allotted to relations among doctors in contrast to the six pages devoted to patient-oriented concerns (Sperry, 1950). The new code was adopted in 1957 as the abbreviated “Ten Principles of Medical Ethics” (Chapman, 1979).

In 1977, the Judicial Council of AMA initiated another revision. There were three major areas of concern: the language of the code needed to be updated, including the elimination of references to gender; the specific condemnation of chiropractic as an "unscientific cult" needed to be eliminated; and language interpreted as restraining trade needed to be changed due to a judgement rendered against the AMA on a suit brought against it by the United Stated Federal Trade Commission (AMA Council, 1992; Ballantine, 1979). This new revision was adopted in 1980.

The American Psychiatric Association (APA), founded in 1844 as the Association of Medical Superintendents of American Institutions for the Insane, is the oldest national medical society in the United States. This group was concerned about protecting itself from complaints by patients of maltreatment and wrongful commitment (Andreasen, 1994; Musto, 1981). Although Percival had written on the care of lunatics in his code of medical ethics, the only reference to the care of the mentally ill in the first AMA code of ethics was the inclusion of insane asylums in a list of institutions of interest to physicians (Leake, 1927:1975).
Two years after the adoption of the AMA code of ethics, a Connecticut physician, Worthington Hooker (1849/1972), published a study of medical ethics in the United States. Two chapters in his study related to the treatment of the mentally ill. Hooker recommended early treatment of the mentally ill in an institutional setting, with regulation of their activities. He also advocated honesty in dealings with the mentally ill, which ran contrary to the widespread practice of employing deception with the insane. Largely due to the suggestions of Hooker, decisions regarding the insane, particularly commitment to an institution, were left to experts in the field (Musto, 1981).

In 1970, the American Psychiatric Association requested that its Ethics Committee develop a code of ethics that was specific to psychiatry. This request emerged from society's increasing scrutiny of the treatment of mentally ill persons and the associated legal challenges of commitment (e.g., Lynch v. Baxley, 1974; O'Conner v. Donaldson, 1975). The traditional paternalistic attitudes that psychiatrists shared with other medical specialists were being questioned by a society that was increasingly concerned about people's individual rights. In particular, the use of electro-convulsive therapy, behavior modifying drugs, and neurosurgical practices were being questioned (Moore, 1978; Musto, 1981). The APA Ethics Committee, chaired by C. H. Hardin Branch, worked for three years to develop an ethics code with the AMA insisting that the Committee work within the constraints of the Principles of Medical Ethics. Specifically, the Committee was permitted to add to the principles but was not able to subtract from them. A series of annotations, therefore, was developed that can be changed or added to as needed by a vote of APA's Board of Trustees and the Assembly of District Branches.
Recognizing that ethical issues involved in the treatment of children and adolescents were often quite different from those involved in the treatment of adults, the Council of the American Academy of Child Psychiatry (AACP) in 1980 adopted a code of ethics that established guidelines for the child and adolescent psychiatrist (AACP, 1982). The code consists of a preamble and 17 principles, and appears in Appendix A.

Psychology

The American Psychological Association (APA) was founded in 1892 under the leadership of G. Stanley Hall (Sokol, 1992). In 1938, the APA Committee on Scientific and Professional Ethics (Committee-I) was formed to consider the drafting of a code of ethics, but there was little support within the membership for a codified system at that time. Although not formally empowered to do so, the Committee-I spent much of its time reviewing complaints against psychologists and investigating unethical practices in a private and informal manner (APA, 1952; Golann, 1970a; Hobbs, 1948). In 1943, the APA voted that the Committee-I make an attempt to codify the principles on which they based their informal decisions, but it was not until 1947 that this codification process began.

The Committee-I began the task of formulating a code by working under the assumption that such a code would affect group behavior as well as express the ideals of the profession. This movement was based on early concerns about ethical behavior among psychologists, as expressed in letters written to the American Psychologist during
the 1940’s. For example, these letters expressed concern in such areas as advertising in various telephone directories (Allport, 1948; David, 1948) and the dispensing of advice over the radio (Snyder, 1949). These concerns were buttressed by the adoption of codes by various state psychological associations such as New York (Harris, 1952) and Minnesota (APA), as well as the publication of articles in professional journals in which recommendations were made concerning the development of a code of ethics by the APA (Bixler & Seeman, 1946; Sutich, 1944).

The APA’s Committee on Ethical Standards for Psychology (Committee-II), chaired by Edward C. Tolman, published a series of articles in 1951 making available to the membership a tentative formulation of ethical standards (APA Committee on Ethical Standards for Psychology, 1951a, 1951b, 1951c, 1951d, 1951e, 1951f). The proposed standards were the result of three years of empirical research by the Committee-II. This development coincided, in part, with the aftermath of World War II and the associated realization on the part of psychologists of their respective role in providing psychological services to members of the armed services, as well as the realization of the cruelties committed by Nazi Germany in their “scientific” work on human subjects (Golann, 1970a, 1970b; Reese & Fremouw, 1984).

Prior to World War II, most psychologists were engaged in academic instruction and research, where existing scientific research codes provided adequate guidance for them (Rich, 1952). As the activities of psychologists became more diverse, there was a greater need for a code of ethics that addressed the unique needs of psychologists (Hobbs, 1948). In addition, the profession was becoming large enough after the war (i.e., 7500
members of APA by 1948) to make regulation of professional relationships desirable (Hackbusch, 1948), as well as result in an elevation of the professional status of psychologists on the part of the public (Hobbs, 1948). Moreover, the unwritten code used by the Committee-I to investigate questionable practices and to guide psychologists inquiring about acceptable practices, was considered by 1947 to be "tenuous, elusive, and unsatisfactory" (Hobbs, 1948, p. 81). The President of APA, Donald G. Marquis, therefore appointed in 1947 the Committee-II members to draft a formal code of ethics.

Nicholas Hobbs, a member of the Committee-II, outlined a proposal for the development of an ethics code in an article in the American Psychologist in 1948. Historically, most ethics codes established by professional groups had used the committee-recommendation technique, whereby an elite board or committee used deductive processes to develop a code for the membership of the organization. Hobbs proposed an inductive, empirical approach that he felt was uniquely suited to psychologists. By utilizing Hobbs' approach, the goal of the Committee-II was to develop a code with which psychologists could identify, and which would affect their behavior rather than only be memorized for exams and then be forgotten (Hobbs, 1948). Although the Committee-II was aware that this research approach would take more time than the committee-recommendation approach, the belief was also that the active involvement of the membership of APA would have the effect of encouraging psychologists to think about ethical standards immediately and, hopefully, modify their behavior (Hobbs, 1948).

The Committee-II first outlined criteria for the development and application of a code and identified 16 objectives. These included: (1) the use of an empirical process
involving intensive research and widespread participation; (2) the use of specific terms rather than generalities and exhortations to virtuous behavior; (3) comprehensiveness; (4) the inclusion of the concerns of specialists; (5) maximum clarity in writing; (6) a provision for revision of the code by simple methods; (7) adoption of the code, item by item, by will of the majority following a carefully planned educational program; (8) provision for the continuous collection of illustrative case material; (9) provision for enforcement; and, (10) provision for continuing research to evaluate the effectiveness of the code developed (Hobbs, 1948).

A research plan was developed by the Committee-II that involved the collection of vignettes of situations involving ethical decision making. Each of the 7,500 members of APA was sent a letter asking them to describe (1) a professional situation that they had first-hand knowledge of that had ethical implications, and (2) the ethical issue they felt was involved (APA Committee, 1949; Golann, 1969; Hobbs, 1948). Over 1,000 responses were received that were then collated and classified into six categories: public responsibility, client relationships, teaching, research, writing and publishing, and professional relationships (Golann, 1969). Members of the Committee-II drafted general statements of standards in the six categories that were identified based on the various incidents that were submitted. A subcommittee made suggestions for revisions, and these drafts were further revised by the Committee-II and approved for Publication in tentative form in the American Psychologist for study and comment by the membership (APA Committee, 1951a, 1951b, 1951c, 1951d, 1951e, 1951f). This part of the process took 2.5 years. During the academic year 1951-52, discussions of the tentative code were held at
universities; psychological association meetings at local, state, and regional levels; and in various forums organized by APA (Golann, 1969).

Many members expressed opinions about the proposed code of ethics, and in 1952 a number of responses were published in the American Psychologist that expressed contrasting views. While most members favored a code of some sort and made recommendations for refining the proposed code, there were those who were opposed to a code altogether. For example, Calvin S. Hall thought that a code of ethics played "into the hands of crooks" and made those who were covered by the code "feel smug and sanctimonious..." (Hall, 1952, p. 430). Others, while generally supporting the code, felt it went too far in speaking of matters related to etiquette and good sense (e.g., Adkins, 1952; Hunt, 1952; Keegan, 1952). The Committee-II revised the code of ethics based on the suggestions received, and prepared a final revision to present to the APA governing body, the Council of Representatives.

On September 4, 1952 the APA Council of Representatives adopted for a three-year trial period the Ethical Standards of Psychologists as an official association policy (APA Committee, 1958). This 171-page document was divided into six independent sections, containing a total of 106 principles. It was published in 1953 as the Ethical Standards of Psychologists (APA, 1953), and had a companion casebook volume.

A new Committee on Ethical Standards (Committee-III) was appointed in 1955 to review the code and determine what revisions were necessary. Few complaints were received about the code, but those who did express dissatisfaction thought it was too long and included too many principles, many of which were thought to be nothing but
common courtesies (APA Committee, 1958). The Committee-III set about the task of reducing the length of the code, eliminating overlapping principles, and maintaining those principles related to ethical issues rather than those involving such things as common courtesies (APA Committee, 1958; DePalma, 1961). In June, 1958, after three years of work and nine revisions, the Committee-III presented for consideration to the APA membership a code with 18 major principles, with each principle followed by explanatory paragraphs (APA, 1958; Holtzman, 1960). Comments were solicited, considered, and incorporated into the revision approved by the Board of Directors of APA (APA, 1959) which were to be in effect for a three-year trial period. In 1963 this latter code was adopted by the Council of Representatives with some modifications (APA, 1963). Subsequently, the ethics code went through five additional revisions between 1963 and 1992 (APA, 1968, 1977, 1979, 1981a, 1990, 1992b), with these revisions not involving extensive surveys of the membership on ethical issues or critical incidents (Pope & Vetter, 1992). In 1981, the name of the code was changed to Ethical Principles of Psychologists, and in 1992 the name was changed again to Ethical Principles of Psychologists and Code of Conduct.

In addition to the Ethical Principles of Psychologists and Code of Conduct, numerous specialty guidelines have been developed. For example, specialty guidelines now exist for clinical, counseling, school, and industrial/organizational psychologists (APA, 1981b, 1981c, 1981d, 1981e, 1987): for the use of educational or psychological testing (APA, 1950, 1985); for the use of computer-based tests (APA, 1987); for research with human participants (APA, 1973a, 1982); for psychologists conducting growth
groups (APA, 1973b); on the use and care of laboratory animals (APA, 1986); for psychologists performing child custody evaluations in divorce proceedings (APA, 1994a); for providers of services to diverse populations (APA, 1993a); and an AIDS-related policy (APA, 1992a). The guidelines were prepared as “advisory” statements to the APA membership, and under no conditions were they to supplant the ethics code that was in existence at the time that these different guidelines were published (Morris, personal communication, 1995).

The most recent revision, “Ethical Principles of Psychologists and Code of Conduct” (APA, 1992b), was begun in 1986 and completed in 1992. This was a major revision, influenced in part by an increase in ethics complaints filed against psychologist members of APA as well as an increase in malpractice lawsuits against psychologists. In addition, the overly broad language of some of the 1986 ethical principles, with no clear distinction between aspirational goals and minimal standards, was felt to place the psychologist in a vulnerable position. Also, psychologists were now frequently performing some services, such as forensic evaluations, for which there was little guidance (Canter et al., 1994; Haas & Malouf, 1995; Nagy, 1994).

The 1992 Ethics Code was divided into unenforceable aspirational goals, which are contained in the preamble and General Principles, and enforceable minimal standards that are contained in the Ethical Standards (APA, 1992b; see Appendix A). Procedures were also adopted in November 1992 for future revisions of the code (APA, 1993b). This latter code is presently under the initial stages of revision, with a draft version of the revised code expected in 1999 (Morris, personal communication, 1996).
Social Work

Social work was established as a profession in the late 19\textsuperscript{th} century and began with a focus on the morality of the clients being served. R. C. Cabot defined social work in 1907 as "the attempt to understand and to mould faulty character" (Cabot, 1926). This point of view was later assailed by those who emphasized social and economic conditions as the source of individual problems. By the late 1940\textquotesingle s, there had been a significant change in the focus of social work, and concerns about morality and ethics were shifted from the client to the profession itself (Cabot, 1926; Reamer, 1987b, 1994).

The notion of the development of an ethics code for social work was first put forth by Van Kleeck and Taylor (1922). Some writers, however, questioned whether social work was in fact a profession versus a vocation, while others believed that social workers, based on their devotion to "ideals of service rather than to pecuniary reward" (Van Kleeck & Taylor, 1922, p. 167), were already ethical in their practice and did not need a code of ethics. Practicing social workers, however, were more frequently encountering situations that presented choices between conflicting ideals, and they wanted standards of conduct to assist them in making decisions regarding various dilemmas that they encountered (Levy, 1974).

Various social work organizations discussed and drafted codes of ethics, but it was not until 1947 that a national organization, The American Association of Social Workers (AASW), adopted a code of ethics (Johnson, 1955; Reamer, 1994; Yelaja, 1982). The code adopted by the AASW included principles of professional conduct in the
areas of community, the agency for which one worked, colleagues, clients, and the profession itself (Johnson, 1955).

The next development was the formation in 1955 of what is now the largest national organization representing professional social workers in the United States, the National Association of Social Workers (NASW: Wells & Masch, 1986). The governing body of NASW, the Delegate Assembly, adopted its first code of ethics in 1960, consisting of first-person proclamations and a preamble. The proclamations were concerned with issues such as privacy, giving precedence to professional responsibility over personal interests, and competence. The preamble stated the ideals central to the profession of social work, such as the responsibility to uphold humanitarian and democratic ideals, the furthering of professional knowledge and competence, and respect for the individual (NASW, 1967/1982).

The 1960 code was criticized for being too abstract and providing little guidance for resolving ethical conflicts. Additionally, there were no provisions for handling ethical complaints (McCann & Cutler, 1979; Reamer, 1987a). In 1967, the code was amended to include a provision requiring work toward the elimination of discrimination (NASW, 1967/1982; Wells & Masch, 1986), but no major changes were made in the code. A task force, directed by Charles Levy, was established by the NASW Delegate Assembly in 1977 to revise the code of ethics, with the objective being to make it more relevant to practice (Reamer, 1987a). This major revision of the NASW Code of Ethics was adopted in 1979 by the NASW Delegate Assembly and went into effect on July 1, 1980 (NASW,
The revised code, while maintaining the essence of the original 1960 code, provided guidelines for ongoing practice decisions (Yelaja, 1982).

The revised code (NASW, 1980) contained a preamble and 16 practice principles organized into six major sections. The preamble presented the purpose of the code, the social work values on which it was based, and the implementation of the code. The principles address the responsibilities and obligations of a social worker in six different areas: individual conduct and comportment as a social worker, to clients, to colleagues, to employers and employing organizations, to the social work profession, and to society as a whole. Some principles are concrete (e.g., not engaging in sexual conduct with a client), while others are abstract ethical ideals (e.g., acting to prevent practices that are inhumane or discriminatory).

The 1979 code was revised twice. The U. S. Federal Trade Commission, in 1986, began an inquiry into the policies of the NASW concerning possible restraint of trade due to certain statements in the code of ethics. As a result of this inquiry, principles applying to solicitation of clients from colleagues or one's agency were removed from the code of ethics, and the wording related to accepting compensation for making a referral was modified (Reamer, 1995a). Five new principles, three related to social worker impairment and two related to dual relationships, were added to the code of ethics in 1993 (NASW, 1993).

A task force was established in 1993 by the NASW Delegate Assembly with the task of substantially revising the code for submission to the Delegate Assembly in 1996 (NASW Code of Ethics Committee, 1995; Reamer, 1995b), and was adopted by elected
delegates in August 1996 ("Assembly adopts." 1996). The adopted revision (NASW. 1996) is substantially different from previous versions of the code of ethics. Specifically, it is divided into a preamble addressing the mission of the social work profession, a section on the purpose of the ethics code, six aspirational ethical principles, and the ethical standards, which are divided into six areas (See Appendix A).

Graduate Training in Ethical Practices

Until the 1960’s, ethics training in professional education was primarily left to informal instruction, supervisor-supervisee interactions, and/or modeling. It was felt that ethics could not be taught, but rather than one had to select ethical individuals to train and then model ethical behavior in training and supervision (Cabot, 1926; Handelsman, 1986b). In the mid-1960’s, society became concerned with professional accountability, and as a result, many practices of the mental health community (e.g., electroconvulsive therapy, involuntary commitment, and the provision of inadequate treatment in residential psychiatric institutions) came under close scrutiny (Appelbaum, 1988). Principle-based moral theories, as well as legal concerns, began to make inroads into professional ethics, influencing how professional ethical principles were codified, practiced and taught (Beauchamp & Childress, 1983; Haas & Malouf, 1995; Kitchener, 1984b; Ross, 1930).

Callahan and Bok (1980), project coordinators for the Hastings Center Project on the Teaching of Ethics, established four goals for ethics education: (1) stimulate the moral imagination, (2) facilitate the development of skills for analyzing moral issues, (3) elicit a sense of moral obligation and personal responsibility, and (4) enable the learner both to tolerate and resist moral ambiguity and disagreements. In professional schools
they maintained that the teaching of ethics should not only introduce students to the moral ideals and dilemmas particular to their professions, but should also assist them in understanding the relationship of the profession to the values of the larger society within which they work (Callahan & Bok, 1980).

**Psychiatry**

Current medical school accreditation requirements call for a committee that "shall advise on and monitor the... regular review of ethical, socioeconomic, medical/legal, and cost-containment issues that affect graduate medical education" (AMA, 1994b, p. 14). Additionally, psychiatry residency programs are required to teach about relevant ethical issues (AMA, 1994b). These requirements do not specify the method by which these issues should be addressed or the amount of time necessary to devote to them.

In the late 1960's, the first formal medical education programs were introduced on the teaching of humanities and human values, with such programs rapidly appearing in the 1970's in many medical schools in America. Currently, the teaching of medical ethics as part of a student's medical education has become almost universal across all medical schools (AMA, 1976; AMA, 1980; Pellegrino, Hart, Henderson, Loeb, & Edwards, 1985; Pellegrino & McElhinney, 1982; Veatch & Sollitto, 1976). The dominant approach, developed by Beauchamp and Childress (1983), has been the teaching of the four prima facie principles: beneficence, nonmaleficence, autonomy, and justice. Teaching methods include formally structured classes, seminars, rounds, and supervision during residency (Appelbaum & Reiser, 1981; Bloch, 1980; Culver et al., 1985; Goldman & Arbuthnot, 1979). Several authors have criticized recently the four-principle method (e.g., Clouser &
Gert, 1990; Holmes, 1990), with other methods being suggested, such as: virtue ethics, a
greater focus on actual cases, and casuistry (Abrams, 1979; Kuczewski, Wicclair, Arnold,
Pinkus, & Aumann, 1994; Pellegrino, 1993; Wildes, 1993).

Psychology

Since 1979, the American Psychological Association has required graduate
programs training professional psychologists that seek accreditation to offer instruction in
ethics, including familiarization with the APA ethics code that is current (APA Council.
1979). For a program to be accredited by APA, it must be in substantial compliance with
the accreditation criteria. Doctoral-level school psychology training programs, for
example, may be accredited by either the National Council of Accreditation of Teacher
Education (NCATE) and/or APA. NCATE adopted the training standards of the National
Association of School Psychologists (NASP) in 1976, which includes guidelines for
training in ethics (Jacob & Hartshorne, 1991). Currently, if a training program in school
psychology is APA accredited, it also becomes NCATE and NASP accredited (Morris.
personal communication, 1996).

The first specific course in professional ethics in psychology was offered in 1947
at the University of Ottawa (DePalma & Drake, 1956). In 1954, in a survey of graduate
psychology programs, DePalma and Drake (1956) found only 40% offered ethics training
either as a separate course or as a topic embedded in other courses. Two surveys of ethics
education in the 1970s (Jorgensen & Weigel, 1973; Tymchuk et al., 1979) indicated
increasing support for ethics instruction. By 1979, 55% of programs surveyed required an
ethics course of all students, and 96% reported some attention to ethics (Tymchuk et al.,
In a 1990 survey of APA-approved graduate psychology programs, all 129 respondents included ethics instruction in their curriculum. The primary format was a separate class and more than 50% allocated more than 30 hours to ethics instruction (Vanek, 1990). However, surveys devoted solely to ethics issues may get a biased response sample, with schools not offering ethics courses choosing not to respond. A 1987 review of curricula of doctoral programs in clinical psychology (O'Donohue, Plaud, Mowatt, & Fearon, 1989) found that only 67% of the 119 APA-approved programs reviewed offered courses in professional ethics.

Goals of ethics education in graduate psychology programs may include the development of a decision making process, an increasing sensitivity to ethical issues in professional activity, and a thorough understanding of the APA's Ethical Principles of Psychologists (APA, 1992b; Eberlein, 1987; Kitchener, 1984a; Vanek, 1990). As in medical ethics education, principle ethics as articulated by Beauchamp and Childress (1983) and by Kitchener (1984b), is the dominant approach. An emphasis is placed on sorting through the prima facie principles relevant in an ethical dilemma and application of the ethics code to professional responsibilities (Jordan & Meara, 1990).

**Social Work**

In its curriculum policy statement, the United States Council on Social Work Education (CSWE), the accreditation body for schools of social work, requires the inclusion of values and ethics content. Learning objectives are to be clearly organized and supported by an appropriate methodology (CSWE, 1992). The curriculum policy statement, first adopted by the CSWE in 1982 and most recently updated in 1992,
specifies content areas for educational programs granting MSW and BSW degrees (Barker, 1995).

Despite this mandate from CSWE, the proportion of social work education programs devoting specific course time to the area of ethics and values appears to be diminishing. The first survey of values education in social work schools was conducted in 1955 by Johnson (1955). She surveyed 28 member schools of the Council on Social Work Education in the United States and Canada, to determine the extent of direct instruction in ethics in social work education. Fifteen of the 27 schools (56%) that responded taught ethics as a special course. Of the 12 that did not have a separate class, all but one stated that ethics was taught in other courses or in fieldwork. A survey conducted 25 years later by Yelaja (1982) revealed that only 12 graduate schools in the United States and Canada had specialized courses on values and ethics. Most schools felt these topics were covered adequately in other courses. A 1989 survey of graduate social work programs (Black, Hartley, Whelley, & Kirk-Sharp, 1989) found that only seven of 73 programs offered a specific course on ethics.

Values and ethics education has long been controversial among social work educators. Among the reasons for this lack of consensus on values and ethics content in curriculum are a concern about mixing secular and religious matters, a fear of indoctrination of students, and a relativist view of moral principles (Bloch & Bonovich, as cited in Yelaja, 1982). Another stated concern, also cited in medicine and psychology (N. Koff, personal communication, December 28, 1995), is curriculum overload, with numerous concerns competing for coursework time (Berliner, 1989).
A periodical of the National Association of Social Workers. NASW News.
publishes a regular section focused on ethical issues and adjudication, with the purpose of familiarizing members with the ethics code and to illustrate the importance of careful, ethical professional practice (Berliner, 1989: "Board takes action," 1995). Fear of negative consequences, however, is not considered to be the primary motivator for ethical behavior, and graduate programs are encouraged by NASW to include teaching of the code of ethics, case examples for discussion, and decision making processes in their curriculum (Berliner, 1989; Hokenstad, 1987; Pope, Keith-Spiegel, & Tabachnick, 1986).

Research on Ethical Practices across Professions

Confidentiality

The confidential relationship between therapist and client is considered by many to be essential for an effective therapeutic relationship (e.g., Benedek, 1992; Everstine et al., 1980; Gustafson & McNamara, 1987; Jagim, Wittman, & Noll, 1978). Confidentiality and privacy, recognized as important in the doctor-patient relationship since before the time of Hippocrates (Lindenthal & Thomas, 1992), continue to be highly valued in society and expected of mental health professionals (Bersoff, 1995; Miller & Thelen, 1986; Smith-Bell & Winslade, 1994). Confidentiality is addressed in the ethics codes of the American Psychological Association (APA, 1992b), the American Psychiatric Association (ApA, 1993), the National Association of School Psychologists (NASP) and the National Association of Social Workers (NASW, 1996).

Although historically, confidentiality has been primarily a matter of professional ethics, it has also become incorporated into legislation and case law (DeKraai & Sales,
With respect to ethical practices, confidentiality refers to a promise or implied contract with the client that the therapist will not reveal what is learned in the course of the therapeutic relationship without first obtaining the client's informed consent (e.g., Jacob & Hartshorne, 1991; Shah, 1969). Legally, confidentiality statutes, designed as antigossip legislation, are included in the professional practices sections of most state regulatory statutes. In states with such statutes, the disclosure of confidential client information can result in civil or criminal liability in addition to professional reprimand (DeKraai & Sales, 1982).

A second type of law relating to confidentiality, privileged communication, prevents information disclosed in certain special relationships from being revealed in legal proceedings unless the patient or client authorizes such disclosure (DeKraai & Sales, 1982; Weisberg & Wald, 1984). Wigmore (1961) specified four criteria, which are deemed even today as essential in determining legal and ethical privileged communication:

1. The communications must originate in a confidence that will not be disclosed.
2. This element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties.
3. The relation must be one which in the opinion of the community ought to be sedulously fostered.
4. The injury that would inure to the relation by the disclosure of the communications must be greater that the benefit thereby gained for the correct disposal of the litigation (p. 527).

In Wigmore's widely accepted conceptualization, if any of these statements does not apply, it would negate the justification of privilege. Wigmore took a utilitarian perspective, as can be seen in his point #4 above, whereby the costs and benefits of an action are weighed to determine the ethical action.

Attorney-client and spousal privilege are grounded in common law, but all other confidential communications are privileged only when granted by statute (Weisberg & Wald, 1984). Psychiatrists gained privilege under the physician-patient state statutes, with New York being the first state to grant such privilege in 1828. Psychologists and social workers gradually gained privileged communication rights after World War II (Knapp & VandeCreek, 1987). Every state currently has some sort of privilege statute pertaining to communications between psychotherapists and patients (Knapp & VandeCreek, 1987). Due to a recent United States Supreme Court ruling, confidential communications between a licensed psychotherapist and a client during the course of evaluation or treatment are protected from compelled disclosure in federal courts as well as in state courts (Seppa, 1996).

The type of privilege and to whom it is granted varies from state to state (DeKraai & Sales, 1982). Privileged communication statutes protect mental health professionals from being compelled to divulge information obtained during the provision of services unless the information is exempt from privilege (DeKraai & Sales, 1982). However,
privilege belongs to the client, and once the client has either waived privilege or compromised it, the relevant testimony must be provided (Shah, 1969).

Despite its elevated status, the duty of confidentiality is not inviolable. Numerous pressures, some legal and some practical, infringe on a professional's ability to maintain confidentiality. Practical issues include third party payment systems, access to information by office personnel and team members, information shared in group and family therapy sessions, the transfer of records due to client mobility, e-mail and cellular telephone communications, and computer storage and transfer of client information (Benedek, 1992; Bok, 1982; DeKraai & Sales, 1984; Morris, 1996). Legal infringements on confidentiality include statute and case law concerned with the "duty to warn or protect," as well as other mandated reporting laws (e.g., Child Abuse, 1974; Tarasoff v. Regents of the University of California, 1976).

In balancing the right of the individual to absolute secrecy against the safety rights of society, the institution of law is likely to take the utilitarian view of the greatest good for the greatest number (e.g., Lindenthal & Thomas, 1992). Among mental health professionals, many believe that confidentiality should be absolute (e.g., Roth & Meisel, 1977; Siegel, 1979), others have accepted certain exceptions as necessary for the protection of the individual and society (e.g., Appelbaum, 1985; Bok, 1982), and some believe the breaching of confidentiality can be therapeutically useful (e.g., Carlson, Friedman, & Riggert, 1987; Taylor & Adelman, 1989).
Professional Views of Confidentiality

Surveys of mental health professionals have consistently shown that confidentiality is considered to be essential in developing and maintaining an effective therapeutic relationship, and is seen as an important, perhaps the most important, ethical responsibility (e.g., Crowe, Grogan, Jacobs, Lindsey, & Mark, 1985; Jagim et al., 1978; Lindenthal, Amaranto, Jordan, & Wepman, 1984; Lindenthal & Thomas, 1980, 1982).

In an early survey study concerning psychiatric ethics, Little and Strecker (1956) sent 67 questionnaires to their colleagues in Philadelphia, and received 38 usable responses. The questionnaire consisted of nine vignettes, chosen from actual occurrences in psychiatric practice, which primarily concerned the breaking of confidentiality for societal good. They received diverse responses, with many psychiatrists indicating a willingness to breach confidentiality in a variety of cases. The authors defined privileged communication as "the doctor has the privilege of deciding whether or not he will reveal to others what is said to him in confidence" (p. 458). This study, which was carried out prior to the Tarasoff ruling and the passage of mandatory reporting laws, suggests that many psychiatrists accepted the idea of societal interest impinging on absolute confidentiality.

Wiskoff (1960) conducted a similar study with psychologists. He surveyed 501 Associates and Fellows in the Clinical, Counseling, and Industrial Psychology Divisions of the American Psychological Association and obtained a return of 73.6% (n = 369). The survey instrument consisted of 22 vignettes, each involving a situation of divided loyalty conflict between a client and society. Three of the vignettes, in the opinion of the author,
presented incidents of imminent danger constructed around the themes of treason, homicide, or suicide. The ethical standards current at the time of the study (APA, 1953) stated that information should be released to the proper authorities in situations where the psychologist, in the course of treatment, became aware of clear and imminent danger to an individual or society. The results showed that the determination to release information regarding a homicide incident was 64% of the sample, 45% of the sample for the treason incident, and 42% for the suicide incident. Wiskoff attributed the lack of agreement among the participants as a lack of ethics training, which resulted in an ignorance or nonconformity to APA principles, diverse interpretations of the vignettes, and/or difficulty in determining what signifies clear and imminent danger.

Jagim et al. (1978) surveyed mental health professionals in North Dakota concerning their knowledge of and attitudes toward confidentiality, privilege, and the disclosure of information to third parties. The sample included psychiatrists (n = 13), psychologists (n = 29), social workers (n = 15), and seven other mental health professionals (five counselors and two “others”) for a total of 64 responses from 100 mailings. Ninety-eight percent of those surveyed agreed that confidentiality was an essential ingredient in a therapeutic relationship and that there was a professional and ethical obligation to maintain confidentiality. Ninety-five percent felt that patients or clients expected their communications would be held in confidence by the therapist. However, a majority of respondents indicated they would disclose confidential information in the case of duty to warn (76%) and mandatory reporting situations (63%). The results also showed confusion on the part of the participants regarding the meaning
of privilege. with one-half of the respondents indicating a belief that privilege belongs to
the therapist rather than the client.

After the enactment of a psychotherapist-patient privilege statute in Texas in
1979, Shuman and Weiner (1982) examined two opposing assumptions about
psychotherapist-patient privilege that had been the subject of debate: that effective
therapy cannot take place in the absence of privilege, and that the judicial process is
seriously undermined by the granting of privilege. To examine the validity of these
assumptions, questionnaires were administered to patients, laypersons, judges, and the
186 members of the North Texas Psychiatric Society. Of the 84 therapists who responded
to the questionnaire (a response of 45%), 55% were unaware of the existence of a
privilege statute. Only 22% (n = 16) felt that their patients limited disclosures during
therapy due to the status of confidentiality in Texas. Additionally, of the patients who
responded to the survey (n = 79), 91% indicated that the existence of privilege did not
influence their decision to seek therapy. Shuman and Weiner concluded that, contrary to
the assertions of advocates of psychotherapist-patient privilege, only a small percentage
of individuals consider the existence of privilege in making decisions about seeking
psychiatric treatment. Through interviews with 48 state and federal judges in Dallas
County Texas, the author concluded that the number of judicial cases in which relevant
evidence is excluded is small.

In a sample of psychiatrists (n = 200), psychologists (n = 92), and internists (n =
147) in New Jersey, representing a 41% survey response, Lindenthal and Thomas (1980)
found that attitudes toward confidentiality were affected by professional training and
clinical orientation. Internists were found to be the most willing to break confidentiality when confronted with a potentially dangerous situation, and psychologists were the least likely. Among psychologists and psychiatrists, those who espoused a psychoanalytic orientation were the least willing to break confidentiality.

Limits of Confidentiality

Researchers have investigated the impact of the limits of confidentiality on perceptions of counselor trustworthiness and on self-disclosure. Most studies have been based on simulations of therapy (e.g., Kobocow, McGuire, & Blau, 1983; Merluzzi & Brischetto, 1983; Muehleman, Pickens, & Robinson, 1985; Woods & McNamara, 1980), or surveys of professionals (e.g., Jagim et al., 1978), or on data from current or former mental health patients (e.g., McGuire, Toal, & Blau, 1985; Miller & Thelen, 1986; Taube & Elwork, 1990). In one study, Merluzzi & Brischetto (1983) investigated the impact of confidentiality limits on perceptions of counselor trustworthiness. They had 200 male undergraduates listen to audiotaped counselor-client interactions that ended in either a decision by the counselor to breach or to maintain confidentiality. An ANOVA of trustworthiness revealed a "confidentiality by problem seriousness" interaction that indicated that with increasingly serious client problems, the breaching of confidentiality was associated with significantly lower ratings of trustworthiness as compared with all other conditions (e.g., confidential condition, moderately serious problem condition).

In an interview analogue study involving 60 undergraduate students, Woods and McNamara (1980) found that instructions regarding confidentiality prior to the interview had a very strong effect on the depth of self-disclosure. In contrast, Muehleman et al.
(1985), found little evidence of significant inhibition of disclosure when detailed information about the limits of confidentiality was provided. In a study involving 90 junior high school students, Kobocow et al. (1983) also found that varying degrees of assurance of confidentiality had little impact on the frequency of self-disclosure. However, in a follow-up questionnaire, 60% of the students listed assurance of confidentiality as being one of the statements made prior to the interview, when in fact, only one third of the interviewees was given such an assurance. This suggests that these participants have been socialized to believe that confidentiality exists in such relationships.

In a study by Schmid et al., 1983, involving 30 inpatients at the Western Psychiatric Institute and Clinic in Pittsburgh, it was found that confidentiality was highly valued by the patients and that they felt their relationships with staff members were improved by the knowledge that communications were confidential. Information for the study was obtained by interviewing all patients who were preparing for discharge during a four-week period. Although this study involved a small, homogeneous client population, it adds support to the contentions of psychotherapists about the importance of confidentiality in the therapeutic relationship.

While some studies exploring the effects of confidentiality and privilege on the therapeutic relationship have shown that assurances of privacy have little effect on disclosures in therapy (e.g., Kobocow et al., 1983; Muehleman et al., 1985; Shuman & Weiner, 1982), others have indicated that the assurance of privacy does have an effect on self-disclosure (e.g., McGuire et al., 1985; Merluzzi & Brischetto, 1983; Woods &
McNamara, 1980). Taube and Elwork (1990) felt that conflicting evidence about the importance of confidentiality in the therapeutic relationship was due to the wrong question being asked. Rather than asking whether privacy is always important, they felt the question was: to whom is privacy important and under what circumstances. Adult psychotherapy outpatients were administered a questionnaire concerning the extent to which they would be self-disclosing about a number of issues. Taube and Elwork found that willingness to self-disclose was affected by two factors: the extent to which patients were informed about the law, and the extent to which the law was consequential to them.

Two studies assessed the public's knowledge and attitudes regarding the confidentiality of therapeutic communications. McGuire et al. (1985) surveyed 50 outpatients, 26 inpatients, and 50 adults who had never received mental health services. They found that all subjects, and particularly inpatients, valued confidentiality and expected it in their communications with therapists. Miller and Thelen (1986) found that the general population saw confidentiality as very important in therapy, and were generally unaware of limitations to confidentiality. Of those surveyed, 74% felt there should be no exceptions to confidentiality.

Children and Confidentiality

The ethical and legal responsibilities of a therapist working with a child or adolescent client are often ambiguous. Although the Supreme Court has established that children are entitled to basic constitutional rights (e.g., In re Gault, 1967; Planned Parenthood v. Danforth, 1976), these rights have been construed as narrower than those of adults (e.g., Bellotti v. Baird, 1979; Parham v. J. R., 1979). Thus, it is unclear when a
particular minor (typically under 18 years-of-age) is considered competent to make
decisions and when decision making powers are left to the parent or the state (Nurcombe
& Partlett, 1994).

The rights of minors involving confidentiality are tied to their right to consent to
treatment. It has been argued that the parental right to authorize treatment implies the
right of access to confidential communications (Myers, 1982). Laws giving some minors
the legal authority to consent to treatment and/or to control confidentiality rights, vary
amongst jurisdictions, and there are no clear criteria for determining when an
unemancipated minor is competent (Arambula et al., 1993; Nurcombe & Partlett, 1994).
The American Psychiatric Association (ApA Task Force, 1979) has suggested that 12
years-of-age be used as a benchmark for authorizing release of confidentiality
information. Grisso and Vierling (1978), after a review of the cognitive developmental
literature, concluded that minors of 15 years-of-age and above, as a group, are competent
to provide consent.

An exploratory investigation by McGuire (1974) of the attitudes and practices of
mental health professionals regarding confidentiality issues in the treatment of children,
found a trend toward maintaining the same degree of confidentiality with children as with
adults. Responses to each of the 25 questions spanned the entire range in a modified
Likert scale, four-choice format (strongly agree to strongly disagree), indicating a
diversity of opinion and practice among professionals in the two-state area surveyed.
McGuire suggests that this finding was due to the lack of a set of guidelines with regard
to the notion of confidentiality in psychotherapy with children.
Melton (1981) surveyed community mental health clinics in Virginia after the passage of a statute that gave minors the right to consent to mental health treatment. The area of confidentiality was found to be the most unclear after passage of the new law. When children were brought for treatment by their parents, 51.2% of the clinics gave parents access to materials from the child's therapy session; however, when the minor sought treatment independently, 53.7% of the clinics did not provide such information. Messenger and McGuire (1981) interviewed 39 children aged 6 to 15 years, who were receiving outpatient therapy, and asked them about their conception of confidentiality in the psychotherapeutic relationship. The researchers concluded that a child's conception of confidentiality evolves gradually into one consistent with those guidelines for maintaining confidentiality with adult clients. They suggested that ethical guidelines be made more specific in regard to children in therapy, clearly identifying the conditions under which confidentiality for children should be granted the same status as that of adults, and stating those conditions under which it should be modified. Additionally, they indicated that clarification is needed in regard to access to children's records by parents or guardians.

Rae and Worchel (1991) conducted a survey of the ethical beliefs and behaviors of pediatric psychologists. A survey questionnaire modeled after that used by Pope et al. (1987) regarding adult clients, was mailed to 300 randomly selected psychologists who were members of both the Society of Pediatric Psychology and the APA. They obtained 169 responses (56.3%). Psychologists were asked to rate 101 behaviors about the extent to which they engaged in the behavior and the extent to which they considered the
behavior ethical or unethical. Significant differences were found for breaking confidentiality under various conditions and circumstances, such as age of client, type of illegal activity, and self-destructive versus other-destructive conditions. There was a significant trend to believe confidentiality could be breached for children more than for adolescents. In the case of adolescent substance abuse, psychologists were more likely to break confidentiality if an adolescent was using intravenous drugs (49%) than if he or she was using alcohol (27%), marijuana (18%), or tobacco (13%). In all types of substance abuse, children were more likely to have such abuse reported to a third party. An overwhelming 95% of the respondents felt it was ethical to break confidentiality to report child abuse and to reveal that a client was homicidal, and 93% felt it was ethical to reveal a client was suicidal.

Reporting Laws

There are two major types of reporting laws: child abuse reporting laws and duty to protect reporting laws. Each imposes an affirmative duty on psychotherapists to reveal confidential information obtained in therapy in order to provide protection for a putative victim. Two constructs associated with ethical principles, “beneficence” and “confidentiality,” are involved in both the duty to protect and child abuse reporting laws. The justification for these mandates, which necessarily involve the breaching of confidentiality, is based on the utilitarian principle of “calculation of effects.” Although confidentiality is a prima facie duty, in select cases the balance shifts in favor of the duty to act beneficently. As stated by Justice Tobriner in the Tarasoff (1976) decision, “Protective privilege ends where the public peril begins” (p. 347).
Mandatory reporting laws.

The general purpose of mandatory child abuse reporting laws is to protect children by preventing further abuse of a victim, to facilitate the provision of treatment for children who have been abused, and to deter future abuse through the punishment or rehabilitation of the abuser (Smith-Bell & Winslade, 1994). In 1963, the American Humane Association and the United States Children's Bureau presented model mandatory reporting statutes that they had developed (Hutchinson, 1993). That same year, California became the first state to enact a mandatory reporting law that required specified persons to report suspected child abuse (Cunningham, 1984). Currently all 50 states, the District of Columbia, Samoa, Guam, Puerto Rico, and the Virgin Islands have such reporting laws; however, the definitions of reportable abuse and neglect, the age limit of the avowed victim, the categories of mandated reporters, and penalties for failure to report vary amongst jurisdictions (Heymann, 1986). In 1994, over three million reports were made to Child Protective Services agencies across the United States (Daro, 1995), with mandated professionals accounting for approximately half of those reports (Anderson et al., 1993).

Immunity from civil or criminal liability for reporting is provided in all states, and in 45 states failure to report can result in criminal penalties (Heymann, 1986). Despite conflicting opinions (e.g., Agatstein, 1989; Ansell & Ross, 1990; Guyer, 1990; Smith & Meyer, 1984; Smith-Bell & Winslade, 1994), professional organizations have endorsed reporting laws as necessary for the protection of children, and compliance with reporting laws is considered to be consistent with ethical practices (AMA, Council, 1992b; APA,

Research into compliance with reporting laws have drawn survey samples from a range of sources of mandated professionals, and with few exceptions (e.g., Lamond, 1989; Morris, Johnson, & Clasen, 1985), such studies have been conducted through anonymous mailings. Samples drawn from professional organizations (e.g., Finlayson & Koocher, 1991; Kennel & Agresti, 1995; Swoboda et al., 1978), or from limited geographic regions (e.g., Beck & Ogloff, 1995; Kalichman et al., 1989; Swoboda et al., 1989; Wilson & Gettinger, 1989) may not be representative of non-association members or of other geographical areas, thus limiting generalizability. Additional threats to external validity are the relatively low rate of return that is typical of mail-out questionnaires, i.e., the average return being between 15 and 60 per cent, and the associated difficulty in obtaining and analyzing nonrespondent data (Kerlinger, 1973).

Researchers have attempted to identify reasons for the relatively low rates of compliance with reporting laws. For example, an early study of mental health professionals in Nebraska (Swoboda et al., 1978) found that a significant portion of respondents were ignorant of basic laws relating to privileged communication and the reporting of child abuse. More recent studies, however, have found a high degree of
knowledge concerning reporting responsibilities (e.g., Beck and Ogloff, 1995; Kalichman et al., 1989; Zellman, 1990).

Beck and Ogloff (1995), for example, in a study of psychologists in British Columbia, found that the primary reason for failure to report was a perceived lack of sufficient evidence. This desire for supporting evidence before reporting suspected abuse has also been found in studies by Brosig and Kalichman (1992), Kalichman and Brosig (1993), Finlayson and Koocher (1991), and Zellman (1990). Other factors found to be significant in reporting decisions have included sex of professional (Finlayson & Koocher, 1991; Kennel & Agresti, 1995), the professional's theoretical orientation (Nicolai & Scott, 1994), expectations concerning the effect of filing a report (Kalichman et al., 1989; Zellman, 1990), admission or denial of abuse by the accused father (Kalichman et al., 1989), and the age of the victim (Kennel & Agresti, 1995).

Duty to warn/protect laws.

In 1974 the California Supreme Court, in the Tarasoff case, established that therapists had a legal duty to warn potential victims of possible violence by a patient. Two years later, in reaction to the intense controversy created by the decision (see Gurevitz, 1977), the California Supreme Court re-reviewed the case and modified its decision. In the 1976 decision, the court held that the duty was to protect, rather than warn, the intended victim, which opened the door to a wider variety of options. Thus duty to warn means one is required to warn the intended victim, whereas the duty to protect may require various steps. Depending on the nature of the case, in addition to warning the victim, the duty to protect notion means the professional could also call the police, or
arrange for hospitalizing the potentially violent patient. As with child abuse reporting
laws, the legal duty to protect, which extends to those patients who are at risk for injury
to themselves, is considered ethical practice and is included in the adopted ethical
fact, the ethical guidelines of the American Psychiatric Association, the American
Psychological Association, and the National Association of Social Workers each
explicitly stated prior to the Tarasoff ruling that confidentiality could be compromised to

Wise (1978) conducted a survey of psychiatrists (n = 1,272) and psychologists (n
= 179) in California to determine the effect of the new duty-to-protect legislation on the
practice of psychotherapy. Questionnaires were mailed approximately one year after the
second Tarasoff decision to a sample of state-licensed psychologists and to the total
membership of the California Psychiatric Association. A response of 34-35% was
obtained with the results revealing that the majority of respondents did not discuss
confidentiality with their patients and believed that patients would be inhibited by the
knowledge that confidentiality might be breached. Nevertheless, almost 70% of the
therapists who responded believed that there were situations that justified the breaching
of confidentiality. Therapists reported that they experienced more anxiety when violence
was brought up during therapy than they had prior to the Tarasoff ruling, that they had
increased their efforts to assess violence, and it appeared they had warned more potential
victims.
In a departure from the anonymous survey method, Beck (1982) used a semistructured interview with psychiatrists in the Boston area with whom he was personally acquainted, to determine the impact of the Tarasoff ruling on the practice of psychotherapy. Of the 38 psychiatrists interviewed, 42% had been involved in a case in which a warning was given, and an additional 32% had considered giving a warning but found another method to resolve the potentially violent situation. In only four cases was the warning considered to have a negative impact on the therapeutic relationship, and in these cases the warning was either not discussed first with the patient, or was later considered to be unwarranted. In the other 14 cases, the impact was considered to be positive (n = 2) or no impact was apparent (n = 12). This study was limited to academic psychiatrists who Beck hypothesized may be more comfortable with the duty to protect than private practitioners, due to the ready availability of colleagues with whom to discuss difficult cases, and the network of services available to them in their work settings. This limited the external validity of the results; however, the internal validity of the study was enhanced by the discussion of actual cases rather than by relying on hypothetical vignettes.

Bowers, Givelber, and Blitch (1986) examined the impact of the Tarasoff ruling on psychotherapeutic practice, surveying the perceptions and beliefs psychotherapists held about Tarasoff, and their reported behavior in response to the Tarasoff ruling. They sent questionnaires to 1000 members each of the American Psychiatric Association, the American Psychological Association, and the National Association of Social Workers, located in the eight largest metropolitan areas in the United States. They had a response
of 57%, with responses evenly distributed geographically. In 1980, when the survey was carried out, only a small percentage of respondents had not heard of Tarasoff or "a case like it." Respondents widely misinterpreted the duty associated with the Tarasoff ruling as requiring a therapist to warn a potential victim, whereas the requirement is for the therapist to exercise "reasonable care" to protect a potential victim. In addition to warning a potential victim, many respondents also believed they were required to notify other third parties, such as family members or police. The authors noted a growing acceptance amongst mental health professionals, both in California and in other states, of the obligation to protect potential victims, accepting it as both legally and ethically binding. By 1987, fewer than 10% of psychologists surveyed by Pope, Tabachnick and Keith-Spiegel viewed the breaking of confidentiality as unethical in order to prevent violence.

By 1988, as a result of the growing number of reported cases of Acquired Immune Deficiency Syndrome (AIDS) and the Human Immunodeficiency Virus (HIV), conceptual articles and guidelines for practitioners concerning ethical treatment of AIDS/HIV clients began appearing in the literature (e.g., APA, 1986; Dyer, 1988; Gray & Harding, 1988; Kain, 1988; Lamb, Clark, Drumheller, Frizzell, & Surrey, 1989; Morrison, 1989; Perry, 1989; Reamer, 1991). Lamb et al. (1989), for example, used the Tarasoff ruling as a framework for decision making in AIDS-related cases, where consideration was given to breaking confidentiality to protect third parties from infection. Despite the apparent similarity of AIDS/HIV cases to other duty-to-warn/protect cases, the courts have not yet clearly resolved whether Tarasoff applies (Harding, Gray, & Neal,
Dyer (1988) argued that applying a legal solution to such dilemmas ignored the moral ambiguity inherent in individual cases, and did not advance the social goal of protecting the vulnerable individual. Perry (1989) also argued against the application of Tarasoff to HIV/AIDS cases, maintaining that ultimately, strict confidentiality in the treatment of such patients would better serve the public interest. In addition, psychotherapists need to be aware of their own state law regarding HIV-positive patients, as in some states disclosure of HIV status is prohibited.

There is as yet little empirical evidence pertaining to the actual practice of mental health workers regarding warning of third parties in AIDS/HIV cases. For example, Trotten, Lamb, and Reeder (1990) investigated two variables, degree of dangerousness and identifiability of victim, as they related to a clinician's determination to break confidentiality in AIDS-related situations. Questionnaires were mailed to 1000 members of the American Psychological Association (Members of the Division of Clinical Psychology and the Division of Psychotherapy), and 241 usable responses were obtained (24% response). Decisions to breach confidentiality were highly related to perceived degree of dangerousness, and, to a lesser degree, to the identifiability of the victim. Clinicians who had previous contact with AIDS patients in psychotherapy were less likely to consider breaking confidentiality than those who had not had such contact. The generalizability of this study is limited by the low return (24%). Given that 52% of the respondents reported previous professional contact with AIDS patients, one might speculate that those with such contact might have been more motivated to respond.
As part of a larger survey of pediatric psychologists, Rae and Worchel (1991) asked whether psychologists felt it was ethical to report that a sexually promiscuous adolescent had AIDS. A significant number of respondents, 31%, were unsure of what they should do. Breaking confidentiality was endorsed by 47% of the respondents, versus 22% who felt it would not be ethical to do so.

McGuire, Nieri, Abbott, Sheridan, and Fisher (1995) investigated two factors in relation to AIDS patients: homophobic attitudes and degree of dangerousness. Questionnaires were sent to 1,800 in-state licensed psychologists identified through the Florida Psychological Association. Florida requires completion of a continuing education course on HIV-AIDS for obtaining or renewing a professional psychology license, has a strong legal stance on the protection or privacy of HIV-positive individuals, and, under certain conditions, allows licensed psychotherapists to warn partners of HIV-positive clients. A return of 36% was obtained, of which 625 responses were usable for analysis. Of this sample, 67% indicated direct experience with HIV-positive clients. Consistent with the results obtained by Totten et al. (1990), degree of probable dangerousness was significantly related to the likelihood of breaching confidentiality. Although the overall homophobia scores for this sample were low, increases in homophobia scores were significantly linked to an increased likelihood to breach confidentiality in AIDS-related cases.

Studies of physicians (Kelly, Lawrence, Smith, Hood, & Cook, 1987) and clinical/counseling psychologists and social workers (Crawford, Humfleet, Ribordy, Ho, & Vickers, 1991; O'Hare, Williams, & Ezoviski, 1996) have revealed that practitioners in
these groups hold negative and biased attitudes towards homosexuals and people with AIDS/HIV. Given that these views are also prevalent in the larger society (Herek & Glunt, 1988), the importance of privacy rights is heightened by the likelihood of discrimination against these individuals.

The American Psychiatric Association (APA, 1986; APA Ad Hoc Committee on AIDS Policy, 1988), the American Psychological Association (APA, 1992a), the American Medical Association (AMA, 1987; AMA Council on Ethical and Judicial Affairs, 1988), and the National Association of Social Workers (NASW Delegate Assembly, 1990), have adopted policy statements regarding the treatment of AIDS/HIV patients. All stress the need for strict adherence to confidentiality standards, but also recognize that confidentiality may need to be breached in certain, compelling situations. The American Psychiatric Association stresses that all other alternatives need to be addressed before the breaching of confidentiality, but do not delineate what those alternatives might be (APA Ad Hoc Committee, 1988). The National Association of Social Workers (NASW Delegate Assembly, 1990) recommends that agencies establish clear guidelines for their workers in regard to the responsibility to warn third parties of the potential for infection, and suggests that these guidelines be based on the NASW Code of Ethics and the duty-to-protect principle established by Tarasoff (1976). The American Psychological Association’s policy statement related to confidentiality and HIV (1992a) makes recommendations for relevant legislation, but does not offer specific guidelines for practitioners.
Multiple Relationships

A multiple relationship occurs whenever a nontherapeutic secondary relationship develops between the therapist and the client. The secondary relationship could be social, financial, professional, or sexual, and may be concurrent or consecutive. Multiple relationships often cannot be avoided completely, particularly in small and or rural communities, and are not necessarily unethical. When evaluating the conflicts of multiple relationships, the practitioner must consider the power differential in the relationship, the possibility of exploitation of the client and the therapeutic relationship, confidentiality, and the possible negative impact on clinical decision making (Haas & Malouf, 1995; Morris, 1993).

Sexual relationships with current clients are explicitly prohibited in the ethics codes of the American Psychiatric Association (APA, 1993), the American Psychological Association (APA, 1992b), and the National Association of Social Workers (NASW, 1996). Sexual intimacies with former clients are prohibited by the APA and NASW ethics codes, and are discouraged but not prohibited two years after the cessation of therapy in the APA ethics code. The current ethics codes of the APA and the NASW also prohibit the acceptance of former sexual partners as clients. Additionally, the newly adopted NASW ethics code prohibits sexual contact with a client's relatives or individuals with whom the client maintains a personal relationship (NASW, 1996). Nonsexual dual relationships are addressed in the ethics codes of the APA and NASW, but not in the ethics code of the APA. The NASW ethics code warns against "relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client"
(NASW, 1996, §1.06c). The APA ethics code (1992b), while recognizing that multiple relationships may be difficult to avoid in certain communities, discourages such relationships: "... if it appears likely that such a relationship reasonably might impair the psychologist's objectivity or otherwise interfere with the psychologist's effectively performing his or her functions as a psychologist, or might harm or exploit the other party" (§1.17). This new wording of the standard has been criticized by Sonne (1994) as being nonspecific and leaving a large loophole for the unscrupulous practitioner.

Most research and commentary involving multiple relationships has focused on sexual relationships between therapists/physicians and their respective adult patients or former patients (e.g., Akamatsu, 1988; Appelbaum & Jorgenson, 1991; Bates & Brodsky, 1989; Bouhoutsos et al., 1983; Gartrell et al., 1987; Kardener, Fuller & Mensh, 1973; Pope, 1990; Pope et al., 1986; Pope Levenson, & Schover, 1979). The degree to which such sexual intimacies involve minor clients has been explored in a study by Bajt and Pope (1989). They surveyed 100 senior psychologists (obtaining a 90% return), asking for instances of sexual intimacies between a therapist and a minor client that they had personal knowledge of through their professional work. Twenty-two of the 90 respondents reported having knowledge of such cases involving minors, with a total of 81 incidents reported. Male patients were involved in 56% of the incidents, with the ages of the patients ranging from 7 through 16 years of age. In a survey of pediatric psychologists, Rae and Worcel (1991) asked about being sexually attracted to a child, and about hugging and kissing children, adolescents and parents of clients. Sexual attraction to a child was reported by 3% of the respondents; 25% of the respondents
reported being rarely or sometimes attracted to an adolescent, and 45% reported being sexually attracted rarely or sometimes to a parent. Attitudes toward hugging and kissing clients was clearly influenced by age, with a majority reporting such behavior was acceptable with children, but less acceptable with adolescents. No questions were asked concerning sexual activity with children and adolescents. Becoming sexually involved with a parent of a former client was rated as unequivocally unethical by 69% of the respondents.

In a review of the research of therapist-patient sexual involvement, Pope (1990) identified patterns in the data. The predominant pattern in therapist-patient sexual involvement is a male therapist with a female patient. Among those admitting sexual involvement with a patient, percentages ranged from a low of 85% male versus 15% female in a study by Holroyd and Brodsky (1977) to a high of 96% male versus 4% female in a study by Bouhoutsos et al. (1983). Additionally, male practitioners are far more likely than female practitioners to engage in and endorse both sexual and nonsexual dual relationships. Sexual involvement typically involves a patient significantly younger than the therapist, with an average age difference of 10 to 12 years between them. Borys and Pope (1989) found no significant differences in the rates of involvement among psychologists, psychiatrists, and social workers.

Pope and Vetter (1992) collected descriptions of ethically troubling or challenging incidents from a random sample of 1,319 members of the American Psychological Association. They received responses from 679 psychologists (response of 51%) describing incidents in 23 categories. The maintenance of clear therapeutic boundaries
(not including sexual issues) was the second most frequently described category (17% of the incidents). The authors felt the incidents were indicative of a lack of clarity concerning multiple relationships in the ethics code that was current at the time (APA, 1989); that the ethics code failed to recognize the special difficulties of those working in small communities; and that it did not distinguish between incidental contacts and secondary relationships.

In an exploratory study, Anderson and Kitchener (1996) attempted to identify the types of nonromantic, nonsexual relationships that may occur between psychotherapists and former clients. They asked psychologists (63 responses, 20% of total sample) to describe up to three instances of a nonromantic nonsexual relationship between a psychologist and a former client, and were asked how they viewed each incident ethically. They obtained a total of 91 usable critical incidents. Due to the low response, they drew only tentative implications from the data. A wide variety of incidents were described, many of which involved circumstantial contact. The majority of incidents described were considered by the respondents to be ethical. For example, having a former client join the church the therapist attends, or incidental encounters at social events. This differed from findings in the Borys and Pope study (1989) in which the majority of respondents stated that posttherapy relationships were rarely or never ethical. The authors speculated that this discrepancy could be due to idealistic responses on surveys concerning how one should act versus evaluation of actual incidents. Posttherapy nonsexual relationships are not addressed in the current APA ethics code (APA, 1992b).
The problem of multiple relationships involving therapists working with minor clients has not been adequately addressed in the research literature. In addition to the minor client, the therapist must consider relationships with the client's family or guardians, conflicting professional roles (i.e., forensic services), and nonprofessional roles in activities that might involve the client or the client's family, such as sports activities or business dealings (Morris, 1993). Rae and Worchel (1991) included items involving dual relationships in their survey of pediatric psychologists. The majority of respondents considered it unethical to provide therapy for the child or adolescent of a friend, to accept a gift of considerable value from a minor client, or to be sexually attracted to a minor client. Accepting a gift of minimal value was considered to be ethical practice by the majority of respondents.

**Competence**

Professional activity should only be engaged in within the bounds of one's experience, training, and ability. The mental health professional is responsible for recognizing and communicating accurately to others his or her limitations as well as areas of competence (Corsini, 1994). Additionally, the therapist must have the judgement to determine to whom such skills should be applied, and under what circumstances (Haas & Malouf, 1995).

The therapist is primarily responsible for determining whether he or she is competent in a particular area. What may appear to be an adequate training and competence level to some may seem inadequate to others. In a vignette study by Haas et al. (1986) ethical dilemmas which involved competence issues had the lowest consensus
on the appropriate ways to handle such problems as compared to other ethical dilemmas. Respondents were asked whether knowledge of the general principles of sex therapy was sufficient to establish competence in that area. Respondents were divided on what determined competence in the situation, with about half feeling that in these circumstances a client requesting sex therapy should be referred to another therapist, and about 45% feeling it was adequate to discuss one’s qualifications with the client and allow them to determine the therapist’s competence. About 3% of the ethical dilemmas submitted in a national survey of members of the American Psychological Association (Pope and Vetter, 1992) involved competence issues, including professionals who did not keep their skills and knowledge base current, and concern about recognizing one’s own limits of competence. Additionally, from 1992 to 1993, 42% of the cases opened by the APA Ethics Committee for investigation of complaints concerned the psychologist’s failure to practice competently (APA, 1993b, 1994b).

Knowledge of one’s own belief system and personal prejudices and stereotypes, as well as the belief systems of clients, is also a component of competence (Cayleff, 1986). The American Medical Association (1987) and the American College of Physicians (1988), for example, have declared the refusal by physicians to treat HIV-infected persons to be a violation of professional ethics. Melton (1988), however, has suggested that such universal mandates may not maximize social benefit due to homophobic attitudes and lack of adequate qualifications of health care providers. For example, Sobocinski (1990) recommends that psychologists who have internalized homophobic attitudes refrain from entering into therapy with gay and lesbian clients.
Professional effectiveness may also be compromised by the therapist's emotional health, substance abuse, or own personal problems. Psychologists and social workers are specifically mandated by their respective ethics codes to take remedial action if their own professional performance is compromised by personal problems (APA, 1992b; NASW, 1996), and psychiatrists and social workers are encouraged to intercede when they become aware of an impaired colleague who continues to practice (APA, 1992; NASW, 1996). Practicing while impaired is considered an ethics violation by the American Psychological Association, and thus requires psychologists with personal knowledge of such impairment to first seek informal resolution and, if unsuccessful, report the violation to state or national committees on professional ethics or to state licensing boards (APA, 1992b). In a national study of clinical psychologists, Pope et al. (1987) reported that 59.3% of the respondents acknowledged having worked when too distressed to be effective, and 5.7% reported that they conducted therapy while under the influence of alcohol.

**Comparative Research on Ethical Practices and Beliefs**

Research on ethical practices and beliefs has generally been conducted within one profession, and these studies have been difficult to compare due to methodological differences (Borys & Pope, 1989). A comparative study by Conte et al. (1989) surveyed 203 practicing psychotherapists on the faculty of a medical school. They obtained a response of 50% (n = 101) which included licensed psychiatrists, psychologists, and psychiatric social workers. Their purpose was to survey attitudes on behaviors related to psychotherapy in six areas: sexual contact, socialization, confidentiality, harm to third
parties and/or to patients themselves, encouraging changes in patients' personal lives during therapy, and use of the media. They employed a 4-point rating scale that ranged from acceptable to grounds for malpractice. They found few significant differences in the attitudes of the three groups surveyed, but differences were evident when the respondents were grouped according to theoretical orientation. On items concerning sexual or romantic involvement with a current or former patient, psychoanalytically oriented therapists were more likely to see these behaviors as decidedly unethical. Non-psychoanalytically oriented therapists, who were grouped together, saw such activities as moderately inappropriate.

Crenshaw and Lichtenberg (1993) surveyed mental health professionals in Kansas on their forewarning and informing practices on the limits of confidentiality imposed by mandatory child abuse reporting laws. Surveys were sent to professionals on the mailing lists of the Kansas Behavioral Sciences Regulatory Board (consisting of psychologists and social workers), the Kansas Association for Marriage and Family Therapy, and the Kansas Psychiatric Association. Of 1,412 surveys mailed out, 428 usable surveys were returned for a response of 30.3%. Respondents included licensed psychologists (n = 115), registered masters-level psychologists (n = 90), licensed clinical social workers (n = 152), marriage and family therapists (n = 30), and psychiatrists (n = 41). Licensed psychologists were the most likely to provide a warning to all clients before a disclosure (41.7%), and psychiatrists were the least likely to provide such a warning (only 15% reported routinely forewarning all clients). Marriage and family counselors and licensed
clinical social workers were the most likely to inform clients of the limits of confidentiality once they suspected them of committing abuse.

Borys (1988) conducted a large-scale survey of 800 male and 800 female clinicians randomly selected from the membership directories of the American Psychological Association, the American Psychiatric Association, and the National Association of Social Workers. The survey focused on psychotherapy with adult clients. Of the 4,800 potential respondents, 2,332 returned the survey forms, for a response of 49%. Although this was the first national study to focus on nonsexual multiple relationships, results indicating significant gender differences were consistent with earlier studies of sexualized multiple relationships. Specifically, male respondents indicated a greater tendency to engage in multiple relationships in the areas of social/financial involvement and dual professional roles than did female respondents. They also tended to engage in such multiple relationships more often with female clients than with male clients. These gender differences were consistent for social workers, psychiatrists, and psychologists. Differences among professional groups were found for incidental involvements (e.g., one-time events or special occasions in which therapeutic boundaries were altered at the initiation of the client) and social/financial involvements (e.g., buying goods or services from a client). Psychologists viewed incidental involvements as more ethical than did either social workers or psychiatrists. Social/financial involvements were rated as less ethical by psychiatrists than by either psychologists or social workers. In regards to theoretical orientation, there was a significant difference between psychodynamically oriented clinicians (58% of the respondents) and all other groups,
with psychodynamically oriented therapists consistently ranking as more unethical explicitly prohibited social and financial multiple relationships.

A study of psychiatrists, psychologists, medical students, and graduate psychology students in Sweden (Morris, Melin, & Larsson, 1996) compared ethical attitudes in four areas: economical relationships with a client, sexual or close personal relationships with a client, confidentiality, and professionalism. Psychiatrists and psychologists were significantly more strict than were the medical students. Psychiatrists and psychologists had very strict attitudes about economic, sexual, or friendship relationships with current clients, but were much less strict about such relationships with former clients. All four groups surveyed felt it was more acceptable to have a sexual relationship with a former client than to have a friendship with a current client. In addition, females were found to be stricter than males in all areas except professionalism.
CHAPTER THREE

METHOD

This is a descriptive study consisting of mailed questionnaires. The participants, survey instrument, and the procedure that was used are described in this chapter.

Participants

The present study surveyed a sample of psychologists, psychiatrists, and social workers who, respectively, hold membership in the National Register of Health Services Providers in Psychology (NR), the American Academy of Child and Adolescent Psychiatry (AACAP), and the American Board of Examiners in Clinical Social Work (ABECSW). Each participant was self-identified in their respective association's membership register as providing child-oriented mental health services, and having completed clinical training and licensure/certification in their respective profession. These three latter professional organizations were selected to maximize the inclusion of professionals who are not only licensed/certified in their respective profession but who also meet common education and training criteria as established by their respective organizations.

A randomized sample of 1,000 members of each professional organization was developed using the following techniques: (1) NR and ABECSW - a computer-generated random sample was produced of those respective psychologists and social workers that identified themselves as working with children; (2) AACAP - a manually-generated random sample of psychiatrists was obtained from the 1996 AACAP directory, with every sixth entry included in the sample.
Surveys were returned by 1,029 of the selected participants, resulting in a response return of 34%. Specifically, of the 1,000 surveys sent to each professional group, 26% were returned from psychiatrists, 33% were returned from psychologists, and 39% were returned from social workers. A total of 50 of the returned surveys was not usable due to incomplete data, or stated inability to complete the form. The overall response of 34% is comparable to that obtained by similar surveys regarding ethical beliefs, which have obtained responses ranging from 26% to 59% (Borys, 1988; Conte, Plutchik, Picard, & Karasu, 1989; Gartrell et al., 1986; Haas, Malouf, & Mayerson, 1988; Lukomski, 1996; Pope, Tabachnick, & Keith-Spiegel, 1987).

Survey Instrument

A two-part questionnaire (Appendices B and C), based on a review of the literature (e.g., Jagim et al., 1978; Lindenthal et al., 1984; Morris, 1993) as well as questionnaires used in previous ethics studies (e.g., Borys, 1988; Morris, Melin, & Larsson, 1996; Pope et al., 1987, 1988; Pope & Vetter, 1992; Rae & Worche, 1991), was mailed to each respondent with a cover letter (Appendix D) and a self-addressed stamped return envelope. The first part (Part I) addressed demographic and professional information. The second part (Part II) contained 43 behavior description items which respondents were asked to rate based on their belief concerning the following: (1) how ethical they felt each behavior description was, and (2) how frequently they felt the behavior described occurred in their practice. A Likert-type four-point rating scale was used, with the four points being: (1) Never, (2) Sometimes, (3) Frequently, and (4) Always.
The three ethical domain areas assessed were confidentiality, competence, and multiple relationships (See Appendix E). These areas were selected based on a survey that solicited examples of ethical dilemmas faced by members of the American Psychological Association (Pope & Vetter, 1992), and on the types of cases most often investigated by the APA Ethics Committee (APA, 1993b, 1994b).

Content validity of the three domain areas was confirmed by having six child-oriented licensed/certified psychologists, social workers, and psychiatrists rate the items as belonging to one of the three domains. Only those items on which five of the six raters agreed were included in the survey. Pilot testing of the survey was then conducted with third-year school psychology doctoral students enrolled in an ethics course. Each student in the class had completed at least their school psychology practicum experience. The students were asked to provide feedback on the wording of the survey items, as well as on their understanding of the content of the cover letter and survey instructions. The revised survey was pilot tested on a second group of third-year school psychology graduate students enrolled in a child psychopathology course. Following the second pilot testing, the survey was pilot-tested on a group of child-oriented psychiatrists, psychologists, and social workers in the Greater Tucson, Arizona area for additional feedback. The final version of the survey included modifications based on feedback from these latter pilot participants.

Dependent Measures

The dependent measures for the present study were the following:
Ethical Behavior Score—the mean of the total score of each participant on the 42-item survey

Multiple Relationships Domain Score—the mean score for the ratings of the 16 items that were rated as pertaining to multiple relationship issues (one item was dropped as it had zero variance)

Competence Domain Score—the mean score for the ratings of the 10 items that were rated as pertaining to competence issues

Confidentiality Domain Score—the mean score for the ratings of the 16 items that were rated as pertaining to confidentiality

Procedure

A package containing the following materials was sent to each participant: a cover letter (Appendix D), a demographic questionnaire (Appendix B), the survey form (Appendix C), and a self-addressed prepaid return envelope for the completed survey. The survey was mailed during May 1997 and respondents were asked to complete and return their questionnaires by June 6, 1997. As each survey was received, it was coded for the region of the United States from which it originated (i.e., North, South, Midwest, and West).

In order to ensure confidentiality, each respondent was asked to return the survey information without recording his or her name or address on the survey. Those who wished to receive a summary of the findings were instructed to enclose a separate note with their name and address or include this information on the return envelope
Data Analysis

The Statistical Package for the Social Sciences 6.1 (1996) was used for the data analyses. The following analyses were conducted:

1. frequency tables were developed to describe the participants in terms of demographic and professional variables:

2. one-way analyses of variance (ANOVA) were conducted for each professional group and for the total sample to determine if there was a significant difference (p < .05) in the domains or total mean scores based on reported percentage of practice with children and adolescents.

3. coefficient alpha (α) reliability was calculated to determine the internal consistency of the three domains (multiple relationships, competence, and confidentiality) and of the total instrument:

4. one-way analyses of variance (ANOVA) were calculated to determine if there was a significant difference in the domains or total mean scores based on professional group:

5. one-way analyses of variance (ANOVA) were calculated to determine if there was a significant difference in the domains or total mean scores based on respondent characteristics (therapeutic orientation, age, date of degree, work setting, and years of practice);

6. t-tests for independent samples were calculated to determine if there was a significant difference in the domains or total mean scores based on respondent characteristics (gender and ethics training):
7. one-way analyses of variance (ANOVA) were conducted to determine if there was a significant difference in scores on ethical behavior statements based on professional group;

8. t-tests for independent samples were calculated to determine if there was a significant difference in scores on ethical behavior statements based on gender;

9. two-way analyses of variance (ANOVA) were conducted to determine if there was a significant interaction effect for profession by gender;

10. a t-test for correlated observations was calculated on two sets of questions differing only by age of client (e.g., child or adolescent) to determine if there was a difference in belief based on the age of the client.

The probability of a Type I error was set at < .05 for all analyses except those ANOVAs and t-tests calculated to determine if there were differences based on professional group or gender and scores on individual ethical behavior statements, where the probability rate was set at < .001. Post hoc testing was conducted using the Bonferroni method ($p < .05$) in order to control for the overall error rate.
CHAPTER FOUR

RESULTS

Characteristics of the Sample

The demographic characteristics of the respondents, total and by profession, are presented in Table 1. The sample consisted of 49% male and 48% female (3% no response) with 90% being Caucasian. Males and females were unevenly distributed among the three professional groups, with females being the majority amongst the social worker group (68%), and males being in the majority amongst both the psychologists (60%) and the psychiatrists (63%). Psychiatrists made up the most ethnically diverse group, with 18% of the respondents belonging to groups other than Caucasian. Only a small group of respondents were under 35 years of age (3%). The largest age group (43%) was in the 45 to 54 years range. The total sample was fairly well distributed regionally. Among psychologists, however, there was an overrepresentation of respondents from the South (38%), and an apparent under representation from the North (9%).

The professional characteristics of the respondents are presented in Table 2. Three therapeutic orientations accounted for 84% of the responses, namely, cognitive-behavioral, eclectic, and psychodynamic. Sixty-seven percent (67%) of the respondents obtained their highest degree in the 1970's or 1980's, and 71% have been practicing for 15 years or more. Solo private practice was the primary work setting for 38% of the respondents, while another 37% of the respondents were divided between either group private practice (18%) or outpatient mental health clinic settings (19%). Each of the other
### Table 1.

Demographic Characteristics of Respondents by Profession

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Psychiatrists</th>
<th>Psychologists</th>
<th>Social Workers</th>
<th>Total</th>
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<td>N = 263</td>
<td>N = 330</td>
<td>N = 386</td>
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<td>35-44</td>
<td>96 (37)</td>
<td>75 (23)</td>
<td>45 (12)</td>
<td>216 (22)</td>
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<tr>
<td>45-54</td>
<td>82 (31)</td>
<td>140 (42)</td>
<td>194 (50)</td>
<td>416 (43)</td>
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**North**: Connecticut, Delaware, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Vermont  
**South**: Alabama, Arkansas, Washington DC, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, Rhode Island, South Carolina, Tennessee, Texas, Virginia, West Virginia  
**West**: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming  
**Midwest**: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin
Table 2.

Professional Characteristics of Respondents

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<th>Characteristic</th>
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<td>N = 330</td>
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<td>N = 979</td>
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<td>%</td>
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Table 2. (continued)

Professional Characteristics of Respondents

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<th>Characteristic</th>
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<tr>
<td>Work Setting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Mental Health Clinic</td>
<td>67 26</td>
<td>38 12</td>
<td>76 20</td>
<td>181 19</td>
</tr>
<tr>
<td>Solo Private Practice</td>
<td>74 28</td>
<td>124 38</td>
<td>169 44</td>
<td>367 38</td>
</tr>
<tr>
<td>Group Private Practice</td>
<td>36 14</td>
<td>86 26</td>
<td>49 13</td>
<td>171 18</td>
</tr>
<tr>
<td>Inpatient Clinic/Hospital Setting</td>
<td>17 7</td>
<td>17 5</td>
<td>9 2</td>
<td>43 4</td>
</tr>
<tr>
<td>Residential Treatment Center</td>
<td>8 3</td>
<td>5 2</td>
<td>8 2</td>
<td>21 2</td>
</tr>
<tr>
<td>University/Academic Dept.</td>
<td>23 9</td>
<td>13 4</td>
<td>8 2</td>
<td>44 5</td>
</tr>
<tr>
<td>University/Medical School</td>
<td>18 7</td>
<td>14 4</td>
<td>6 2</td>
<td>38 4</td>
</tr>
<tr>
<td>Community College</td>
<td>0 0</td>
<td>0 0</td>
<td>0 0</td>
<td>0 0</td>
</tr>
<tr>
<td>Student Health Center</td>
<td>4 2</td>
<td>3 1</td>
<td>0 0</td>
<td>7 1</td>
</tr>
<tr>
<td>Public or Private School Setting</td>
<td>4 2</td>
<td>6 2</td>
<td>34 9</td>
<td>44 5</td>
</tr>
<tr>
<td>Other</td>
<td>10 4</td>
<td>24 7</td>
<td>27 7</td>
<td>61 6</td>
</tr>
<tr>
<td>N/R</td>
<td>2 1</td>
<td>0 0</td>
<td>0 0</td>
<td>2 &lt;1</td>
</tr>
</tbody>
</table>
seven work settings (i.e., inpatient clinic/hospital setting, residential treatment center, university/academic department, university/medical school, community college, student health center, public or private school setting) was endorsed by less than 5% of the respondents. Moreover, formal ethics training was reported by 87% of the respondents, with 94% of the psychologists reporting such training versus 80% for psychiatrists, and 84% for social workers.

Although surveys were sent to professionals who identified themselves in their professional organizations as child-oriented practitioners, a number of respondents indicated that less than one-half of their practice involved children or adolescents. To determine if there was a significant difference in ethical ratings among groups based on percentage of practice with children and adolescents, one-way analyses of variance (ANOVA) were conducted for each professional group and for the total sample, with the Ethical Behavior Rating as the dependent variable. No significant differences were found for the total sample, $F (2, 938) = .59, p > .05$, for psychiatrists, $F (2, 251) = .58, p > .05$, for psychologists, $F (2, 317) = .63, p > .05$, or for social workers, $F (2, 364) = 3.48, p > .05$. Therefore, for the purpose of analysis, all respondents were lumped together regardless of their reported percentage of practice with children and adolescents.

Reliability of Survey Instrument

To obtain internal consistency estimates of reliability, Cronbach’s coefficient alpha ($\alpha$) was computed on the total ethical behavior score, and on the three domain scores (i.e., multiple relationships, competence, and confidentiality). One item ("Become sexually involved with a child client") was dropped from the analyses of the total ethical
behavior score and the multiple relationships domain score since it had zero variance. The total ethical behavior score (42 items) obtained a coefficient alpha (α) of .81, which was considered adequate as an overall indicator of ethical sensitivity. The reliability scores for the three domains also obtained adequate reliability scores, namely, multiple relationships (16 items) α = .79; confidentiality (16 items) α = .72; and competence (10 items) α = .73.

**Ethical Behavior Ratings and Professional Group**

Four one-way analyses of variance (Glass & Hopkins, 1984) were conducted to determine if there was a difference between the three professional groups and their score on each ethical behavior domain as well as on their total ethical behavior score. The means and standard deviations for each professional group and their respective four ethical ratings scores are presented in Table 3. On the Ethical Behavior Rating, an overall indicator of ethical sensitivity, significant differences were found between professional groups, $F (2, 948) = 21.83, p < .001, \eta^2 = .04$. Follow-up Bonferroni tests indicated a significant difference between social workers and both psychologists and psychiatrists, but not between psychiatrists and psychologists, with the social workers' scores being lower (i.e., more conservative/less accepting) than the other two groups. With regard to multiple relationships a significant difference was found across professional groups, $F (2, 969) = 31.37, p < .001, \eta^2 = .06$. Follow-up Bonferroni tests indicated a significant difference between social workers and both psychiatrists and psychologists, as well as between psychologists and psychiatrists, with psychiatrists being the least conservative/most accepting in their ratings and social workers being the
<table>
<thead>
<tr>
<th>Group</th>
<th>Psychiatrists</th>
<th>Psychologists</th>
<th>Social Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Ethical Behavior Score</td>
<td>255</td>
<td>1.64</td>
<td>.23</td>
</tr>
<tr>
<td>Multiple Relationships Domain Score</td>
<td>263</td>
<td>1.47</td>
<td>.29</td>
</tr>
<tr>
<td>Competence Domain Score</td>
<td>262</td>
<td>1.75</td>
<td>.34</td>
</tr>
<tr>
<td>Confidentiality Domain Score</td>
<td>263</td>
<td>1.73</td>
<td>.34</td>
</tr>
</tbody>
</table>
most conservative/least accepting. With regard to the competence domain, a significant
difference was also found across groups, $F (2, 969) = 13.30, p < .001$, partial $\eta^2 = .03$.
Follow-up Bonferroni tests for the competence domain indicated a significant difference
between psychiatrists, the least conservative/most accepting, and both social workers and
psychologists. There was no significant difference between psychologists and social
workers. No significant difference was found across groups in terms of the confidentiality
domain, $F (2, 976) = 2.87, p > .05$.

**Ethical Behavior Ratings and Gender**

An independent-samples $t$ test (Glass & Hopkins, 1984) was conducted to
determine if there was a significant difference in ethical beliefs between males and
females. The means and standard deviations for gender and the four ethical behavior
ratings are presented in Table 4. The analyses revealed significant findings for total
ethical behavior, $t (927) = 7.37, p < .001$, $\eta^2 = .06$; multiple relationships, $t (948) = 9.19,
$ $p < .001$, $\eta^2 = .08$; competence, $t (948) = 4.91, p < .001$, $\eta^2 = .03$; and confidentiality, $t$
(955) = 2.34, $p = .02$, $\eta^2 = .01$. In each case females were found to have more
conservative/less accepting scores than males.

To determine if there was a significant interaction between profession and gender,
3 x 2 analyses of variance were conducted for each domain and the total ethical behavior
score. The means and standard deviations for ethical behavior ratings as a function of
these two factors are presented in Table 5. The ANOVA indicated no significant
interaction between profession and gender for the total ethical behavior score, $F (2, 923)$
$= .13, p = .88$, for the multiple relationships domain, $F (2, 944) = 1.40, p = .25$, for the
Table 4.

**Means and Standard Deviations for the Four Ethical Ratings Scores by Gender**

<table>
<thead>
<tr>
<th>Score</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethical Behavior Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>473</td>
<td>456</td>
</tr>
<tr>
<td>M</td>
<td>1.63</td>
<td>1.52</td>
</tr>
<tr>
<td>SD</td>
<td>.23</td>
<td>.20</td>
</tr>
<tr>
<td>Multiple Relationships Domain Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>480</td>
<td>470</td>
</tr>
<tr>
<td>M</td>
<td>1.46</td>
<td>1.31</td>
</tr>
<tr>
<td>SD</td>
<td>.29</td>
<td>.21</td>
</tr>
<tr>
<td>Competence Domain Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>480</td>
<td>470</td>
</tr>
<tr>
<td>M</td>
<td>1.71</td>
<td>1.61</td>
</tr>
<tr>
<td>SD</td>
<td>.34</td>
<td>.30</td>
</tr>
<tr>
<td>Confidentiality Domain Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>483</td>
<td>474</td>
</tr>
<tr>
<td>M</td>
<td>1.74</td>
<td>1.69</td>
</tr>
<tr>
<td>SD</td>
<td>.37</td>
<td>.33</td>
</tr>
</tbody>
</table>
Table 5.

Means and Standard Deviations for the Four Ethical Ratings Scores for Gender by Professional Group

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th></th>
<th>Females</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>M</td>
<td>SD</td>
<td>N</td>
</tr>
<tr>
<td>Ethical Behavior Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>161</td>
<td>1.67</td>
<td>.25</td>
<td>86</td>
</tr>
<tr>
<td>Psychologists</td>
<td>194</td>
<td>1.62</td>
<td>.21</td>
<td>117</td>
</tr>
<tr>
<td>Social Workers</td>
<td>118</td>
<td>1.58</td>
<td>.22</td>
<td>253</td>
</tr>
<tr>
<td>Multiple Relationships</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domain Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>165</td>
<td>1.53</td>
<td>.32</td>
<td>90</td>
</tr>
<tr>
<td>Psychologists</td>
<td>196</td>
<td>1.46</td>
<td>.28</td>
<td>121</td>
</tr>
<tr>
<td>Social Workers</td>
<td>119</td>
<td>1.38</td>
<td>.25</td>
<td>259</td>
</tr>
<tr>
<td>Competence Domain Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>165</td>
<td>1.79</td>
<td>.35</td>
<td>89</td>
</tr>
<tr>
<td>Psychologists</td>
<td>196</td>
<td>1.67</td>
<td>.31</td>
<td>122</td>
</tr>
<tr>
<td>Social Workers</td>
<td>119</td>
<td>1.67</td>
<td>.33</td>
<td>259</td>
</tr>
<tr>
<td>Confidentiality Domain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>165</td>
<td>1.73</td>
<td>.36</td>
<td>90</td>
</tr>
<tr>
<td>Psychologists</td>
<td>197</td>
<td>1.76</td>
<td>.39</td>
<td>123</td>
</tr>
<tr>
<td>Social Workers</td>
<td>121</td>
<td>1.72</td>
<td>.33</td>
<td>261</td>
</tr>
</tbody>
</table>
competence domain, $F(2, 944) = .38, p = .69$, or for the confidentiality domain, $F(2, 951) = .39, p = .68$. Significant main effects were found for the total ethical behavior score by profession, $F(2, 923) = 10.67, p < .001$, partial $\eta^2 = .02$, and by gender, $F(1, 923) = 32.94, p < .001$, partial $\eta^2 = .03$; for the multiple relationships domain by profession, $F(2, 944) = 15.29, p < .001$, partial $\eta^2 = .03$, and by gender, $F(1, 944) = 55.11, p < .001$, partial $\eta^2 = .06$; and for the competence domain by profession, $F(2, 944) = 9.28, p < .001$, partial $\eta^2 = .02$, and by gender, $F(1, 944) = 17.62, p < .001$, partial $\eta^2 = .02$. The ANOVA indicated no significant main effect for the confidentiality domain score by profession, $F(2, 951) = 1.35, p = .26$, or by gender, $F(1, 951) = 2.45, p = .12$.

Ethical Behavior Ratings and Therapeutic Orientation

Four one-way analyses of variance (ANOVA) were conducted to determine if there was a difference between therapeutic orientation and scores on each domain and the ethical behavior score. Since cognitive-behavioral, eclectic, and psychodynamic orientations accounted for 84% of the respondents, only these three orientations were included in the analyses. The means and standard deviations for these three therapeutic orientations and the four ethical behavior ratings are presented in Table 6. No significant differences were found for therapeutic orientation on the total ethical behavior score, $F(2, 789) = 1.82, p > .05$, the competence domain score, $F(2, 808) = 2.93, p > .05$, or the confidentiality domain score, $F(2, 814) = .17, p > .05$. A significant difference, however, was found for the multiple relationships domain, $F(2, 808) = 4.26, p = .01$, partial $\eta^2 = .01$. Follow-up Bonferroni tests indicated a significant difference between eclectic and
Table 6.

Means and Standard Deviations for the Four Ethical Ratings Scores by Therapeutic Orientation

<table>
<thead>
<tr>
<th>Therapeutic Orientation</th>
<th>Ethical Behavior Score</th>
<th>Multiple Relationships Domain Score</th>
<th>Competence Domain Score</th>
<th>Confidentiality Domain Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>M</td>
<td>SD</td>
<td>n</td>
</tr>
<tr>
<td>Eclectic</td>
<td>336</td>
<td>1.60</td>
<td>.23</td>
<td>345</td>
</tr>
<tr>
<td>Psychodynamic</td>
<td>240</td>
<td>1.56</td>
<td>.22</td>
<td>246</td>
</tr>
<tr>
<td>Cognitive-Behavioral</td>
<td>216</td>
<td>1.57</td>
<td>.22</td>
<td>220</td>
</tr>
</tbody>
</table>
psychodynamic practitioners, with psychodynamic clinicians being more conservative/less accepting than the eclectic clinicians on the multiple relationships domain.

**Ethical Behavior Ratings and Age**

The means and standard deviations for age groupings and the four ethical behavior ratings scales are found in Table 7. One-way analyses of variance (ANOVA) were conducted with the four age groupings as the factors and with the four ethical behavior mean scores as the dependent variables. A significant difference was found on the competence domain, $F (3, 965) = 6.12, p < .001$, partial $\eta^2 = .02$. A follow-up Bonferroni test indicated a significant difference between the age group 55 years and above and two other age groups, below 35 years, and 35 to 44 years, with the older age group of clinicians being more conservative/less accepting in their ratings. In addition, there was also a significant difference between the 45 to 54 age group and the below 35 age group, again with the older age group being more conservative/less accepting in their ratings. No significant differences were found on the total ethical behavior rating, $F (3, 944) = 1.46, p > .05$, for the confidentiality domain, $F (3, 972) = .33, p > .05$, or for the multiple relationships domain, $F (3, 965) = 1.89, p > .05$.

**Ethical Behavior Ratings and Date of Degree**

One-way analyses of variance (ANOVA) were conducted to determine if there were significant differences between groups based on the date of the practitioner's highest degree and their ethical beliefs. The means and standard deviations for date of degree and the four ethical behavior ratings scales are found in Table 8. No significant
Table 7.

Means and Standard Deviations for the Four Ethical Ratings Scores by Age

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Ethical Behavior Score</th>
<th>Multiple Relationships Domain Score</th>
<th>Competence Domain Score</th>
<th>Confidentiality Domain Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>M</td>
<td>SD</td>
<td>n</td>
</tr>
<tr>
<td>&lt;35</td>
<td>27</td>
<td>1.64</td>
<td>.22</td>
<td>27</td>
</tr>
<tr>
<td>35-44</td>
<td>209</td>
<td>1.60</td>
<td>.22</td>
<td>214</td>
</tr>
<tr>
<td>45-54</td>
<td>405</td>
<td>1.58</td>
<td>.21</td>
<td>413</td>
</tr>
<tr>
<td>≥55</td>
<td>307</td>
<td>1.57</td>
<td>.23</td>
<td>315</td>
</tr>
</tbody>
</table>
Table 8.

Means and Standard Deviations for the Four Ethical Ratings Scores by Date of Degree

<table>
<thead>
<tr>
<th>Date of Degree By Decade</th>
<th>Ethical Behavior Score M SD</th>
<th>Multiple Relationships Domain Score M SD</th>
<th>Competence Domain Score M SD</th>
<th>Confidentiality Domain Score M SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1940's</td>
<td>13 1.65 .24</td>
<td>13 1.41 .29</td>
<td>13 1.57 .42</td>
<td>13 1.91 .38</td>
</tr>
<tr>
<td>1950's</td>
<td>49 1.53 .25</td>
<td>50 1.32 .29</td>
<td>50 1.61 .31</td>
<td>50 1.71 .35</td>
</tr>
<tr>
<td>1960's</td>
<td>152 1.57 .24</td>
<td>157 1.39 .27</td>
<td>157 1.63 .33</td>
<td>158 1.72 .37</td>
</tr>
<tr>
<td>1970's</td>
<td>352 1.59 .21</td>
<td>359 1.40 .26</td>
<td>359 1.68 .33</td>
<td>364 1.73 .34</td>
</tr>
<tr>
<td>1980's</td>
<td>287 1.57 .22</td>
<td>293 1.39 .27</td>
<td>293 1.69 .33</td>
<td>294 1.68 .35</td>
</tr>
<tr>
<td>1990's</td>
<td>84 1.60 .18</td>
<td>85 1.39 .21</td>
<td>85 1.66 .28</td>
<td>85 1.77 .33</td>
</tr>
</tbody>
</table>
differences were found for the total ethical behavior rating, $F (5, 931) = 1.02, p > .05,$ for the competence domain, $F (5, 951) = 1.23, p > .05,$ for the confidentiality domain, $F (5, 958) = 2.25, p > .05,$ or for the multiple relationships domain, $F (5, 951) = .84, p > .05$.

**Ethical Behavior Ratings and Work Setting**

Of the 10 work settings included in the questionnaire, three accounted for 74% of the respondents’ work settings (i.e., solo private practice, group private practice, and outpatient mental health center). These latter three settings were therefore included in the subsequent analyses.

One-way analyses of variance (ANOVA) were conducted to determine if there were significant differences between groups based on the three work settings and their respective ethical beliefs. The means and standard deviations for work setting and the four ethical behavior ratings scales are found in Table 9. No significant differences were found for the total ethical behavior rating, $F (2, 694) = .89, p > .05,$ for the competence domain, $F (2, 710) = .54, p > .05,$ or for the multiple relationships domain, $F (2, 710) = .96, p > .05.$ There was, however, a significant difference for the confidentiality domain, $F (2, 716) = 3.91, p = .02,$ partial $\eta^2 = .01,$ with follow-up Bonferroni tests indicating a significant difference between practitioners in solo private practice and those practicing in an outpatient mental health center, with the latter having the more conservative/less accepting scores.

**Ethical Behavior Ratings and Years in Practice**

The means and standard deviations for number of years in practice and the four ethical behavior ratings scales are found in Table 10. Number of years in practice was
Table 9.

**Means and Standard Deviations for the Four Ethical Ratings Scores by Work Setting**

<table>
<thead>
<tr>
<th>Work Setting</th>
<th>Ethical Behavior Score</th>
<th>Multiple Relationships Domain Score</th>
<th>Competence Domain Score</th>
<th>Confidentiality Domain Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>M</td>
<td>SD</td>
<td>n</td>
</tr>
<tr>
<td>Outpatient Clinic/Hospital</td>
<td>175</td>
<td>1.57</td>
<td>.22</td>
<td>178</td>
</tr>
<tr>
<td>Solo Private Practice</td>
<td>354</td>
<td>1.58</td>
<td>.23</td>
<td>364</td>
</tr>
<tr>
<td>Group Private Practice</td>
<td>168</td>
<td>1.56</td>
<td>.20</td>
<td>171</td>
</tr>
</tbody>
</table>
Table 10.

Means and Standard Deviations for the Four Ethical Ratings Scores by Years in Practice

<table>
<thead>
<tr>
<th>Years in Practice</th>
<th>Ethical Behavior Score</th>
<th>Multiple Relationships Domain Score</th>
<th>Competence Domain Score</th>
<th>Confidentiality Domain Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>M</td>
<td>SD</td>
<td>n</td>
</tr>
<tr>
<td>&lt;6</td>
<td>84</td>
<td>1.61</td>
<td>.23</td>
<td>84</td>
</tr>
<tr>
<td>6 to 14</td>
<td>169</td>
<td>1.57</td>
<td>.20</td>
<td>174</td>
</tr>
<tr>
<td>15 to 24</td>
<td>358</td>
<td>1.57</td>
<td>.22</td>
<td>366</td>
</tr>
<tr>
<td>&gt;24</td>
<td>310</td>
<td>1.58</td>
<td>.24</td>
<td>318</td>
</tr>
</tbody>
</table>
divided into four groups, less than 6 years, 6 to 14 years, 15 to 24 years, and more than 24 years. One-way analyses of variance (ANOVA) were conducted with the four groupings of years in practice with the four ethical behavior mean scores as the dependent variables. No significant differences were found for the total ethical behavior rating, $F(3, 917) = .66$, $p > .05$, for the competence domain, $F(3, 938) = 2.38$, $p > .05$, the confidentiality domain, $F(3, 945) = .52$, $p > .05$, or for the multiple relationships domain, $F(3, 938) = 1.02$, $p > .05$.

**Ethical Behavior Ratings and Ethics Training**

An independent-samples $t$ test was conducted to determine if there was a significant difference in ethical beliefs between those practitioners who had formal ethics training and those who did not. The means and standard deviations for ethics training and the four ethical behavior ratings are presented in Table 11. There were no significant differences for the total ethical behavior rating, $t(947) = - .11$, $p > .05$, for the competence domain, $t(968) = .74$, $p > .05$, the confidentiality domain, $t(975) = - .67$, $p > .05$, or the multiple relationships domain, $t(968) = .18$, $p > .05$.

**Professional Group and Beliefs about Specific Practices**

One-way analyses of variance (ANOVA) were conducted to determine if there were differences between the three professional groups on each of the 42 ethical behavior statements. Significant differences ($p < .001$) were found for 18 of the 42 items (43%). Follow-up pairwise comparisons were conducted using the Bonferroni procedure with a significance level of .05. The means and standard deviations for those items on which psychiatrists’ ratings were significantly less conservative/more accepting than those of
Table 11.

Means and Standard Deviations for the Four Ethical Ratings Scores by Ethics Training

<table>
<thead>
<tr>
<th>Ethics Training</th>
<th>Ethical Behavior Score</th>
<th>Multiple Relationships Domain Score</th>
<th>Competence Domain Score</th>
<th>Confidentiality Domain Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formal Training</td>
<td>823 1.58 .22</td>
<td>841 1.39 .26</td>
<td>842 1.67 .32</td>
<td>847 1.71 .35</td>
</tr>
<tr>
<td>No Training</td>
<td>126 1.58 .23</td>
<td>129 1.39 .29</td>
<td>128 1.65 .33</td>
<td>130 1.74 .34</td>
</tr>
</tbody>
</table>
psychologists and social workers are presented in Table 12. The means and standard deviations for those items on which social workers’ ratings were significantly more conservative/less accepting than those of psychologists or psychiatrists are presented in Table 13. Table 14 contains the item on which psychologists’ ratings were significantly less conservative/more accepting than those of both social workers and psychiatrists, and Table 15 contains the means and standard deviations for the two items on which social workers’ ratings were significantly more conservative/less accepting than those of psychologists.

Multiple Relationships

Of the 18 ethical belief statement items for which a significant difference was found between professional groups, 12 (67%) were in the multiple relationships category, accounting for 75% of the 16 items in this domain. Specifically, significant differences were found between the professional groups on the following items: “treat the child of a close friend,” $F (2, 973) = 42.02, p < .001, \text{partial } \eta^2 = .08$, “treat the child/adolescent of an employee or colleague,” $F (2, 966) = 58.76, p < .001, \text{partial } \eta^2 = .11$, or “accept as a client a member of a youth sports team that you coach,” $F (2, 962) = 13.98, p < .001, \text{partial } \eta^2 = .03$. In each case, the pairwise comparisons showed that psychiatrists were less conservative/more accepting in their responses than were either psychologists or social workers, and psychologists were less conservative/more accepting than social workers in regard to treating the child of a close friend. There were no significant differences between psychologists and social workers on the other two items.
Table 12.

**Means and Standard Deviations for Ethical Belief Statements by Profession: Items with Psychiatrists being Significantly (p < .001) Less Conservative/More Accepting than Psychologists and Social Workers**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Psychiatrists</th>
<th>Psychologists</th>
<th>Social Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treat the child of a close friend.</td>
<td>261 1.65 .68</td>
<td>329 1.35 .55</td>
<td>386 1.24 .50</td>
</tr>
<tr>
<td>Begin a social relationship with the p/g of a current minor client.</td>
<td>262 1.22 .43</td>
<td>329 1.10 .30</td>
<td>386 1.06 .27</td>
</tr>
<tr>
<td>Accept a service or product from a p/g as payment for professional services rendered to a minor client.</td>
<td>263 1.65 .63</td>
<td>326 1.52 .57</td>
<td>384 1.35 .53</td>
</tr>
<tr>
<td>Enter into a business relationship w/a p/g of a current minor client.</td>
<td>263 1.17 .39</td>
<td>329 1.09 .28</td>
<td>386 1.06 .24</td>
</tr>
<tr>
<td>Treat the child/adolescent of an employee or colleague.</td>
<td>263 1.99 .62</td>
<td>326 1.60 .53</td>
<td>380 1.51 .57</td>
</tr>
<tr>
<td>Accept as a client a member of a youth sports team that you coach.</td>
<td>262 1.57 .66</td>
<td>326 1.42 .61</td>
<td>377 1.32 .56</td>
</tr>
<tr>
<td>Treat minor clients of cultures other than your own without seeking consultation/supervision.</td>
<td>261 2.20 .68</td>
<td>323 1.87 .67</td>
<td>380 1.87 .66</td>
</tr>
<tr>
<td>Treat a child or adolescent who has a psychological problem which you do not have experience in treating, but do have an understanding of the general treatment principles.</td>
<td>262 2.16 .66</td>
<td>327 1.97 .55</td>
<td>380 2.00 .61</td>
</tr>
</tbody>
</table>
Table 13.

Means and Standard Deviations for Ethical Belief Statements by Profession: Items with Social Workers being Significantly \((p < .001)\) More Conservative/Less Accepting than Psychologists and Psychiatrists

<table>
<thead>
<tr>
<th>Statement</th>
<th>Psychiatrists</th>
<th>Psychologists</th>
<th>Social Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treat the child of a close friend.</td>
<td>261</td>
<td>329</td>
<td>386</td>
</tr>
<tr>
<td>Begin a social relationship with the p/g of a former minor client.</td>
<td>263</td>
<td>326</td>
<td>386</td>
</tr>
<tr>
<td>Become sexually involved with the p/g of a former minor client.</td>
<td>263</td>
<td>329</td>
<td>386</td>
</tr>
<tr>
<td>Accept a service or product from a p/g as payment for professional services rendered to a minor client.</td>
<td>263</td>
<td>326</td>
<td>384</td>
</tr>
<tr>
<td>Enter into a business relationship w/a p/g of a former minor client.</td>
<td>260</td>
<td>327</td>
<td>386</td>
</tr>
<tr>
<td>Being sexually attracted to a child client but never acting on it.</td>
<td>253</td>
<td>312</td>
<td>375</td>
</tr>
<tr>
<td>Being sexually attracted to an adolescent client but never acting on it.</td>
<td>251</td>
<td>311</td>
<td>375</td>
</tr>
<tr>
<td>Discuss progress of therapy with p/g of an adolescent client without adolescent’s consent.</td>
<td>257</td>
<td>323</td>
<td>378</td>
</tr>
<tr>
<td>Use a psychological treatment when there is not sufficient empirical evidence to support its use.</td>
<td>259</td>
<td>323</td>
<td>370</td>
</tr>
</tbody>
</table>
Table 14. Means and Standard Deviations for Ethical Belief Statements by Profession: Item with Psychologists Significantly ($p < .001$) Less Conservative/More Accepting than Social Workers and Psychiatrists

<table>
<thead>
<tr>
<th>Item</th>
<th>Psychiatrists</th>
<th>Psychologists</th>
<th>Social Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Become sexually involved with a former client who is currently 18 years of age or older, and it is two years since the termination of therapy.</td>
<td>261 1.11 .36</td>
<td>326 1.23 .45</td>
<td>381 1.10 .31</td>
</tr>
</tbody>
</table>
Table 15.

**Means and Standard Deviations for Ethical Belief Statements by Profession: Item with Social Workers Significantly (p < .001) More Conservative/Less Accepting than Psychologists**

<table>
<thead>
<tr>
<th></th>
<th>Psychiatrists</th>
<th></th>
<th>Psychologists</th>
<th></th>
<th>Social Workers</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>M</td>
<td>SD</td>
<td>n</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Inform p/g of a minor client's sexual orientation without client's consent.</td>
<td>260</td>
<td>1.18</td>
<td>.44</td>
<td>325</td>
<td>1.24</td>
<td>.50</td>
</tr>
<tr>
<td>Discuss progress of therapy with p/g of a child client without child's consent.</td>
<td>257</td>
<td>2.24</td>
<td>.93</td>
<td>324</td>
<td>2.37</td>
<td>.98</td>
</tr>
</tbody>
</table>
A significant difference was also found between the three groups on "begin a social relationship with the parent/guardian of a current minor client," $F(2, 974) = 18.45$, $p < .001$, partial $\eta^2 = .04$, with post hoc analysis revealing that psychiatrists were less conservative/more accepting than both psychologists or social workers. A significant difference was also found between groups on "begin a social relationship with the parent/guardian of a former minor client," $F(2, 972) = 13.36$, $p < .001$, partial $\eta^2 = .03$, and "become sexually involved with the parent/guardian of a former minor client," $F(2, 975) = 11.76$, $p < .001$, partial $\eta^2 = .02$. In each case, the post hoc analysis indicated that social workers were significantly more conservative than both psychologists and psychiatrists. On the item, "become sexually involved with a former client who is currently 18 years or older, and it is two years since termination of therapy," there was also a significant difference between the groups, $F(2, 965) = 12.68$, $p < .001$, partial $\eta^2 = .03$, with the post hoc analysis revealing that psychologists were significantly less conservative/more accepting than either psychiatrists or social workers.

Significant differences were also found for "enter into a business relationship with a parent/guardian of a current minor client," $F(2, 975) = 9.73$, $p < .001$, partial $\eta^2 = .02$, "enter into a business relationship with a parent/guardian of a former minor client," $F(2, 970) = 11.36$, $p < .001$, partial $\eta^2 = .02$, and "accept a service or product from a parent/guardian as payment for professional services rendered to a minor client," $F(2, 970) = 23.23$, $p < .001$, partial $\eta^2 = .05$. In each case, post hoc analyses showed that social workers were significantly more conservative/less likely to find these practices acceptable than were either psychologists or psychiatrists.
Competence

Significant differences were found for four of the 10 (40%) ethical behavior statements in the competence domain. Specifically, significant differences were found between professional groups on the items “use a psychological treatment when there is not sufficient empirical evidence to support its use,” $F(2, 949) = 29.91, p < .001$, partial $\eta^2 = .06$, “treat minor clients of cultures other than your own without seeking consultation/supervision,” $F(2, 961) = 22.86, p < .001$, partial $\eta^2 = .05$, and “treat a child or adolescent who has a psychological problem which you do not have experience in treating, but do have an understanding of the general treatment principles,” $F(2, 966) = 8.30, p < .001$, partial $\eta^2 = .02$. In each of the latter instances, post hoc analyses showed that psychiatrists were less conservative/more accepting than were either psychologists or social workers. Additionally, psychologists were less conservative/more accepting than social workers for the item “use a psychological treatment when there is not sufficient empirical evidence to support its use.”

Confidentiality

Significant results were found for three of the 16 (19%) ethical belief statements in the area of confidentiality. Specifically, significant differences were found on the items, “discuss progress of therapy with a parent/guardian of an adolescent client without adolescent’s consent,” $F(2, 955) = 9.10, p < .001$, partial $\eta^2 = .02$, and “discuss progress of therapy with a parent/guardian of a child client without child’s consent,” $F(2, 958) = 8.43, p < .001$, partial $\eta^2 = .02$, with post hoc analyses showing that social workers were significantly more conservative/less accepting than either
psychologists or psychiatrists. A significant difference was also found on the item, “inform parent/guardian of a minor client’s sexual orientation without the client’s consent,” $F (2, 962) = 9.30, p < .001$, partial $\eta^2 = .02$, with post hoc analyses revealing that psychologists were significantly less conservative/more accepting than were social workers or psychiatrists.

**Gender and Beliefs about Specific Practices**

Independent-samples $t$-tests were conducted to determine if there was a significant difference between males and females in their responses to specific professional practices. The means and standard deviations for the items on which the ratings for males and females were found to be significantly different are found in Table 16. In all cases, females were more conservative/less accepting in their ratings.

**Multiple Relationships**

Nine of the 15 (60%) statements that were found to have significant differences ($p < .001$) by gender were in the multiple relationships category. Specifically, males were less conservative/more accepting than females regarding: “treat the child of a close friend,” $t (952) = 8.0, p < .001, \eta^2 = .06$; “accept as a client a member of a youth sports team that you coach,” $t (941) = 7.5, p < .001, \eta^2 = .06$; “begin a social relationship with the parent/guardian of a current minor client,” $t (953) = 5.5, p < .001, \eta^2 = .03$; “become sexually involved with the parent/guardian of a former minor client,” $t (954) = 5.6, p < .001, \eta^2 = .03$; “enter into a business relationship with the parent/guardian of a current minor client,” $t (954) = 5.7, p < .001, \eta^2 = .03$; “enter into a business relationship with the parent/guardian of a former minor client.”
Table 16.

**Means and Standard Deviations for Ethical Belief Statements by Gender: Items with Females being Significantly (p < .001) More Conservative/Less Accepting than Males**

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th></th>
<th>Females</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n  M  SD</td>
<td>n  M  SD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treat the child of a close friend.</td>
<td>481 1.53 .67</td>
<td>473 1.23 .46</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Begin a social relationship with the p/g of a current minor client.</td>
<td>482 1.17 .39</td>
<td>473 1.06 .25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Become sexually involved with the p/g of a former minor client.</td>
<td>483 1.20 .43</td>
<td>473 1.07 .26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accept a service or product from a p/g as payment for professional services rendered to a minor client.</td>
<td>482 1.59 .64</td>
<td>469 1.39 .52</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enter into a business relationship w/a p/g of a current minor client.</td>
<td>483 1.15 .37</td>
<td>473 1.04 .20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enter into a business relationship w/a p/g of a former minor client.</td>
<td>482 1.46 .58</td>
<td>469 1.29 .49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being sexually attracted to a child client but never acting on it.</td>
<td>461 1.59 .92</td>
<td>457 1.31 .68</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being sexually attracted to an adolescent client but never acting on it.</td>
<td>457 1.84 .91</td>
<td>458 1.47 .74</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accept as a client a member of a youth sports team that you coach.</td>
<td>478 1.56 .68</td>
<td>465 1.27 .50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treat an adolescent’s homosexuality as a form of pathology.</td>
<td>473 1.47 .69</td>
<td>465 1.23 .45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use a psychological treatment when there is not sufficient empirical evidence to support its use.</td>
<td>475 1.65 .66</td>
<td>455 1.46 .59</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treat minor clients of cultures other than your own without seeking consultation/supervision.</td>
<td>477 2.04 .66</td>
<td>465 1.85 .69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inform p/g of a minor client’s sexual orientation without client’s consent.</td>
<td>476 1.25 .51</td>
<td>467 1.09 .30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perform a child custody evaluation by seeing only the child and the one parent who made the appointment.</td>
<td>478 1.29 .49</td>
<td>463 1.18 .43</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discuss progress of therapy with p/g of an adolescent client without adolescent’s consent.</td>
<td>471 1.80 .88</td>
<td>465 1.57 .71</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
client,” $t(949) = 4.9, p < .001, \eta^2 = .03$; and, “accept a service or product from a parent/guardian as payment for professional services rendered to a minor client,” $t(949) = 5.3, p < .001, \eta^2 = .03$.

### Competence

Four of the 10 (40%) professional practices within the competence domain were found to have significant differences between males and females, with females always taking the more conservative/less accepting position: “treat an adolescent’s homosexuality as a form of pathology,” $t(936) = 6.4, p < .001, \eta^2 = .04$; “use a psychological treatment when there is not sufficient empirical evidence to support its use,” $t(928) = 4.7, p < .001, \eta^2 = .02$; “treat minor clients of cultures other than your own without seeking consultation/supervision,” $t(940) = 4.4, p < .001, \eta^2 = .02$; and, “perform a child custody evaluation during the time that you are also the child’s therapist,” $t(939) = 3.6, p < .001, \eta^2 = .01$.

### Confidentiality

In the confidentiality domain, males were more likely than females to rate as acceptable “discuss the progress of therapy with parent/guardian of an adolescent client without the adolescent’s consent,” $t(934) = 4.4, p < .001, \eta^2 = .02$, and “inform the parent or guardian of a minor client’s sexual orientation without the client’s consent,” $t(941) = 5.7, p < .001, \eta^2 = .03$.

### Sexual Attraction and Involvement with Minor Clients

Two statements, “become sexually involved with a child client,” and “become sexually involved with an adolescent client,” were almost unanimously rated as never
being ethical. One person, a male psychiatrist, rated "become sexually involved with an adolescent client" as sometimes being ethical, but all other respondents rated both questions as never being ethical. Two related questions, concerning sexual attraction to children or adolescents, "being sexually attracted to a child client but never acting on it," and "being sexually attracted to an adolescent client but never acting on it," had responses ranging from "never" to "always." Many of those responding "always" noted that "attraction" is neither ethical nor unethical, but is simply a feeling; they maintained that it is acting or not acting on the attraction that is in the specific realm of ethics. Social workers were significantly more conservative/less accepting than psychologists and psychiatrists on the items, "being sexually attracted to a child client but never acting on it," $F (2, 937) = 17.65, p < .001$, partial $\eta^2 = .04$, and "being sexually attracted to an adolescent client but never acting on it," $F (2, 934) = 19.49, p < .001$, partial $\eta^2 = .04$. In addition, females were significantly more conservative/less accepting than were males on the items, "being sexually attracted to a child client but never acting on it," $t (916) = 5.27, p < .001$, $\eta^2 = .03$, and "being sexually attracted to an adolescent client but never acting on it," $t (913) = 6.92, p < .001$, $\eta^2 = .05$.

Items Specific to Children versus Adolescents

Three sets of paired items looked at the same professional practice as it relates to children and to adolescents. A $t$-test for correlated observations (Glass & Hopkins, 1984) was conducted to determine if there was a difference in beliefs toward certain confidentiality practices based on the age of the client. The means and standard deviations are presented in Table 17.
Table 17.

Means and Standard Deviations for Child versus Adolescent Paired Items

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Items</td>
<td>939</td>
<td>2.19</td>
<td>.76</td>
</tr>
<tr>
<td>Adolescent Items</td>
<td>939</td>
<td>2.05</td>
<td>.65</td>
</tr>
</tbody>
</table>
A significant difference was found, with respondents rating beliefs about breaking confidentiality with adolescent clients more conservatively than breaking confidentiality with child clients, $t(939) = 9.18, p < .001$.

Ethical Beliefs and Perceived Frequency of Occurrence of Each Behavior

The survey instrument included a frequency-of-occurrence rating of the described behaviors in the respondent's practice. A review of the completed surveys and comments made by respondents indicated that the instructions for this portion of the survey were unclear. Many of the ethical behaviors included in the survey were noted by the respondent as never occurring in their practice. As the survey instrument did not have a distinction between behaviors not applicable to their practice, and behaviors the practitioner had an opportunity to engage in but chose not to, these data were not considered interpretable. Therefore, the correlation between child mental health services workers' ratings concerning their ethical beliefs about certain behavior items and their ratings of the perceived frequency of occurrence of each behavior, was not calculated.

Summary of Qualitative Comments

Approximately 40% of the respondents wrote comments on the survey form (See Appendix F). Comments ranged from general concerns associated with practice in a rural area, to statements about personal experiences.

Multiple Relationships

The ethical behavior statements that elicited the most comments were “being attracted to a child client but never acting on it,” and “being attracted to an adolescent client but never acting on it.” Many respondents noted that these statements described
feelings rather than behaviors, and therefore were not ethical issues (i.e., "Thoughts are thoughts!"). Those respondents making such statements generally rated the behaviors as "always" ethical. Several respondents went on to state, however, that therapists experiencing such feelings should seek consultation or treatment, and should refer their child or adolescent patient to another therapist.

On a number of the statements related to multiple relationships, it was noted that in a rural area or in a military setting social/nonprofessional contact with clients and their parents/guardians can be difficult to avoid. It was also stated that circumstances may require the provision of services, e.g., "If you are the only psychiatrist you may have no choice; necessary treatment may not otherwise be available. Obviously not the best." and "We are in a rural area – sometimes only choice."

In response to the statement "accept a service or product from a parent/guardian as payment for professional services rendered to a minor client," one respondent stated, "A self-pay parent paid me in 'bicycles' that I would have bought. I credited full price and reported it." Another stated, "For low income clients I sometimes have them do community service to 'balance' the fee."

Competence

There were a number of responses to the statement, "use a psychological treatment when there is not sufficient empirical evidence to support its use." Some respondents questioned whether any treatments fit this description, (e.g., "Is there ever sufficient empirical evidence?"), while others questioned certain therapies such as EMDR and psychodynamic psychotherapy.
In regard to the statement, "treat an adolescent's homosexuality as a form of pathology," some respondents felt it was not an ethical issue. Others were accepting of this practice as ethical in cases where they determined the sexual orientation was "ego dystonic." The statement, "treat minor clients whose values or beliefs are not consistent with your own values" elicited the following responses: "This requires constant vigilance and awareness. I do not treat patients when I feel distaste for their values;" "It's my job to keep these separate;" and "This applies to all teenagers."

Confidentiality

Statements concerning reporting to Child Protective Services (i.e., "inform CPS after you learn directly from the minor client that the client is being sexually abused;" "inform CPS after you learn directly from a third party that the client is being sexually abused;" "inform CPS after you learn directly from the client of past sexual abuse;" "inform CPS after you learn directly from the minor client that the client is being physically abused"), elicited comments referring to state law, as well as the following comments: "Depends on social class of client;" "...further investigation is mandatory;" "military falsely accuse;" "if you believe it;" and "need to verify."
CHAPTER FIVE
DISCUSSION

This chapter summarizes the results of the present study and discusses the findings in relation to the scholarly literature on the ethical beliefs and practices of psychiatrists, psychologists, and social workers. The limitations of the present study and recommendations for further research are also addressed.

Purpose of the Study

The purpose of the present study was to examine the ethical beliefs of psychiatrists, psychologists, and social workers in the areas of confidentiality, competence, and multiple relationships, and to determine if these ethical beliefs varied based on certain professional and demographic characteristics. Ethical beliefs about specific aspects of clinical practice with children and adolescents were examined, including confidentiality, competence, and multiple relationships.

Ethical Beliefs and Gender

The results showed, in general, that the ethical belief rating scores of females were consistently and significantly more conservative/less accepting than the rating scores of males on the total ethical behavior rating score, as well as on each of the ethical belief domains, namely, multiple relationships, competence, and confidentiality. A two-way analysis of variance (ANOVA) was conducted to determine if the significant differences found in the one-way analyses of variance were the result of a Type I error. The results of the $3 \times 2$ ANOVA were found to be consistent with those of the one-way analyses of variance. These findings regarding gender are consistent with those of Borys
(1988), who surveyed adult-oriented psychologists, psychiatrists, and social workers. Specifically, she found that in the area of dual relationships female therapists viewed social/financial involvements with clients (e.g., accepting a service or product as payment for therapy; becoming friends with a client after termination; etc.), as well as dual professional roles with clients (e.g., providing therapy to an employee; allowing a client to enroll in one’s class for a grade; etc.), as significantly “less ethical” than did male therapists. In addition, she reported that female therapists with a primarily female clientele rated incidental involvements (e.g., accepting a client’s invitation to a special occasion) as significantly “more ethical” than did male therapists. In comparing this latter finding to the present study, the closest comparison would be on the item, “attend a social function at the invitation of a minor child,” and it was found that males and females did not significantly differ on this item.

The present findings are also consistent with those of Rae and Worchel (1991), who found that the female psychologist members of the Society of Pediatric Psychology were more likely than males to give extreme ratings on 39 of the 101 behaviors surveyed in which the females rated the items as either “unquestionably not or under rare circumstances ethical” or “unquestionably yes or under many circumstances ethical.” Rae and Worchel indicated that a possible explanation for this difference was that females are more cautious in their approach to issues due to socialization, or alternatively, females are more confident in their analysis of moral dilemmas. Gender differences in moral reasoning have also been explored by Gilligan (1982) who argued that women are more attuned to relationships than are men, and, thus, are more likely to assess the impact of
their actions on a particular relationship when making decisions about their behavior. Similarly, Holroyd and Brodsky (1977), suggested that women may be more sensitive than men to the impact of their behavior in possible multiple relationship situations due to the fact that females have more often than males been in the victim/survivor role rather than in the perpetrator role.

Ethical Beliefs and Profession

Of the three professional groups, social workers, with the highest percentage of female respondents (68%), were consistently found to be the most conservative/least accepting on their ethical belief rating scores on statements involving competence and multiple relationships, as well as on their total ethical behavior rating score. No significant differences were found among professional groups in regard to the confidentiality domain. A two-way analysis of variance (ANOVA) confirmed results of the one-way analyses of variance (ANOVA). Further analysis of the data indicated there was no profession by gender interaction effect, suggesting that the more conservative ratings of the social worker group were not due to the higher percentage of female social workers. These findings, however, are not consistent with those of Borys (1988) who found that adult-oriented psychiatrists viewed (1) social/financial dual relationships and (2) incidental involvements with clients as “less ethical” than did either psychologists or social workers. Moreover, in contrast to Borys’ findings, the present findings revealed that psychiatrists were significantly more accepting/less conservative in their ratings on certain social/financial relationship items (e.g., “enter into a business relationship with the parent or guardian of a current client;” “accept a service or product from a parent or
guardian as payment for professional services rendered to a minor client;" "treat the child of a close friend;" and "treat the child/adolescent of an employee or colleague") than were psychologists or social workers.

These latter disparate results may be partially explained by a difference in the stated theoretical orientation of the psychiatrists in the Borys study, as well as in the adult emphasis of that study. Specifically, the present study used only psychiatrists listed in the American Academy of Child and Adolescent Psychiatry, whereas Borys included only adult-oriented psychiatrists. Second, psychiatrists in the Borys study were more likely than either psychologists or social workers to have chosen psychodynamic as their theoretical orientation, whereas in the present study, of the three theoretical orientations chosen by 84% of respondents (i.e., eclectic, psychodynamic, and cognitive-behavioral) "psychodynamic" was only chosen by 27% of the psychiatrists. Third, a minimum of 10 years separates the data gathering of the two studies and, therefore, it may be that the ethical beliefs of social workers and psychologists have changed over the last decade regarding multiple relationships, especially with the recent revision in the social workers' code of ethics (1996) and the psychologists' code having a major revision in 1992. The process of revision of the ethics codes provided for discussion of ethical issues in professional publications (e.g., Assembly, 1996; NASW, Code of Ethics Revision Committee, 1996) and at conferences (e.g., APA, Ethics Committee, 1993). Fourth, the types of therapeutic relationships that various professionals engage in may have changed under the prevailing managed care systems. If psychiatrists are increasingly engaged in psychopharmacological practice or medical management rather than psychotherapy, they
may view certain practices—particularly in the multiple relationships domain—as more acceptable. Similarly, if clinical social workers are increasingly the therapists of choice for managed care organizations, they may have become more conservative as their role in the mental health system has changed.

Ethical Beliefs and Demographic/Professional Characteristics

With regard to theoretical orientation, psychodynamic clinicians in general were found to be more conservative/less accepting than eclectic practitioners on the multiple relationships domain. This finding is similar to Borys (1988) who found significant differences regarding theoretical orientation on all three dual relationship factors studied (i.e., incidental involvements, social/financial involvements, and dual professional roles), with psychodynamic clinicians rating all such involvements as “less ethical” than respondents of other theoretical orientations. Similarly, Conte et al. (1989) found that psychoanalytic psychiatrists and psychologists were more conservative/less accepting in regard to survey items involving sexuality than were nonpsychoanalytic clinicians. In addition, Lindenthal and Thomas (1980) found that psychologists and psychiatrists with a psychoanalytic orientation were the least likely to state a willingness to break confidentiality. On the other hand, in regard to informed consent, Somberg, Stone and Claiborn (1993) found that therapists with a cognitive-behavioral approach believed it was more important to inform clients of alternatives to therapy than did psychodynamic therapists, and thought that informing clients of the length of treatment was more important than did therapists with eclectic or psychodynamic orientations. These findings suggest that certain ethical issues contain different degrees of salience for the various
therapeutic orientations. Widiger and Rorer (1984) noted this possible conflict among
theories of psychotherapy and ethics codes, and argued that it is not possible to have a
single set of ethical principles that is consistent with the various therapeutic orientations.

Practitioners in the age group 55 years and above were significantly more
conservative in their ratings related to the competence domain than were those in two
other age groups, below 35 years and 35 to 44 years. This could be due to a learning-by-
experience effect. Comments written on the survey form next to the competence domain
statements appear to support this notion—for example, some of the respondents wrote, "It
was a big mistake. Only one. Paid for my mistake;" "More often in the beginning of my
career."

Work setting was also found to be an important variable with respect to ethical
beliefs. Specifically, practitioners in solo practice were found to be less
conservative/more accepting of revealing confidential information than were those
clinicians whose primary work setting was an outpatient mental health center. A possible
explanation for this finding may be that practitioners who work in a setting that provides
for collegial contact have greater opportunities for peer supervision than do practitioners
in solo private practice.

Multiple Relationships

Multiple relationships are not entirely avoidable, nor are they inherently unethical
(Morris, 1997). For example, a number of respondents commented that some social
interactions with clients could not be avoided due to the nature of the community in
which the respondents lived, such as an overseas military base or a small town. A few
respondents even noted that it was sometimes necessary to engage in a business relationship with the parent or guardian of a client, as there may be no other source available for a particular service. The current APA ethics code (1992) specifically addresses this issue, stating in Standard §1.17a that in certain communities and situations contact may not be avoidable, but that psychologists must be sensitive to any potentially harmful effects of contacts outside the therapeutic relationship. Although nonsexual dual relationships are addressed in the current NASW ethics code (1996), the problems associated with practicing in a small community are not addressed. Similarly, nonsexual dual relationships are not addressed in the Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry (ApA, 1993).

Psychiatrists were found to be significantly more accepting of multiple relationships in the areas of “financial involvement” and “accepting as clients the children of friends or employees/colleagues,” than were psychologists or social workers. This could be related to the lack of prohibitions against nonsexual multiple relationships in the ApA code of ethics (ApA, 1993). It could also be that these practices are more accepted generally within the medical community. On the other hand, for the behavior description, “become sexually involved with a former client who is currently 18 years of age or older, and it is two years since the termination of therapy,” psychologists were significantly more accepting/less conservative in rating this statement than were either psychiatrists or social workers. In fact, one respondent, a male psychologist, stated next to his rating, “We’re now married!” This finding may be due to the fact that the APA (1992) ethics code specifically states in Standard §4.07 that “Psychologists do not engage
in sexual intimacies with a former patient or client for at least two years after cessation or termination of professional services.” In contrast, the ApA ethics code (1993) and the NASW ethics code (1996) both state that sexual activity with a former client is unethical, with no qualification for the amount of time that has passed since the cessation of therapy.

With regard to those behavior descriptions involving sexual attraction to child or adolescent clients, a number of comments were made by respondents. Many commented that attraction in and of itself was not an ethical issue. For example, comments such as, “A feeling has nothing to do with ethics” were not unusual on the survey. This appears to be supported by the findings as well. Specifically, 70% of the respondents chose “never” ethical for the rating of “Being sexually attracted to a child client but never acting on it,” whereas only 52% rated as “never” ethical the item, “Being sexually attracted to an adolescent client but never acting on it.” When broken down by profession, the results showed that there was a significant difference between the percentage of social workers (78%) who rated sexual attraction to a child as never being ethical versus psychologists (62%) and psychiatrists (58%) who rated this behavior as never ethical. These findings are somewhat consistent with Pope, Tabachnick, and Keith-Spiegel (1987) who found that 23% of the 456 psychologists who responded to an ethical beliefs survey rated the statement “Being sexually attracted to a client” as being never or under rare circumstances being ethical.
Confidentiality

Respondents were in the greatest agreement in the area of confidentiality. Of interest, however, is the lack of consensus on items related to child abuse and duty to protect reporting laws. Mandatory child abuse reporting laws are in effect in all 50 states and the District of Columbia, and all professional organizations consider compliance with such reporting laws to be consistent with ethical practices (AMA, Council, 1992b; APA, Committee, 1995; NASW, 1981). Despite this, only 84% of the respondents rated as “always” ethical the statement, “Inform Child Protection Services after you learn directly from the minor client that the client is being sexually abused,” and 81% rated as “always” ethical the statement “Inform Child Protection Services after you learn directly from the minor client that the client is being physically abused.” These findings are consistent with the findings of Rae and Worchel (1991) who reported that only 79% of the pediatric psychologist respondents considered breaking confidentiality to report child abuse to be unquestionably ethical. Although a number of respondents to the present study commented that state law required reporting child abuse, a few commented in the following manner: “Depends on social class of the client,” and “Need to verify.”

The legal duty to protect—which extends to those clients who are at risk for injury to themselves—is similarly considered by professional organizations to be an ethical practice (ApA, 1993; APA, 1992b; NASW, 1996). In spite of this notion, only 86% of the respondents considered it to be “always” ethical to break confidentiality if a minor client is suicidal and only 87% if the client is homicidal. A number of respondents commented that they informed their clients of the reporting laws at the onset of therapy.
Although the majority of therapists report agreement with reporting laws, given the possible ramifications for both the therapist and the client if the therapist chooses not to report under mandated circumstances, the under 10% who rated breaking confidentiality under such circumstances as "rarely" or "never" ethical are of concern.

Breaking confidentiality to report a client's AIDS or HIV status has been compared to the duty to warn obligation under the Tarasoff ruling (e.g., Lamb et al., 1989). Although all 50 states and the District of Columbia have laws that mandate reporting diagnosed cases of AIDS to state health officials, state laws are not uniform in their approach to the disclosure of HIV status. Legal and ethical theorists are not in agreement as to what policy should be adopted regarding confidentiality and AIDS/HIV status (e.g., ABA, 1988; Knapp & VandeCreek, 1989; Zonona, 1989), and although policy statements have been developed by professional organizations (ApA Ad Hoc Committee, 1988; APA, 1992b; NASW, Delegate Assembly, 1990) specific guidelines have not yet been established in the various ethics codes of these organizations. This confusion is reflected in the number of respondents (46) who did not respond to the behavior description, "Report a minor client's HIV status to other professionals", more omissions than for any other statement. Additionally, several respondents wrote "Don't know" or question marks next to the statement. Of those who did respond, however, 67% felt it was always ethical to break confidentiality in this case. Similarly, in a study of pediatric psychologists (Rae & Worchel, 1991), 31% of the respondents, when asked about breaking confidentiality when a sexually promiscuous adolescent has AIDS, said they were unsure, and 47% said they would break confidentiality.
Competence

Statements involving issues related to competence were far less likely to be rated at the extremes (“always” ethical or “never” ethical) than were those in the multiple relationships or confidentiality domains. Professional competence, which involves practicing only within the bounds of one’s experience, training, and ability, requires a subjective evaluation of the part of the practitioner. What may appear adequate to one person may seem inadequate to others. Competence also involves knowledge of one’s own belief system as well as the belief systems of clients, and personal problems that may compromise professional effectiveness. The inherent subjectivity involved in evaluations of competence may have affected ratings in this area.

Training in Ethics

No significant differences were found in ethical ratings between groups based on whether the respondent had formal ethics training. This is consistent with a study by Haas, Malouf, and Mayerson (1988) who explored ethical decision-making amongst psychologists. There are a number of possible explanations for this lack of effect for ethics training. First, it may be that formal ethics training has no noticeable effect on ethical beliefs, or more importantly, on ethical decision-making. Research suggests there is a discrepancy between understood ethical principles and the implementation of these principles (Bernard & Jara, 1986; Bernard et al., 1987; Wilkins et al, 1990). Second, the diversity of experiences lumped together under “formal ethics training” may dilute whatever effect does exist. “Formal ethics training” for the purposes of this study could have been experiences ranging from a one-day seminar or a single lecture to courses
devoted only to ethics. Third, the majority of professionals who belong to their respective associations may be familiar with the basic ethical guidelines of their organization regardless of their formal ethics training. This basic understanding could be adequate for responding to a survey questionnaire, but those without formal ethics training may not be familiar with ethical problem-solving techniques that would assist them in their approach to ethical dilemmas.

Limitations of Findings

As is common in survey research, the findings of this study are restricted to those willing to participate in a mailed survey. Responses to mailed surveys are typically 30% to 60%, and the characteristics of nonrespondents are unknown. Respondents may have had a greater interest in ethical issues than the average practitioner. The population of interest in this study, child-oriented mental health practitioners, is a subgroup of mental health professionals. Characteristics of the respondents could not be compared with the population, as demographic information was not available for this subgroup. Furthermore, the assessment of ethical beliefs is susceptible to socially desirable responses.

Ethical issues are complex, and the forced choice response utilized in this study did not permit respondents to elaborate on their choices. The statement format did not provide for the many variables that might affect how one responds to an ethical dilemma, a problem noted by a number of respondents. Additionally, ratings on a survey, while they may imply a certain ethical sensitivity and knowledge of ethical issues, do not necessarily reflect one's actual practice or decision making ability.
Future Research

This was an exploratory study that provided information on the ethical beliefs of psychiatrists, psychologists, and social workers. Further research is needed to explore why unethical behavior occurs and which practitioners are more vulnerable to ethical violations. The effectiveness of teaching methods used in ethics courses needs to be evaluated. Longitudinal studies could be undertaken to discern the long-lasting effects, if any, of ethics education.

The professional practices survey used in the present study consisted of ethical belief statements that were developed based on previous research. Factor analysis on the current instrument indicated three factors. Factor one consisted of statements in the multiple relationships and competence domains. Factor two contained statements related to reporting laws, and factor three contained nine other confidentiality-related statements. Six statements did not load on any factor. Use of this survey instrument needs to be replicated to determine what dimensions exist, and to analyze why some statements did not load on any of the factors.
APPENDIX A

ETHICS CODES
Principles of Medical Ethics

With Annotations Especially Applicable to Psychiatry

In 1973, the American Psychiatric Association published the first edition of THE PRINCIPLES OF MEDICAL ETHICS WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY. Subsequently, revisions were published as the Board of Trustees and the Assembly approved additional annotations. In July of 1980, the American Medical Association approved a new version of the Principles of Medical Ethics (the first revision since 1957) and the APA Ethics Committee incorporated many of its annotations into the new Principles, which resulted in the 1981 edition and subsequent revisions.

FOREWORD

ALL PHYSICIANS should practice in accordance with the medical code of ethics set forth in the Principles of Medical Ethics of the American Medical Association. An up-to-date expression and elaboration of these statements is found in the Opinions and Reports of the Council on Ethical and Judicial Affairs of the American Medical Association. Psychiatrists are strongly advised to be familiar with these documents. However, these general guidelines have sometimes been difficult to interpret for psychiatry, so further annotations to the basic principles are offered in this document. While psychiatrists have the same goals as all physicians, there are special ethical problems in psychiatric practice that differ in coloring and degree from ethical problems in other branches of medical practice, even though the basic principles are the same. The annotations are not designed as absolutes and will be revised from time to time so as to be applicable to current practices and problems. Following are the AMA Principles of Medical Ethics, printed in their entirety, and then each principle printed separately along with an annotation especially applicable to psychiatry.

PRINCIPLES OF MEDICAL ETHICS

AMERICAN MEDICAL ASSOCIATION

PREAMBLE

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients but also to society, to other health professionals, and to self. The following Principles, adopted by the American Medical Association, are not laws but standards of conduct, which define the essentials of honorable behavior for the physician.

SECTION 1
A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

SECTION 2
A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

SECTION 3
A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

SECTION 4
A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

SECTION 5
A physician shall continue to study, apply, and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

SECTION 6
A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.
SECTION 7
A physician shall recognize a responsibility to participate in activities contributing to an improved community.

PRINCIPLES WITH ANNOTATIONS
Following are each of the AMA Principles of Medical Ethics printed separately along with annotations especially applicable to psychiatry.

PREAMBLE
The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession a physician must recognize responsibility not only to patients but also to society to other health professionals, and to self. The following Principles, adopted by the American Medical Association, are not laws but standards of conduct, which define the essentials of honorable behavior for the physician.

SECTION I
A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

1. The patient may place his/her trust in his/her psychiatrist knowing that the psychiatrist's ethics and professional responsibilities preclude him/her gratifying his/her own needs by exploiting the patient. The psychiatrist shall be ever vigilant about the impact that his/her conduct has upon the boundaries of the doctor/patient relationship, and thus upon the well being of the patient. These requirements become particularly important because of the essentially private, highly personal and sometimes intensely emotional nature of the relationship established with the psychiatrist.

2. A psychiatrist should not be a party to any type of policy that excludes, segregates, or demeans the dignity of any patient because of ethnic origin, race, sex, creed, age, socioeconomic status, or sexual orientation.

3. In accord with the requirements of law and accepted medical practice, it is ethical for a physician to submit his/her work to peer review and to the ultimate authority of the medical staff executive body and the hospital administration and its governing body. In case of dispute, the ethical psychiatrist has the following steps available:
   a. Seek appeal from the medical staff decision to a joint conference committee, including members of the medical staff executive committee and the executive committee of the governing board. At this appeal, the ethical psychiatrist could request that outside opinions be considered.
   b. Appeal to the governing body itself.
   c. Appeal to state agencies regulating licensure of hospitals if, in the particular state, they concern themselves with matters of professional competency and quality of care.
   d. Attempt to educate colleagues through development of research projects and data and presentations at professional meetings and in professional journals.
   e. Seek redress in local courts, perhaps through an enjoining injunction against the governing body.
   f. Public education as carried out by an ethical psychiatrist would not utilize appeals based solely upon emotion, but would be presented in a professional way and without any potential exploitation of patients through testimonials.

4. A psychiatrist should not be a participant in a legally authorized execution.

SECTION 2
A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

1. The requirement that the physician conduct himself/herself with propriety in his/her profession and in all the actions of his/her life is especially important in the case of the psychiatrist because the patient tends to model his/her behavior after that of his/her psychiatrist by identification. Further, the necessary intensity of the treatment relationship may tend to activate sexual and other needs and fantasies on the part of both patient and psychiatrist, while weakening the objectivity
necessary for control. Additionally, the inherent inequality in the doctor patient relationship may lead to exploitation of the patient. Sexual activity with a current or former patient is unethical.

2. The psychiatrist should diligently guard against exploiting information furnished by the patient and should not use the unique position of power afforded him/her by the psychotherapeutic situation to influence the patient in any way not directly relevant to the treatment goals.

3. A psychiatrist who regularly practices outside his/her area of professional competence should be considered unethical. Determination of professional competence should be made by peer review boards or other appropriate bodies.

4. Special consideration should be given to those psychiatrists who, due to illness, jeopardize the welfare of their patients and their own reputations and practices. It is ethical, even encouraged, for another psychiatrist to intercede in such situations.

5. Psychiatric services, like all medical services, are dispensed in the context of a contractual arrangement between the patient and the treating physician. The provisions of the contractual arrangement, which are binding on the physician as well as on the patient, should be explicitly established.

6. It is ethical for the psychiatrist to make a charge for a missed appointment when this falls within the terms of the specific contractual agreement with the patient. Charging for a missed appointment or for one not canceled 24 hours in advance need not, in itself, be considered unethical if a patient is fully advised that the physician will make such a charge. The practice, however, should be resorted to infrequently and always with the utmost consideration for the patient and his/her circumstances.

7. An arrangement in which a psychiatrist provides supervision administration to other physicians or nonmedical persons for a percentage of their fees or gross income is not acceptable; this would constitute fee-splitting. In a team of practitioners, or a multi disciplinary team, it is ethical for the psychiatrist to receive income for administration, research education, or consultation. This should be based upon a mutually agreed upon and set fee or salary, open to renegotiation when a change in the time demand occurs. (See also Section 5, Annotations 2, 3, and 4.)

SECTION 3
A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

1. It would seem self-evident that a psychiatrist who is a lawbreaker might be ethically unsuited to practice his/her profession. When such illegal activities bear directly upon his/her practice, this would obviously be the case. However, in other instances, illegal activities such as those concerning the right to protest social injustices might not bear on either the image of the psychiatrist or the ability of the specific psychiatrist to treat his/her patient ethically and well. While no committee or board could offer prior assurance that any illegal activity would not be considered unethical, it is conceivable that an individual could violate a law without being guilty of professionally unethical behavior. Physicians lose no right of citizenship on entry into the profession of medicine.

2. Where not specifically prohibited by local laws governing medical practice, the practice of acupuncture by a psychiatrist is not unethical per se. The psychiatrist should have professional competence in the use of acupuncture. Or, if he/she is supervising the use of acupuncture by nonmedical individuals, he/she should provide proper medical supervision. (See also Section 5, Annotations 3 and 4.)

SECTION 4
A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints the law.

1. Psychiatric records, including even the identification of a person as a patient, must be protected with extreme care. Confidentiality is essential to psychiatric treatment. This is based in part on the special nature of psychiatric therapy as well as on the traditional ethical relationship between physician and patient. Growing concern regarding the civil rights of patients and the possible
adverse effects of computerization, duplication equipment, and data banks makes the dissemination of confidential information an increasing hazard. Because of the sensitive and private nature of the information with which the psychiatrist deals, he/she must be circumspect in the information that he/she chooses to disclose to others about a patient. The welfare of the patient must be a continuing consideration.

2. A psychiatrist may release confidential information only with the authorization of the patient or under proper legal compulsion. The continuing duty of the psychiatrist to protect the patient includes fully apprising him/her of the connotations of waiving the privilege of privacy. This may become an issue when the patient is being investigated by a government agency, is applying for a position, or is involved in legal action. The same principles apply to the release of information concerning treatment to medical departments of government agencies, business organizations, labor unions, and insurance companies. Information gained in confidence about patients seen in student health services should not be released without the students' explicit permission.

3. Clinical and other materials used in teaching and writing must be adequately disguised in order to preserve the anonymity of the individuals involved.

4. The ethical responsibility of maintaining confidentiality holds equally for the consultations in which the patient may not have been present and in which the consultee was not a physician. In such instances, the physician consultant should alert the consultee to his/her duty of confidentiality.

5. Ethically the psychiatrist may disclose only that information which is relevant to a given situation. He/she should avoid offering speculation as fact. Sensitive information such as an individual's sexual orientation or fantasy material is usually unnecessary.

6. Psychiatrists are often asked to examine individuals for security purposes, to determine suitability for various jobs, and to determine legal competence. The psychiatrist must fully describe the nature and purpose and lack of confidentiality of the examination to the examinee at the beginning of the examination.

7. Careful judgment must be exercised by the psychiatrist in order to include, when appropriate, the parents or guardian in the treatment of a minor. At the same time, the psychiatrist must assure the minor proper confidentiality.

8. When in the clinical judgment of the treating psychiatrist the risk of danger is deemed to be significant, the psychiatrist may reveal confidential information disclosed by the patient.

9. When the psychiatrist is ordered by the court to reveal the confidences entrusted to him/her by patients, he/she may comply or he/she may ethically hold the right to dissent within the framework of the law. When the psychiatrist is in doubt, the right of the patient to confidentiality and, by extension, to unimpaired treatment, should be given priority. The psychiatrist should reserve the right to raise the question of adequate need for disclosure. In the event that the necessity for legal disclosure is demonstrated by the court, the psychiatrist may request the right to disclosure of only that information which is relevant to the legal question at hand.

10. With regard for the person's dignity and privacy and with truly informed consent, it is ethical to present a patient to a scientific gathering if the confidentiality of the presentation is understood and accepted by the audience.

11. It is ethical to present a patient or former patient to a public gathering or to the news media only if the patient is fully informed of enduring loss of confidentiality, is competent, and consents in writing without coercion.

12. When involved in funded research, the ethical psychiatrist will advise human subjects of the funding source, retain his/her freedom to reveal data and results, and follow all appropriate and current guidelines relative to human subject protection.

13. Ethical considerations in medical practice preclude the psychiatric evaluation of any person charged with criminal acts prior to access to, or availability of, legal counsel. The only exception is the rendering of care to the person for the sole purpose of medical treatment.

14. Sexual involvement between a faculty member or supervisor and a trainee or student, in those situations in which an abuse of power can occur, often takes advantage of inequalities in the working relationship and may be unethical because: (a) any treatment of a patient being
supervised may be deleteriously affected; (b) it may damage the trust relationship between teacher and student; and (c) teachers are important professional role models for their trainees and affect their trainees’ future professional behavior.

SECTION 5
A physician shall continue to study, apply, and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

1. Psychiatrists are responsible for their own continuing education and should be mindful of the fact that theirs must be a lifetime of learning.

2. In the practice of his/her specialty, the psychiatrist consults, associates, collaborates, or integrates his/her work with that of many professionals, including psychologists, psychometricians, social workers, alcoholism counselors, marriage counselors, public health nurses, etc. Furthermore, the nature of modern psychiatric practice extends his/her contacts to such people as teachers, juvenile and adult probation officers, attorneys, welfare workers, agency volunteers, and neighborhood aides. In referring patients for treatment, counseling, or rehabilitation to any of these practitioners, the psychiatrist should ensure that the allied professional or paraprofessional with whom he/she is dealing is a recognized member of his/her own discipline and is competent to carry out the therapeutic task required. The psychiatrist should have the same attitude toward members of the medical profession to whom he/she refers patients. Whenever he/she has reason to doubt the training, skill, or ethical qualifications of the allied professional, the psychiatrist should not refer cases to him/her.

3. When the psychiatrist assumes a collaborative or supervisory role with another mental health worker, he/she must expend sufficient time to assure that proper care is given. It is contrary to the interests of the patient and to patient care if he/she allows himself/herself to be used as a figurehead.

4. In relationships between psychiatrists and practicing licensed psychologists, the physician should not delegate to the psychologist or, in fact, to any nonmedical person any matter requiring the exercise of professional medical judgment.

5. The psychiatrist should agree to the request of a patient for consultation or to such a request from the family of an incompetent or minor patient. The psychiatrist may suggest possible consultants, but the patient or family should be given free choice of the consultant. If the psychiatrist disapproves of the professional qualifications of the consultant or if there is a difference of opinion that the primary therapist cannot resolve, he/she may, after suitable notice, withdraw from the case. If this disagreement occurs within an institution or agency framework, the differences should be resolved by the mediation or arbitration of higher professional authority within the institution or agency.

SECTION 6
A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

1. Physicians generally agree that the doctor-patient relationship is such a vital factor in effective treatment of the patient that preservation of optimal conditions for development of a sound working relationship between a doctor and his/her patient should take precedence over all other considerations. Professional courtesy may lead to poor psychiatric care for physicians and their families because of embarrassment over the lack of a complete give-and-take contract.

2. An ethical psychiatrist may refuse to provide psychiatric treatment to a person who, in the psychiatrist's opinion, cannot be diagnosed as having a mental illness amenable to psychiatric treatment.

SECTION 7
A physician shall recognize a responsibility to participate in activities contributing to an improved community.
1. Psychiatrists should foster the cooperation of those legitimately concerned with the medical, psychological, social, and legal aspects of mental health and illness. Psychiatrists are encouraged to serve society by advising and consulting with the executive, legislative, and judicial branches of the government. A psychiatrist should clarify whether he/she speaks as an individual or as a representative of an organization. Furthermore, psychiatrists should avoid cloaking their public statement with the authority of the profession (e.g., "Psychiatrists know that..."

2. Psychiatrists may interpret and share with the public their expertise in the various psychosocial issues that may affect mental health and illness. Psychiatrists should always be mindful of their separate role as dedicated citizens and as experts in psychological medicine.

3. On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention, or who has disclosed information about himself/herself through public media. In such circumstances, a psychiatrist may share with the public his/her expertise about psychiatric issues in general. However, it is unethical for a psychiatrist offer a professional opinion about that specific individual unless he has conducted an examination and has been granted proper authorization for such a statement.

4. The psychiatrist may permit his/her certification to be used for the involuntary treatment of any person only following his/her personal examination of that person. To do so, he/she must find that the person, because of mental illness, cannot form a judgment as to what is in his/her own best interests and that, without such treatment, substantial implement is likely to occur to the person or others.
National Association of Social Workers
CODE OF ETHICS
Effective January 1, 1997

Preamble

The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession’s focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living.

Social workers promote social justice and social change with and on behalf of clients. “Clients” is used inclusively to refer to individuals, families, groups, organizations, and communities. Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice. These activities may be in the form of direct practice, community organizing, supervision, consultation, administration, advocacy, social and political action, policy development and implementation, education, and research and evaluation. Social workers seek to enhance the capacity of people to address their own needs. Social workers also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals’ needs and social problems.

The mission of the social work profession is rooted in a set of core values. These core values, embraced by social workers throughout the profession’s history, are the foundation of social work’s unique purpose and perspective:

- service
- social justice
- dignity and worth of the person
- importance of human relationships
- integrity
- competence.

This constellation of core values reflects what is unique to the social work profession. Core values, and the principles that flow from them, must be balanced within the context and complexity of the human experience.

Purpose of the NASW Code of Ethics

Professional ethics are at the core of social work. The profession has an obligation to articulate its basic values, ethical principles, and ethical standards. The NASW Code of Ethics sets forth these values, principles, and standards to guide social workers’ conduct.

The Code is relevant to all social workers and social work students, regardless of their professional functions, the settings in which they work, or the populations they serve.

The NASW Code of Ethics serves six purposes:

1. The Code identifies core values on which social work’s mission is based.
2. The Code summarizes broad ethical principles that reflect the profession’s core values and establishes a set of specific ethical standards that should be used to guide social work practice.
3. The Code is designed to help social workers identify relevant considerations when professional obligations conflict or ethical uncertainties arise.
4. The Code provides ethical standards to which the general public can hold the social work profession accountable.
5. The Code socializes practitioners new to the field to social work’s mission, values, ethical principles, and ethical standards.
6. The Code articulates standards that the social work profession itself can use to assess whether social workers have engaged in unethical conduct. NASW has formal procedures to adjudicate ethics.
complaints filed against its members. In subscribing to this Code, social workers are required to cooperate in its implementation, participate in NASW adjudication proceedings, and abide by any NASW disciplinary rulings or sanctions based on it.

1For information on NASW adjudication procedures, see NASW Procedures for the Adjudication of Grievances.

The Code offers a set of values, principles, and standards to guide decision making and conduct when ethical issues arise. It does not provide a set of rules that prescribe how social workers should act in all situations. Specific applications of the Code must take into account the context in which it is being considered and the possibility of conflicts among the Code’s values, principles, and standards. Ethical responsibilities flow from all human relationships, from the personal and familial to the social and professional.

Further, the NASW Code of Ethics does not specify which values, principles, and standards are most important and ought to outweigh others in instances when they conflict. Reasonable differences of opinion can and do exist among social workers with respect to the ways in which values, ethical principles, and ethical standards should be ranked ordered when they conflict. Ethical decision making in a given situation must apply the informed judgment of the individual social worker and should also consider how the issues would be judged in a peer review process where the ethical standards of the profession would be applied.

Ethical decision making is a process. There are many instances in social work where simple answers are not available to resolve complex ethical issues. Social workers should take into consideration all the values, principles, and standards in this Code that are relevant to any situation in which ethical judgment is warranted. Social workers’ decisions and actions should be consistent with the spirit as well as the letter of this Code.

In addition to this Code, there are many other sources of information about ethical thinking that may be useful. Social workers should consider ethical theory and principles generally, social work theory and research, laws, regulations, agency policies, and other relevant codes of ethics, recognizing that among codes of ethics social workers should consider the NASW Code of Ethics as their primary source. Social workers also should be aware of the impact on ethical decision making of their clients’ and their own personal values and cultural and religious beliefs and practices. They should be aware of any conflicts between personal and professional values and deal with them responsibly. For additional guidance social workers should consult the relevant literature on professional ethics and ethical decision making and seek appropriate consultation when faced with ethical dilemmas. This may involve consultation with an agency-based or social work organization’s ethics committee, a regulatory body, knowledgeable colleagues, supervisors, or legal counsel.

Instances may arise when social workers’ ethical obligations conflict with agency policies or relevant laws or regulations. When such conflicts occur, social workers must make a responsible effort to resolve the conflict in a manner that is consistent with the values, principles, and standards expressed in this Code. If a reasonable resolution of the conflict does not appear possible, social workers should seek proper consultation before making a decision.

The NASW Code of Ethics is to be used by NASW and by individuals, agencies, organizations, and bodies (such as licensing and regulatory boards, professional liability insurance providers, courts of law, agency boards of directors, government agencies, and other professional groups) that choose to adopt it or use it as a frame of reference. Violation of standards in this Code does not automatically imply legal liability or violation of the law. Such determination can only be made in the context of legal and judicial proceedings. Alleged violations of the Code would be subject to a peer review process. Such processes are generally separate from legal or administrative procedures and insulated from legal review or proceedings to allow the profession to counsel and discipline its own members.

A code of ethics cannot guarantee ethical behavior. Moreover, a code of ethics cannot resolve all ethical issues or disputes or capture the richness and complexity involved in striving to make responsible choices within a moral community. Rather, a code of ethics sets forth values, ethical principles, and ethical standards to which professionals aspire and by which their actions can be judged. Social workers’ ethical behavior should result from their personal commitment to engage in ethical practice. The NASW Code of Ethics reflects the commitment of all social workers to uphold the profession’s values and to act ethically.
Principles and standards must be applied by individuals of good character who discern moral questions and, in good faith, seek to make reliable ethical judgments.

**Ethical Principles**

The following broad ethical principles are based on social work's core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. These principles set forth ideals to which all social workers should aspire.

**Value: Service**

Ethical Principle: *Social workers' primary goal is to help people in need and to address social problems.*

Social workers elevate service to others above self-interest. Social workers draw on their knowledge, values, and skills to help people in need and to address social problems. Social workers are encouraged to volunteer some portion of their professional skills with no expectation of significant financial return (pro bono service).

**Value: Social Justice**

Ethical Principle: *Social workers challenge social injustice.*

Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice. These activities seek to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity. Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people.

**Value: Dignity and Worth of the Person**

Ethical Principle: *Social workers respect the inherent dignity and worth of the person.*

Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients' socially responsible self-determination. Social workers seek to enhance clients' capacity and opportunity to change and to address their own needs. Social workers are cognizant of their dual responsibility to clients and to the broader society. They seek to resolve conflicts between clients' interests and the broader society's interests in a socially responsible manner consistent with the values, ethical principles, and ethical standards of the profession.

**Value: Importance of Human Relationships**

Ethical Principle: *Social workers recognize the central importance of human relationships.*

Social workers understand that relationships between and among people are an important vehicle for change. Social workers engage people as partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities.

**Value: Integrity**

Ethical Principle: *Social workers behave in a trustworthy manner.*

Social workers are continually aware of the profession's mission, values, ethical principles, and ethical standards and practice in a manner consistent with them. Social workers act honestly and responsibly and promote ethical practices on the part of the organizations with which they are affiliated.
Value: Competence

Ethical Principle. Social workers practice within their areas of competence and develop and enhance their professional expertise.

Social workers continually strive to increase their professional knowledge and skills and to apply them in practice. Social workers should aspire to contribute to the knowledge base of the profession.

Ethical Standards

The following ethical standards are relevant to the professional activities of all social workers. These standards concern (1) social workers’ ethical responsibilities to clients, (2) social workers’ ethical responsibilities to colleagues, (3) social workers’ ethical responsibilities in practice settings, (4) social workers’ ethical responsibilities as professionals, (5) social workers’ ethical responsibilities to the social work profession, and (6) social workers’ ethical responsibilities to the broader society.

Some of the standards that follow are enforceable guidelines for professional conduct, and some are aspirational. The extent to which each standard is enforceable is a matter of professional judgment to be exercised by those responsible for reviewing alleged violations of ethical standards.

1. SOCIAL WORKERS’ ETHICAL RESPONSIBILITIES TO CLIENTS

1.01 Commitment to Clients

Social workers’ primary responsibility is to promote the well-being of clients. In general, clients’ interests are primary. However, social workers’ responsibility to the larger society or specific legal obligations may on limited occasions supersede the loyalty owed clients, and clients should be so advised. (Examples include when a social worker is required by law to report that a client has abused a child or has threatened to harm self or others.)

1.02 Self-Determination

Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients’ right to self-determination when, in the social workers’ professional judgment, clients’ actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others.

1.03 Informed Consent

(a) Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients’ right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions.

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

(c) In instances when clients lack the capacity to provide informed consent, social workers should protect clients’ interests by seeking permission from an appropriate third party, informing clients consistent with the clients’ level of understanding. In such instances social workers should seek to ensure that the third party acts in a manner consistent with clients’ wishes and interests. Social workers should take reasonable steps to enhance such clients’ ability to give informed consent.
(d) In instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of clients' right to refuse service.

(e) Social workers who provide services via electronic media (such as computer, telephone, radio, and television) should inform recipients of the limitations and risks associated with such services.

(f) Social workers should obtain clients' informed consent before audiotaping or videotaping clients or permitting observation of services to clients by a third party.

1.04 Competence

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

(b) Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques.

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

1.05 Cultural Competence and Social Diversity

(a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.

(b) Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups.

(c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, and mental or physical disability.

1.06 Conflicts of Interest

(a) Social workers should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. Social workers should inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary and protects clients' interests to the greatest extent possible. In some cases, protecting clients' interests may require termination of the professional relationship with proper referral of the client.

(b) Social workers should not take unfair advantage of any professional relationship or exploit others to further their personal, religious, political, or business interests.

(c) Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries. (Dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively.)

(d) When social workers provide services to two or more people who have a relationship with each other (for example, couples, family members), social workers should clarify with all parties which
individuals will be considered clients and the nature of social workers' professional obligations to the various individuals who are receiving services. Social workers who anticipate a conflict of interest among the individuals receiving services or who anticipate having to perform in potentially conflicting roles (for example, when a social worker is asked to testify in a child custody dispute or divorce proceedings involving clients) should clarify their role with the parties involved and take appropriate action to minimize any conflict of interest.

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

(b) Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client.

(c) Social workers will protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person or when laws or regulations require disclosure without a client's consent. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed.

(d) Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent.

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

(f) When social workers provide counseling services to families, couples, or groups, social workers should seek agreement among the parties involved concerning each individual's right to confidentiality and obligation to preserve the confidentiality of information shared by others. Social workers should inform participants in family, couples, or group counseling that social workers cannot guarantee that all participants will honor such agreements.

(g) Social workers should inform clients involved in family, couples, marital, or group counseling of the social worker's, employer's, and agency's policy concerning the social worker's disclosure of confidential information among the parties involved in the counseling.

(h) Social workers should not disclose confidential information to third-party payers unless clients have authorized such disclosure.

(i) Social workers should not discuss confidential information in any setting unless privacy can be ensured. Social workers should not discuss confidential information in public or semipublic areas such as hallways, waiting rooms, elevators, and restaurants.

(j) Social workers should protect the confidentiality of clients during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders social workers to disclose confidential or privileged information without a client's consent and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection.
(k) Social workers should protect the confidentiality of clients when responding to requests from members of the media.

(l) Social workers should protect the confidentiality of clients' written and electronic records and other sensitive information. Social workers should take reasonable steps to ensure that clients' records are stored in a secure location and that clients' records are not available to others who are not authorized to have access.

(m) Social workers should take precautions to ensure and maintain the confidentiality of information transmitted to other parties through the use of computers, electronic mail, facsimile machines, telephones and telephone answering machines, and other electronic or computer technology. Disclosure of identifying information should be avoided whenever possible.

(n) Social workers should transfer or dispose of clients' records in a manner that protects clients' confidentiality and is consistent with state statutes governing records and social work licensure.

(o) Social workers should take reasonable precautions to protect client confidentiality in the event of the social worker's termination of practice, incapacitation, or death.

(p) Social workers should not disclose identifying information when discussing clients for teaching or training purposes unless the client has consented to disclosure of confidential information.

(q) Social workers should not disclose identifying information when discussing clients with consultants unless the client has consented to disclosure of confidential information or there is a compelling need for such disclosure.

(r) Social workers should protect the confidentiality of deceased clients consistent with the preceding standards.

1.08 Access to Records

(a) Social workers should provide clients with reasonable access to records concerning the clients. Social workers who are concerned that clients' access to their records could cause serious misunderstanding or harm to the client should provide assistance in interpreting the records and consultation with the client regarding the records. Social workers should limit clients' access to their records, or portions of their records, only in exceptional circumstances when there is compelling evidence that such access would cause serious harm to the client. Both clients' requests and the rationale for withholding some or all of the record should be documented in clients' files.

(b) When providing clients with access to their records, social workers should take steps to protect the confidentiality of other individuals identified or discussed in such records.

1.09 Sexual Relationships

(a) Social workers should under no circumstances engage in sexual activities or sexual contact with current clients, whether such contact is consensual or forced.

(b) Social workers should not engage in sexual activities or sexual contact with clients' relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to the client. Sexual activity or sexual contact with clients' relatives or other individuals with whom clients maintain a personal relationship has the potential to be harmful to the client and may make it difficult for the social worker and client to maintain appropriate professional boundaries. Social workers—not their clients, their clients' relatives, or other individuals with whom the client maintains a personal relationship—assume the full burden for setting clear, appropriate, and culturally sensitive boundaries.

(c) Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client. If social workers engage in conduct contrary to this prohibition or claim that an exception to this prohibition is warranted because of extraordinary
circumstances, it is social workers—not their clients—who assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally.

(d) Social workers should not provide clinical services to individuals with whom they have had a prior sexual relationship. Providing clinical services to a former sexual partner has the potential to be harmful to the individual and is likely to make it difficult for the social worker and individual to maintain appropriate professional boundaries.

1.10 Physical Contact
Social workers should not engage in physical contact with clients when there is a possibility of psychological harm to the client as a result of the contact (such as cradling or caressing clients). Social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact.

1.11 Sexual Harassment
Social workers should not sexually harass clients. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

1.12 Derogatory Language
Social workers should not use derogatory language in their written or verbal communications to or about clients. Social workers should use accurate and respectful language in all communications to and about clients.

1.13 Payment for Services
(a) When setting fees, social workers should ensure that the fees are fair, reasonable, and commensurate with the services performed. Consideration should be given to clients' ability to pay.

(b) Social workers should avoid accepting goods or services from clients as payment for professional services. Bartering arrangements, particularly involving services, create the potential for conflicts of interest, exploitation, and inappropriate boundaries in social workers' relationships with clients. Social workers should explore and may participate in bartering only in very limited circumstances when it can be demonstrated that such arrangements are an accepted practice among professionals in the local community, considered to be essential for the provision of services, negotiated without coercion, and entered into at the client's initiative and with the client's informed consent. Social workers who accept goods or services from clients as payment for professional services assume the full burden of demonstrating that this arrangement will not be detrimental to the client or the professional relationship.

(c) Social workers should not solicit a private fee or other remuneration for providing services to clients who are entitled to such available services through the social workers' employer or agency.

1.14 Clients Who Lack Decision-Making Capacity
When social workers act on behalf of clients who lack the capacity to make informed decisions, social workers should take reasonable steps to safeguard the interests and rights of those clients.

1.15 Interruption of Services
Social workers should make reasonable efforts to ensure continuity of services in the event that services are interrupted by factors such as unavailability, relocation, illness, disability, or death.
1.16 Termination of Services
(a) Social workers should terminate services to clients and professional relationships with them when such services and relationships are no longer required or no longer serve the clients' needs or interests.

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

(c) Social workers in fee-for-service settings may terminate services to clients who are not paying an overdue balance if the financial contractual arrangements have been made clear to the client, if the client does not pose an imminent danger to self or others, and if the clinical and other consequences of the current nonpayment have been addressed and discussed with the client.

(d) Social workers should not terminate services to pursue a social, financial, or sexual relationship with a client.

(e) Social workers who anticipate the termination or interruption of services to clients should notify clients promptly and seek the transfer, referral, or continuation of services in relation to the clients' needs and preferences.

(f) Social workers who are leaving an employment setting should inform clients of appropriate options for the continuation of services and of the benefits and risks of the options.

2. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO Colleagues

2.01 Respect
(a) Social workers should treat colleagues with respect and should represent accurately and fairly the qualifications, views, and obligations of colleagues.

(b) Social workers should avoid unwarranted negative criticism of colleagues in communications with clients or with other professionals. Unwarranted negative criticism may include demeaning comments that refer to colleagues' level of competence or to individuals' attributes such as race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, and mental or physical disability.

(c) Social workers should cooperate with social work colleagues and with colleagues of other professions when such cooperation serves the well-being of clients.

2.02 Confidentiality
Social workers should respect confidential information shared by colleagues in the course of their professional relationships and transactions. Social workers should ensure that such colleagues understand social workers' obligation to respect confidentiality and any exceptions related to it.

2.03 Interdisciplinary Collaboration
(a) Social workers who are members of an interdisciplinary team should participate in and contribute to decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of the social work profession. Professional and ethical obligations of the interdisciplinary team as a whole and of its individual members should be clearly established.

(b) Social workers for whom a team decision raises ethical concerns should attempt to resolve the disagreement through appropriate channels. If the disagreement cannot be resolved, social workers should pursue other avenues to address their concerns consistent with client well-being.
2.04 Disputes Involving Colleagues
   (a) Social workers should not take advantage of a dispute between a colleague and an employer to obtain a position or otherwise advance the social workers' own interests.
   (b) Social workers should not exploit clients in disputes with colleagues or engage clients in any inappropriate discussion of conflicts between social workers and their colleagues.

2.05 Consultation
   (a) Social workers should seek the advice and counsel of colleagues whenever such consultation is in the best interests of clients.
   (b) Social workers should keep themselves informed about colleagues' areas of expertise and competencies. Social workers should seek consultation only from colleagues who have demonstrated knowledge, expertise, and competence related to the subject of the consultation.
   (c) When consulting with colleagues about clients, social workers should disclose the least amount of information necessary to achieve the purposes of the consultation.

2.06 Referral for Services
   (a) Social workers should refer clients to other professionals when the other professionals' specialized knowledge or expertise is needed to serve clients fully or when social workers believe that they are not being effective or making reasonable progress with clients and that additional service is required.
   (b) Social workers who refer clients to other professionals should take appropriate steps to facilitate an orderly transfer of responsibility. Social workers who refer clients to other professionals should disclose, with clients' consent, all pertinent information to the new service providers.
   (c) Social workers are prohibited from giving or receiving payment for a referral when no professional service is provided by the referring social worker.

2.07 Sexual Relationships
   (a) Social workers who function as supervisors or educators should not engage in sexual activities or contact with supervisees, students, trainees, or other colleagues over whom they exercise professional authority.
   (b) Social workers should avoid engaging in sexual relationships with colleagues when there is potential for a conflict of interest. Social workers who become involved in, or anticipate becoming involved in, a sexual relationship with a colleague have a duty to transfer professional responsibilities, when necessary, to avoid a conflict of interest.

2.08 Sexual Harassment
Social workers should not sexually harass supervisees, students, trainees, or colleagues. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

2.09 Impairment of Colleagues
   (a) Social workers who have direct knowledge of a social work colleague’s impairment that is due to personal problems, psychosocial distress, substance abuse, or mental health difficulties and that interferes with practice effectiveness should consult with that colleague when feasible and assist the colleague in taking remedial action.
   (b) Social workers who believe that a social work colleague’s impairment interferes with practice effectiveness and that the colleague has not taken adequate steps to address the impairment should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.
2.10 Incompetence of Colleagues
   (a) Social workers who have direct knowledge of a social work colleague’s incompetence should consult with that colleague when feasible and assist the colleague in taking remedial action.

   (b) Social workers who believe that a social work colleague is incompetent and has not taken adequate steps to address the incompetence should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.

2.11 Unethical Conduct of Colleagues
   (a) Social workers should take adequate measures to discourage, prevent, expose, and correct the unethical conduct of colleagues.

   (b) Social workers should be knowledgeable about established policies and procedures for handling concerns about colleagues’ unethical behavior. Social workers should be familiar with national, state, and local procedures for handling ethics complaints. These include policies and procedures created by NASW, licensing and regulatory bodies, employers, agencies, and other professional organizations.

   (c) Social workers who believe that a colleague has acted unethically should seek resolution by discussing their concerns with the colleague when feasible and when such discussion is likely to be productive.

   (d) When necessary, social workers who believe that a colleague has acted unethically should take action through appropriate formal channels (such as contacting a state licensing board or regulatory body, an NASW committee on inquiry, or other professional ethics committees).

   (e) Social workers should defend and assist colleagues who are unjustly charged with unethical conduct.

3. SOCIAL WORKERS’ ETHICAL RESPONSIBILITIES IN PRACTICE SETTINGS

3.01 Supervision and Consultation
   (a) Social workers who provide supervision or consultation should have the necessary knowledge and skill to supervise or consult appropriately and should do so only within their areas of knowledge and competence.

   (b) Social workers who provide supervision or consultation are responsible for setting clear, appropriate, and culturally sensitive boundaries.

   (c) Social workers should not engage in any dual or multiple relationships with supervisees in which there is a risk of exploitation of or potential harm to the supervisee.

   (d) Social workers who provide supervision should evaluate supervisees’ performance in a manner that is fair and respectful.

3.02 Education and Training
   (a) Social workers who function as educators, field instructors for students, or trainers should provide instruction only within their areas of knowledge and competence and should provide instruction based on the most current information and knowledge available in the profession.

   (b) Social workers who function as educators or field instructors for students should evaluate students’ performance in a manner that is fair and respectful.

   (c) Social workers who function as educators or field instructors for students should take reasonable steps to ensure that clients are routinely informed when services are being provided by students.
(d) Social workers who function as educators or field instructors for students should not engage in any dual or multiple relationships with students in which there is a risk of exploitation or potential harm to the student. Social work educators and field instructors are responsible for setting clear, appropriate, and culturally sensitive boundaries.

3.03 Performance Evaluation

Social workers who have responsibility for evaluating the performance of others should fulfill such responsibility in a fair and considerate manner and on the basis of clearly stated criteria.

3.04 Client Records

(a) Social workers should take reasonable steps to ensure that documentation in records is accurate and reflects the services provided.

(b) Social workers should include sufficient and timely documentation in records to facilitate the delivery of services and to ensure continuity of services provided to clients in the future.

(c) Social workers’ documentation should protect clients’ privacy to the extent that is possible and appropriate and should include only information that is directly relevant to the delivery of services.

(d) Social workers should store records following the termination of services to ensure reasonable future access. Records should be maintained for the number of years required by state statutes or relevant contracts.

3.05 Billing

Social workers should establish and maintain billing practices that accurately reflect the nature and extent of services provided and that identify who provided the service in the practice setting.

3.06 Client Transfer

(a) When an individual who is receiving services from another agency or colleague contacts a social worker for services, the social worker should carefully consider the client’s needs before agreeing to provide services. To minimize possible confusion and conflict, social workers should discuss with potential clients the nature of the clients’ current relationship with other service providers and the implications, including possible benefits or risks, of entering into a relationship with a new service provider.

(b) If a new client has been served by another agency or colleague, social workers should discuss with the client whether consultation with the previous service provider is in the client’s best interest.

3.07 Administration

(a) Social work administrators should advocate within and outside their agencies for adequate resources to meet clients’ needs.

(b) Social workers should advocate for resource allocation procedures that are open and fair. When not all clients’ needs can be met, an allocation procedure should be developed that is nondiscriminatory and based on appropriate and consistently applied principles.

(c) Social workers who are administrators should take reasonable steps to ensure that adequate agency or organizational resources are available to provide appropriate staff supervision.

(d) Social work administrators should take reasonable steps to ensure that the working environment for which they are responsible is consistent with and encourages compliance with the *NASW Code of Ethics*. Social work administrators should take reasonable steps to eliminate any conditions in their organizations that violate, interfere with, or discourage compliance with the *Code*.
3.08 Continuing Education and Staff Development

Social work administrators and supervisors should take reasonable steps to provide or arrange for continuing education and staff development for all staff for whom they are responsible. Continuing education and staff development should address current knowledge and emerging developments related to social work practice and ethics.

3.09 Commitments to Employers

(a) Social workers generally should adhere to commitments made to employers and employing organizations.

(b) Social workers should work to improve employing agencies’ policies and procedures and the efficiency and effectiveness of their services.

(c) Social workers should take reasonable steps to ensure that employers are aware of social workers’ ethical obligations as set forth in the *NASW Code of Ethics* and of the implications of those obligations for social work practice.

(d) Social workers should not allow an employing organization’s policies, procedures, regulations, or administrative orders to interfere with their ethical practice of social work. Social workers should take reasonable steps to ensure that their employing organizations’ practices are consistent with the *NASW Code of Ethics*.

(e) Social workers should act to prevent and eliminate discrimination in the employing organization’s work assignments and in its employment policies and practices.

(f) Social workers should accept employment or arrange student field placements only in organizations that exercise fair personnel practices.

(g) Social workers should be diligent stewards of the resources of their employing organizations, wisely conserving funds where appropriate and never misappropriating funds or using them for unintended purposes.

3.10 Labor–Management Disputes

(a) Social workers may engage in organized action, including the formation of and participation in labor unions, to improve services to clients and working conditions.

(b) The actions of social workers who are involved in labor–management disputes, job actions, or labor strikes should be guided by the profession’s values, ethical principles, and ethical standards. Reasonable differences of opinion exist among social workers concerning their primary obligation as professionals during an actual or threatened labor strike or job action. Social workers should carefully examine relevant issues and their possible impact on clients before deciding on a course of action.

4. SOCIAL WORKERS’ ETHICAL RESPONSIBILITIES AS PROFESSIONALS

4.01 Competence

(a) Social workers should accept responsibility or employment only on the basis of existing competence or the intention to acquire the necessary competence.

(b) Social workers should strive to become and remain proficient in professional practice and the performance of professional functions. Social workers should critically examine and keep current with emerging knowledge relevant to social work. Social workers should routinely review the professional literature and participate in continuing education relevant to social work practice and social work ethics.

(c) Social workers should base practice on recognized knowledge, including empirically based knowledge, relevant to social work and social work ethics.
4.02 Discrimination
Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, or mental or physical disability.

4.03 Private Conduct
Social workers should not permit their private conduct to interfere with their ability to fulfill their professional responsibilities.

4.04 Dishonesty, Fraud, and Deception
Social workers should not participate in, condone, or be associated with dishonesty, fraud, or deception.

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

(b) Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties interfere with their professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others.

4.06 Misrepresentation
(a) Social workers should make clear distinctions between statements made and actions engaged in as a private individual and as a representative of the social work profession, a professional social work organization, or the social worker's employing agency.

(b) Social workers who speak on behalf of professional social work organizations should accurately represent the official and authorized positions of the organizations.

(c) Social workers should ensure that their representations to clients, agencies, and the public of professional qualifications, credentials, education, competence, affiliations, services provided, or results to be achieved are accurate. Social workers should claim only those relevant professional credentials they actually possess and take steps to correct any inaccuracies or misrepresentations of their credentials by others.

4.07 Solicitations
(a) Social workers should not engage in uninvited solicitation of potential clients who, because of their circumstances, are vulnerable to undue influence, manipulation, or coercion.

(b) Social workers should not engage in solicitation of testimonial endorsements (including solicitation of consent to use a client's prior statement as a testimonial endorsement) from current clients or from other people who, because of their particular circumstances, are vulnerable to undue influence.

4.08 Acknowledging Credit
(a) Social workers should take responsibility and credit, including authorship credit, only for work they have actually performed and to which they have contributed.

(b) Social workers should honestly acknowledge the work of and the contributions made by others.
5. SOCIAL WORKERS’ ETHICAL RESPONSIBILITIES TO THE SOCIAL WORK PROFESSION

5.01 Integrity of the Profession
   (a) Social workers should work toward the maintenance and promotion of high standards of practice.
   (b) Social workers should uphold and advance the values, ethics, knowledge, and mission of the profession. Social workers should protect, enhance, and improve the integrity of the profession through appropriate study and research, active discussion, and responsible criticism of the profession.
   (c) Social workers should contribute time and professional expertise to activities that promote respect for the value, integrity, and competence of the social work profession. These activities may include teaching, research, consultation, service, legislative testimony, presentations in the community, and participation in their professional organizations.
   (d) Social workers should contribute to the knowledge base of social work and share with colleagues their knowledge related to practice, research, and ethics. Social workers should seek to contribute to the profession’s literature and to share their knowledge at professional meetings and conferences.
   (e) Social workers should act to prevent the unauthorized and unqualified practice of social work.

5.02 Evaluation and Research
   (a) Social workers should monitor and evaluate policies, the implementation of programs, and practice interventions.
   (b) Social workers should promote and facilitate evaluation and research to contribute to the development of knowledge.
   (c) Social workers should critically examine and keep current with emerging knowledge relevant to social work and fully use evaluation and research evidence in their professional practice.
   (d) Social workers engaged in evaluation or research should carefully consider possible consequences and should follow guidelines developed for the protection of evaluation and research participants. Appropriate institutional review boards should be consulted.
   (e) Social workers engaged in evaluation or research should obtain voluntary and written informed consent from participants, when appropriate, without any implied or actual deprivation or penalty for refusal to participate; without undue inducement to participate; and with due regard for participants’ well-being, privacy, and dignity. Informed consent should include information about the nature, extent, and duration of the participation requested and disclosure of the risks and benefits of participation in the research.
   (f) When evaluation or research participants are incapable of giving informed consent, social workers should provide an appropriate explanation to the participants, obtain the participants’ assent to the extent they are able, and obtain written consent from an appropriate proxy.
   (g) Social workers should never design or conduct evaluation or research that does not use consent procedures, such as certain forms of naturalistic observation and archival research, unless rigorous and responsible review of the research has found it to be justified because of its prospective scientific, educational, or applied value and unless equally effective alternative procedures that do not involve waiver of consent are not feasible.
   (h) Social workers should inform participants of their right to withdraw from evaluation and research at any time without penalty.
   (i) Social workers should take appropriate steps to ensure that participants in evaluation and research have access to appropriate supportive services.
   (j) Social workers engaged in evaluation or research should protect participants from unwarranted physical or mental distress, harm, danger, or deprivation.
Social workers engaged in the evaluation of services should discuss collected information only for professional purposes and only with people professionally concerned with this information.

Social workers engaged in evaluation or research should ensure the anonymity or confidentiality of participants and of the data obtained from them. Social workers should inform participants of any limits of confidentiality, the measures that will be taken to ensure confidentiality, and when any records containing research data will be destroyed.

Social workers who report evaluation and research results should protect participants’ confidentiality by omitting identifying information unless proper consent has been obtained authorizing disclosure.

Social workers should report evaluation and research findings accurately. They should not fabricate or falsify results and should take steps to correct any errors later found in published data using standard publication methods.

Social workers engaged in evaluation or research should be alert to and avoid conflicts of interest and dual relationships with participants. Social workers should inform participants when a real or potential conflict of interest arises, and should take steps to resolve the issue in a manner that makes participants’ interests primary.

Social workers should educate themselves, their students, and their colleagues about responsible research practices.

6. SOCIAL WORKERS’ ETHICAL RESPONSIBILITIES TO THE BROADER SOCIETY

6.01 Social Welfare
Social workers should promote the general welfare of society, from local to global levels, and the development of people, their communities, and their environments. Social workers should advocate for living conditions conducive to the fulfillment of basic human needs and should promote social, economic, political, and cultural values and institutions that are compatible with the realization of social justice.

6.02 Public Participation
Social workers should facilitate informed participation by the public in shaping social policies and institutions.

6.03 Public Emergencies
Social workers should provide appropriate professional services in public emergencies to the greatest extent possible.

6.04 Social and Political Action
(a) Social workers should engage in social and political action that seeks to ensure that all people have equal access to the resources, employment, services, and opportunities they require to meet their basic human needs and to develop fully. Social workers should be aware of the impact of the political arena on practice and should advocate for changes in policy and legislation to improve social conditions in order to meet basic human needs and promote social justice.

(b) Social workers should act to expand choice and opportunity for all people, with special regard for vulnerable, disadvantaged, oppressed, and exploited people and groups.

(c) Social workers should promote conditions that encourage respect for cultural and social diversity within the United States and globally. Social workers should promote policies and practices that demonstrate respect for difference, support the expansion of cultural knowledge and resources,
advocate for programs and institutions that demonstrate cultural competence, and promote policies that safeguard the rights of and confirm equity and social justice for all people.

(d) Social workers should act to prevent and eliminate domination of, exploitation of, and discrimination against any person, group, or class on the basis of race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, or mental or physical disability.
AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY

CODE OF ETHICS

Preamble

In order to promote and maintain the most appropriate professional conduct of its members and to assure the highest level of services provided by its members to children and adolescents and families, the American Academy of Child and Adolescent Psychiatry affirms the following principles of ethical conduct.

The Academy recognizes that a code of ethics cannot encompass all potential issues; it is a dynamic entity and as such must be subject to growth, revision and modification in the future. Hence, these principles are not laws but rather standards intended to guide the child and adolescent psychiatrist in the conduct of his/her professional activities.

As members of the community of medical professions, the members of the American Academy of Child and Adolescent Psychiatry endorses the principles of Medical Ethics of the American Medical Association* and the Code of Ethics of the American Osteopathic Association. Further, members of the American Academy of Child and Adolescent Psychiatry subscribe to Annotations Especially Applicable to Psychiatry of the principles of Medical Ethics approved by the American Psychiatric Association.

*The current principles of Medical Ethics were adopted by the American Medical Association in June, 1980. The current AOA Annotations are dated 1981. The AOA is presently in the process of revision of the principles of Medical Ethics, but has not yet finalized that process. The Code of Ethics of the American Osteopathic Association was revised in July, 1965. Copies of these materials can be obtained from the Organizations themselves.

Adopted by The Council June 14, 1980

CLARIFICATION NOTES ON THE CODE OF ETHICS

Preamble

These introductory statements attempt to define the purpose of the Code and recognize that a Code of Ethics is not a rigid set of specific roles, but rather a set of broad principles which are intended to serve an educational purpose as well as establishing general guidelines for the conduct of the professional. It is assumed that they will change over time.

The endorsement of the standards formulated by larger groups of more generic physicians attempts to establish the nature of child and adolescent psychiatrist's commitment and their connection to medicine. It further attempts to confine the Academy's involvement to those areas specific to children, families and its own professional concerns. It is clear that the final statement will of necessity require specific reference to standards which are current and formally approved by other organizations.

Adopted by The Council June 14, 1980
The nature of the clinical practice and other activities of the child and adolescent psychiatrist require certain additional clarifications because:

A. The services of a child and adolescent psychiatrist are more often sought by the patient's parents or guardians rather than by the children or adolescents themselves.

B. The services of a child and adolescent psychiatrist may be utilized by agencies not directly or fully responsible for the overall welfare of the child or adolescent patient.

C. Child and adolescent psychiatrists may be involved in consultative activity not directly related to particular identified patients.

D. Child and adolescent psychiatrists may engage in research or instructional activities which involve children and adolescents, both directly and indirectly.

E. The child and adolescent psychiatrist recognizes the unique relationship between child and the parent, the child's need for both nurturing relationships and the support of adults and that there exists a special psychological vulnerability of the child or adolescent, not only in respect to parents but in respect to all other adults as well.

The next portion of the Preamble attempts to define some of the problems and the uniqueness of child and adolescent psychiatry which justifies certain additional ethical considerations.

A. The fact that the services of a child and adolescent psychiatrist are more often sought and paid for by someone other than the index patient creates a general setting quite different from that of adult medicine and psychiatry.

B. Child and adolescent psychiatrists often are employed or retained by state or community mental health agencies, judicial or correctional agencies, child protective services, schools or school systems, private medical or social agencies and other service organizations. In these situations, the child and adolescent psychiatrist may function in a variety of roles, e.g., clinician, administrative consultant, evaluator, supervisor, administrator, therapist and others. In any of these situations and within these various agencies and institutions, the relationship to and responsibility for authority concerning the children and adolescents may vary greatly, often creating ambiguity.

C. Child and adolescent psychiatrists may provide indirect service to children. A given individual might serve as a trainer for teachers or social service workers or as a program consultant to schools regarding curriculum development.

D. As a result of their knowledge of development and the influences of families and the community, child and adolescent psychiatrists recognize the unique needs of children and the potential impact of noxious environmental influences. This paragraph is intended to give specific acknowledgment to the commitment to and understanding of the following principles which emerge from the knowledge basic to child and adolescent psychiatry.
The issues of consent, confidentiality, professional responsibility, authority and behavior must be viewed within the context of development and the overlapping and potentially conflicting rights of the child or adolescent, of the parents, and of society.

**Principle I**

The primary concerns of child and adolescent psychiatrists are the welfare and the optimum development of the individual child or adolescent patient or of the population of children and adolescents being served. Professional judgment and the behaviors or actions which arise from that judgment must be determined by the needs of the child or adolescent patient or population. Optimally, these are assessed in the context of the family and community life. Further, those judgments and behaviors should be based on scientific knowledge and collective and personal experience.

**Principle II**

The child and adolescent psychiatrist shall avoid all actions which may have a detrimental effect on the optimum development of the child. Further, by utilizing means appropriate to the context of the clinical contact with the child or adolescent patient or the population being served, the child and adolescent psychiatrist will strive to reduce any deleterious effects of the behaviors of others.

**Principle III**

The child and adolescent psychiatrist will seek to utilize his/her unique relationship with children, adolescents and families and the potential influence based on that relationship and professional status to foster the optimum development and well-being of the children and families. He/she will avoid exercising that influence principally for his/her own gain or aggrandizement.

**Principle I**

This paragraph is a statement of the major overriding commitment to children and families, and to the fundamental notion of professional competence.

**Principle II**

This paragraph addresses the historic commitment of medicine to "do no harm" and extends that commitment to attempting to reduce the potentially harmful interactions of others. It is acknowledged that there are situations in which "ultimate good" may involve temporary discomfort or the choice between alternatives, none of which are without negative consequences. The principle of "all things considered" is appropriate. When there are difficult choices, the decision should rest with those which have the potential for greatest "ultimate good"."all things considered"

**Principle III**

This paragraph is intended to separate the value of the child and adolescent psychiatrist's relationship to children and families from the value of that relationship to the child and adolescent psychiatrist. There may be coercive influences which act on children and families and require them to participate in therapeutic programs. At times, these may be inappropriate to their needs but may benefit the child and adolescent psychiatrist economically. Any action that involves exploitation of children, parents or others, involved for the physician's personal advantage, is clearly unethical.
Principle IV

The child and adolescent psychiatrist recognizes a larger responsibility to children, adolescents and families, and when possible, will seek to reduce by all appropriate means, the deleterious influence of the actions of other individuals or of society at large on the well-being of children, adolescents and families.

This paragraph makes an ethical commitment to advocacy on behalf of children, adolescents and families.

Principle V

Child and adolescent psychiatrists value and will seek to promote, by all appropriate means, the uniqueness of the individual. They will strive in every way compatible with professional practice to maintain and to enhance the dignity and the self respect of all those served. The evaluation and treatment of a child, adolescent or family and the provision of consultative services focus upon the inherent uniqueness of the individuals involved, their developmental potentials and of the social, economic, ethnic, racial and sexual context within which they live.

This paragraph acknowledges an understanding of individual difference and makes it unethical for professional decisions and actions to reflect personal bias.

Principle VI

A minor or unemancipated child or adolescent may participate in evaluation, treatment or prevention efforts without his or her full concurrence. The formal responsibility for decisions regarding such participation usually resides with the parents or legal guardians; while often important in the clinical context, the agreement of the child or adolescent is not required. Regardless of the locus of decision, however, the child and adolescent psychiatrist should seek to develop with the child(ren) or adolescent(s) being served as thorough an understanding of the professional judgments, opinions and actions as is possible. Age alone is not the primary determinant. Due recognition must be given to the developmental aspects of cognition, emotional responses, social maturity, physical growth, and economic and psychological dependency.

This paragraph acknowledges the parental right of decision-making in regard to the minor or unemancipated child or adolescent, but it also requires that the child and adolescent psychiatrist keep the child or adolescent informed and attempt to develop understanding and hopefully concurrence. It accepts certain developmental limitations in understanding but suggests that the capacities of the child or adolescent must be determined on the basis of functional factors and not of age. Even preschool children can develop understanding if addressed properly and with patience.
Principle VII

Child and adolescent psychiatric evaluations, treatment or prevention activities may involve the participation and ideally the concurrence of many people. In attempting to develop such an agreement, the child and adolescent psychiatrist should seek to provide the parents themselves and those involved in their care and/or treatment (parents or guardians, and where appropriate, the teacher and school, court or correctional agency, physicians and others) as thorough an understanding as can usefully be grasped and therapeutically utilized in the care of the child. Specific confidences of the patient and the parents or guardians and others involved should be protected unless this course would involve untenable risks or betrayal of care-taking responsibility.

Principle VIII

There are situations where specific statutes permit the child or the adolescent to participate in decision-making or to be the final arbiter who makes a decision regarding participation in evaluation, treatment or prevention activities. The precise formulation of applicable law may vary among the states. In such situations, the agreement to participate in evaluation, treatment or prevention activities requires that the children or adolescents be adequately informed and that they give their approval. Further, the children or adolescents need to be helped to recognize the influence of their relationship to family members and the consequences of their decisions.

Principle IX

There are situations where a difference exists in the views of a child or adolescent and parents or guardians regarding a professional judgment or recommendation. This may involve evaluation, treatment or prevention efforts, or the release of information. In such circumstances, the child and adolescent psychiatrist will work toward helping family members resolve these differences. During this process, the child and adolescent psychiatrist will keep constantly in mind the well-being and developmental potential of the child or adolescent, the nature of family relationships and the responsibilities, and the legal and moral prerogatives of both parents and offspring.
Principle X

It is often necessary and appropriate that others outside of the family provide information and that they also be informed regarding professional judgments, opinions, recommendations and actions. The release of any information regarding a minor unemancipated child or adolescent to persons outside the family (including the non-custodial parent) requires the agreement of parents or guardians. Regardless of the locus of decision, the child and adolescent psychiatrist will attempt to inform the child or adolescent of the need and intent to release information and will seek his/her concurrence even though such agreement is not required. Specific confidences of child or adolescent patients and of parents or guardians should be protected unless so doing would involve untenable risks or betrayal of care-taking responsibilities.

Principle XI

It is necessary that the child or adolescent, within his/her capacity for understanding, be clearly apprised of confidentiality in regard both to his/her own communication and those of parents or guardians. He/she should also be informed of the limits to the general principle of confidentiality that the sharing of care-taking responsibility requires.

Principle XII

Where required to do so by the laws of a state, as in cases of child abuse and neglect, or in other situations where the safety and welfare of the patient, children or others involved are in jeopardy, the child and adolescent psychiatrist may divulge confidences. However, in such cases the parties involved must be thoroughly informed in advance of these requirements.

Principle XIII

In those situations when a child and adolescent psychiatrist agrees to evaluate a child, adolescent, parent(s) or other individuals or situations for administrative, legal or quasi-legal purpose, all parties should be informed of the nature and intent of the evaluation and the lack of any ability to protect confidences.

Principle X

This paragraph defines the standard by which information can be released beyond the family.

Principle XI

This paragraph defines it as an ethical responsibility that the child and adolescent psychiatrist establish with a child or adolescent patient an understanding of confidentiality and its limits.

Principle XII

This paragraph acknowledges that laws and judicial precedents do sometimes establish situations in which confidences may be divulged. However, the choice to do so remains with the child and adolescent psychiatrist and the judgment should be based on his/her professional understanding and the moral commitments.

Principle XIII

This paragraph acknowledges that child and adolescent psychiatrists do participate in administrative or court ordered evaluations and that in such circumstances the principles of confidentiality are not applicable. However, the choice regarding such participation remains with the child and adolescent psychiatrist.
Principle XIV

The child and adolescent psychiatrist may be called upon to participate in attempts to control or change the behavior of children or adolescents and if, in his/her opinion, those efforts ignore individuality or are counter to the needs of the child or adolescent, or impede optimum development, or involve efforts solely directed toward conformity, the child and adolescent psychiatrist will avoid acting solely as an agent of the parents, guardians or agencies.

Principle XV

Participation in research poses special ethical problems. In those situations in which research activities hold the possibility of benefit to the children or adolescents involved, the basic principles regarding participation in evaluation or therapeutic interventions apply. It is particularly important that an understanding of the potential risks, as well as benefits, be communicated both to parents or guardians and to the involved children or adolescents.

Where the research activities are not related to potential therapeutic benefits or are not likely to produce some other positive effect on the minor or emancipated child or adolescent subject's well-being, the level of risk becomes critical in the decision-making responsibility. Where risk is minimal, the consent of the parents or guardians is sufficient. Nevertheless, the child and adolescent psychiatrist will seek to inform the child or adolescent regarding the nature of the study, its intent and potential risks and benefits, with the consideration of the developmental capacities of the subject.

Where risk is significant, a child or adolescent developmentally capable of understanding the procedures, risk, and the larger benefits should have the right to refuse to participate regardless of the consent of parents or guardians.

Research which does not involve risks to the subject and in which anonymity can be totally protected does not require consent of parents or subjects.

It is most appropriate that when there is any question regarding the participation of children, adolescents or families in research the child and adolescent psychiatrist seek consultation with colleagues or with an established committee on research involving human subjects.

Principle XIV

It is unethical for a child and adolescent psychiatrist to participate in efforts to control or modify the behavior of a child or adolescent, if those efforts are directed at inappropriate standards.

Principle XV

Research poses difficult ethical problems. In particular, there seem to be two matters which are critical to standards and decisions, i.e., the potential of direct benefit to those subjects who participate in research and the element of risk. These standards propose that where there is the potential of benefit, standards applicable to more usual evaluation and treatment apply. In those situations where direct benefit is not involved and where risk is low e.g., the analysis of voided urine samples or the standardization of new psychological tests, both parental consent and the assent - implying understanding, but not necessarily concurrence of the child or adolescent subject are required. In those situations where risk is more significant, e.g., the administration of a chemical agent or taking a biopsy, the child or adolescent subject should have the right of refusal if he/she is developmentally capable of understanding the procedure. Again, age alone is not the sole determinant. Where there is no risk and where anonymity can be preserved, e.g., statistical research involving past clinical data obtained in a routine manner, it is not necessary to have specific consent either by child or parents.
Principle XVI

Participation of minor or emancipated children or adolescents in instructional activities or in the preparation of educational materials requires the parent's or guardian's consent to participation. Additionally, they must clearly understand the intent of the activity, its expected educational value and the extent of the potential audience. They must also recognize that there are realistic limits to the protection of confidentiality. If they are developmentally capable of understanding the activities, their value and their use, the consent of the children or adolescents involved is also required.

Principle XVII

For the child and adolescent psychiatrist, the source of compensation and the contractual relationship he/she forms in respect to evaluation, treatment, consultation and prevention activities, do not usually involve the index patient or population being served. The source of compensation should not influence professional judgments and behaviors.

Questions or inquiries should be addressed to:

A.A.C.A.P.
Attn: Ethics Committee
3615 Wisconsin Avenue, N.W.
Washington, D.C. 20016-3007
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INTRODUCTION

The American Psychological Association's (APA) Ethical Principles of Psychologists and Code of Conduct (hereinafter referred to as the Ethics Code) consists of an Introduction, a Preamble, six General Principles (A-F), and specific Ethical Standards. The Introduction discusses the intent, organization, procedural considerations, and scope of application of the Ethics Code. The Preamble and General Principles are aspirational goals to guide psychologists toward the highest ideals of psychology. Although the Preamble and General Principles are not, themselves, enforceable rules, they should be considered by psychologists in arriving at an ethical course of action and may be considered by ethics bodies in interpreting the Ethical Standards. The Ethical Standards set forth enforceable rules for conduct as psychologists. Most of the Ethical Standards are written broadly, in order to apply to psychologists in varied roles, although the application of an Ethical Standard may vary depending on the context. The Ethical Standards are not exhaustive. The fact that a given conduct is not specifically addressed by the Ethics Code does not mean that it is necessarily either ethical or unethical.

Membership in the APA commits members to adhere to the APA Ethics Code and to the rules and procedures used to implement it. Psychologists and students, whether or not they are APA members, should be aware that the Ethics Code may be applied to them by state psychology boards, courts, or other public bodies.

This Ethics Code applies only to psychologists' work-related activities, that is, activities that are part of the psychologists' scientific and professional functions or that are psychological in nature. It includes the clinical or counseling practice of psychology, research, teaching, supervision of trainees, development of assessment instruments, conducting assessments, educational counseling, organizational consulting, social intervention, administration, and other activities as well. These work-related activities can be distinguished from the purely private conduct of a psychologist, which ordinarily is not within the purview of the Ethics Code.

The Ethics Code is intended to provide standards of professional conduct that can be applied by the APA and by other bodies that choose to adopt them. Whether or not a psychologist has violated the Ethics Code does not by itself determine whether he or she is legally liable in a court action, whether a contract is enforceable, or whether other legal consequences occur. These results are based on legal rather than ethical rules. However, compliance with or violation of the Ethics Code may be admissible as evidence in some legal proceedings, depending on the circumstances.

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. If the Ethics Code establishes a higher standard of conduct than is required by law, psychologists must meet the higher ethical standard. If the Ethics Code standard appears to conflict with the requirements of law, then psychologists make known their commitment to the Ethics Code and take steps to resolve the conflict in a responsible manner. If neither law nor the Ethics Code resolves an issue, psychologists should consider other professional materials2 and the dictates of their own conscience, as well as seek consultation with others within the field when this is practical.

The procedures for filing, investigating, and resolving complaints of unethical conduct are described in the current Rules and Procedures of the APA Ethics Committee. The actions that APA may take for violations of the Ethics Code include actions such as reprimand, censure, termination of

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2. Professional materials that are most helpful in this regard are guidelines and standards that have been adopted or endorsed by professional psychological organizations. Such guidelines and standards, whether adopted by the American Psychological Association (APA) or its Divisions, are not enforceable as such by this Ethics Code, but are of persuasive value to psychologists, courts, and professional bodies. Such materials include, but are not limited to, the APA's General Guidelines for Providers of Psychological Services (1987), Specialties Guidelines for the Delivery of Services to Clinical Psychologists, Counseling Psychologists, Industrial/Organizational Psychologists, and School Psychologists (1981), Guidelines for Computer-Based Tests and Interpretations (1987), Standards for Educational and Psychological Testing (1985), Ethical Principles in the Conduct of Research With Human Participants (1982), Guidelines for Ethical Conduct in the Care and Use of Animals (1986), Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations (1990), and Publication Manual of the American Psychological Association (4th ed., 1991). The APA Divisions that adopt the Ethics Code as a whole include the APA Division 41 (Forensic Psychology), American Psychology-Law Society, and the Specialty Guidelines for Forensic Psychologists (1991).
APA membership, and referral of the matter to other bodies. Complainants who seek remedies such as monetary damages in alleging ethical violations by a psychologist must resort to private negotiation, administrative bodies, or the courts. Actions that violate the Ethics Code may lead to the imposition of sanctions on a psychologist by bodies other than APA, including state psychological associations, other professional groups, psychology boards, other state or federal agencies, and parties for health services. In addition to actions for violation of the Ethics Code, the APA Bylaws provide that APA may take action against a member after his or her conviction of a felony, expulsion or suspension from an affiliated state psychological association, or suspension or loss of licensure.

PREAMBLE

Psychologists work to develop a valid and reliable body of scientific knowledge based on research. They may apply that knowledge to human behavior in a variety of contexts. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness. Their goal is to broaden knowledge of behavior and, where appropriate, to apply it pragmatically to improve the condition of both the individual and society. Psychologists respect the central importance of freedom of inquiry and expression in research, teaching, and publication. They also strive to help the public in developing informed judgments and choices concerning human behavior. This Ethics Code provides a common set of values upon which psychologists build their professional and scientific work.

This Code is intended to provide both the general principles and the decision rules to cover most situations encountered by psychologists. It has as its primary goal the welfare and protection of the individuals and groups with whom psychologists work. It is the individual responsibility of each psychologist to aspire to the highest possible standards of conduct. Psychologists respect and protect human and civil rights, and do not knowingly participate in or condone unfair discriminatory practices. The development of a dynamic set of ethical standards for a psychologist’s work-related conduct requires a personal commitment to a lifelong effort to act ethically; to encourage ethical behavior by students, supervisees, employees, and colleagues, as appropriate; and to consult with others, as needed, concerning ethical problems. Each psychologist supplements, but does not violate, the Ethics Code’s values and rules on the basis of guidance drawn from personal values, culture, and experience.

GENERAL PRINCIPLES

Principle A: Competence

Psychologists strive to maintain high standards of competence in their work. They recognize the boundaries of their particular competencies and the limitations of their expertise. They provide only those services and use only those techniques for which they are qualified by education, training, or experience. Psychologists are cognizant of the fact that the competencies required in serving, teaching, and/or studying groups of people vary with the distinctive characteristics of those groups. In those areas in which recognized professional standards do not yet exist, psychologists exercise careful judgment and take appropriate precautions to protect the welfare of those with whom they work. They maintain knowledge of relevant scientific and professional information related to the services they render, and they recognize the need for ongoing education. Psychologists make appropriate use of scientific, professional, technical, and administrative resources.

Principle B: Integrity

Psychologists seek to promote integrity in the science, teaching, and practice of psychology. In these activities psychologists are honest, fair, and respectful of others. In describing or reporting their qualifications, services, products, fees, research, or teaching, they do not make statements that are false, misleading, or deceptive. Psychologists strive to be aware of their own belief systems, values, needs, and limitations and the effect of these on their work. To the extent feasible, they attempt to clarify for relevant parties the roles they are performing and to function appropriately in accordance with those roles. Psychologists avoid improper and potentially harmful dual relationships.

Principle C: Professional and Scientific Responsibility

Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and adapt their methods to the needs of different populations. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of their patients, clients, or other recipients of their services. Psychologists’ moral standards and conduct are personal matters to the same degree as is true for any other person, except as psychologists’ conduct may compromise their professional responsibilities or reduce the public’s trust in psychology and psychologists. Psychologists are concerned about the ethical compliance of their colleagues’ scientific and professional conduct. When appropriate, they consult with colleagues in order to prevent or avoid unethical conduct.

Principle D: Respect for People’s Rights and Dignity

Psychologists accord appropriate respect to the fundamental rights, dignity, and worth of all people. They respect the rights of individuals to privacy, confidentiality, self-determination, and autonomy, mindful that legal and other obligations may lead to inconsistency and conflict with the exercise of these rights. Psychologists are aware of cultural, individual, and role differences, including those due to age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language, and socioeconomic status.
Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone unfair discriminatory practices.

### Principle E: Concern for Others' Welfare

Psychologists seek to contribute to the welfare of those with whom they interact professionally. In their professional actions, psychologists weigh the welfare and rights of their patients or clients, students, supervisees, human research participants, and other affected persons, and the welfare of animal subjects of research. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts and to perform their roles in a responsible fashion that avoids or minimizes harm. Psychologists are sensitive to real and ascribed differences in power between themselves and others, and they do not exploit or mislead other people during or after professional relationships.

### Principle F: Social Responsibility

Psychologists are aware of their professional and scientific responsibilities to the community and the society in which they work and live. They apply and make public their knowledge of psychology in order to contribute to human welfare. Psychologists are concerned about and work to mitigate the causes of human suffering. When undertaking research, they strive to advance human welfare and the science of psychology. Psychologists try to avoid misuse of their work. Psychologists comply with the law and encourage the development of law and social policy that serve the interests of their patients and clients and the public. They are encouraged to contribute a portion of their professional time for little or no personal advantage.

### ETHICAL STANDARDS

1. **General Standards**

   These General Standards are potentially applicable to the professional and scientific activities of all psychologists.

1.01 **Applicability of the Ethics Code**

   The activity of a psychologist subject to the Ethics Code may be reviewed under these Ethical Standards only if the activity is part of his or her work-related functions or the activity is psychological in nature. Personal activities having no connection to or effect on psychological roles are not subject to the Ethics Code.

1.02 **Relationship of Ethics and Law**

   If psychologists' ethical responsibilities conflict with law, psychologists make known their commitment to the Ethics Code and take steps to resolve the conflict in a responsible manner.

1.03 **Professional and Scientific Relationship**

   Psychologists provide diagnostic, therapeutic, teaching, research, supervisory, consultative, or other psychological services only in the context of a defined professional or scientific relationship or role. (See also Standards 2.01, Evaluation, Diagnosis, and Interventions in Professional Context, and 7.02, Forensic Assessments.)

1.04 **Boundaries of Competence**

   (a) Psychologists provide services, teach, and conduct research only within the boundaries of their competence, based on their education, training, supervised experience, or appropriate professional experience.

   (b) Psychologists provide services, teach, or conduct research in new areas or involving new techniques only after first undertaking appropriate study, training, supervision, and/or consultation from persons who are competent in those areas or techniques.

   (c) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect patients, clients, students, research participants, and others from harm.

1.05 **Maintaining Expertise**

   Psychologists who engage in assessment, therapy, teaching, research, organizational consulting, or other professional activities maintain a reasonable level of awareness of current scientific and professional information in their fields of activity, and undertake ongoing efforts to maintain competence in the skills they use.

1.06 **Basis for Scientific and Professional Judgments**

   Psychologists rely on scientifically and professionally derived knowledge when making scientific or professional judgments or when engaging in scholarly or professional endeavors.

1.07 **Describing the Nature and Results of Psychological Services**

   (a) When psychologists provide assessment, evaluation, treatment, counseling, supervision, teaching, consultation, research, or other psychological services to an individual, a group, or an organization, they provide, using language that is reasonably understandable to the recipient of those services, appropriate information beforehand about the nature of such services and appropriate information later about results and conclusions. (See also Standard 2.09, Explaining Assessment Results.)

   (b) If psychologists will be precluded by law or by organizational roles from providing such information to particular individuals or groups, they so inform those individuals or groups at the outset of the service.
1.08 Human Differences
Where differences of age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language, or socioeconomic status significantly affect psychologists’ work concerning particular individuals or groups, psychologists obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals.

1.09 Respecting Others
In their work-related activities, psychologists respect the rights of others to hold values, attitudes, and opinions that differ from their own.

1.10 Nondiscrimination
In their work-related activities, psychologists do not engage in unfair discrimination based on age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law.

1.11 Sexual Harassment
(a) Psychologists do not engage in sexual harassment. Sexual harassment is sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with the psychologist’s activities or roles as a psychologist, and that either: (1) is unwelcome, is offensive, or creates a hostile workplace environment, and the psychologist knows or is told this; or (2) is sufficiently severe or intense to be abusive to a reasonable person in the context. Sexual harassment can consist of a single intense or severe act or of multiple persistent or pervasive acts.

(b) Psychologists accord sexual-harassment complainants and respondents dignity and respect. Psychologists do not participate in denying a person academic admission or advancement, employment, tenure, or promotion, based solely upon their having made, or their being the subject of, sexual-harassment charges. This does not preclude taking action based upon the outcome of such proceedings or consideration of other appropriate information.

1.12 Other Harassment
Psychologists do not knowingly engage in behavior that is harassing or demeaning to persons with whom they interact in their work based on factors such as those persons’ age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language, or socioeconomic status.

1.13 Personal Problems and Conflicts
(a) Psychologists recognize that their personal problems and conflicts may interfere with their effectiveness. Accordingly, they refrain from undertaking an activity when they know or should know that their personal problems are likely to lead to harm to a patient, client, colleague, student, research participant, or other person to whom they may owe a professional or scientific obligation.

(b) In addition, psychologists have an obligation to be alert to signs of, and to obtain assistance for, their personal problems at an early stage, in order to prevent significantly impaired performance.

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

1.14 Avoiding Harm
Psychologists take reasonable steps to avoid harming their patients or clients, research participants, students, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

1.15 Misuse of Psychologists' Influence
Because psychologists’ scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence.

1.16 Misuse of Psychologists’ Work
(a) Psychologists do not participate in activities in which it appears likely that their skills or data will be misused by others, unless corrective mechanisms are available. (See also Standard 7.04, Truthfulness and Candor.)

(b) If psychologists learn of misuse or misrepresentation of their work, they take reasonable steps to correct or minimize the misuse or misrepresentation.

1.17 Multiple Relationships
(a) In many communities and situations, it may not be feasible or reasonable for psychologists to avoid social or other nonprofessional contacts with persons such as patients, clients, students, supervisees, or research participants. Psychologists must always be sensitive to the potential harmful effects of other contacts on their work and on those persons with whom they deal. A psychologist refrains from entering into or promising another personal, scientific, professional, financial, or other relationship with such persons if it appears likely that such a relationship reasonably might impair the psychologist’s objectivity or otherwise interfere with the psychologist’s effectively performing his or her functions as a psychologist, or might harm or exploit the other party.

(b) Likewise, whenever feasible, a psychologist refrains from taking on professional or scientific obligations when preexisting relationships would create a risk of such harm.

(c) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist attempts to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code.

Standard 1.08–Standard 1.17 • 5
1.18 Barter (With Patients or Clients)

Psychologists ordinarily refrain from accepting goods, services, or other nonmonetary remuneration from patients or clients in return for psychological services because such arrangements create inherent potential for conflicts, exploitation, and distortion of the professional relationship. A psychologist may participate in bartering only if (1) it is not clinically contraindicated, and (2) the relationship is not exploitative. (See also Standards 1.17, Multiple Relationships, and 1.25, Fees and Financial Arrangements.)

1.19 Exploitative Relationships

(a) Psychologists do not exploit persons over whom they have supervisory, evaluative, or other authority such as students, supervisees, employees, research participants, and clients or patients. (See also Standards 4.05-4.07 regarding sexual involvement with clients or patients.)

(b) Psychologists do not engage in sexual relationships with students or supervisees in training over whom the psychologist has evaluative or direct authority, because such relationships are so likely to impair judgment or be exploitative.

1.20 Consultations and Referrals

(a) Psychologists arrange for appropriate consultations and referrals based principally on the best interests of their patients or clients, with appropriate consent, and subject to other relevant considerations, including applicable law and contractual obligations. (See also Standards 5.01, Discussing the Limits of Confidentiality, and 5.06, Consultations.)

(b) When indicated and professionally appropriate, psychologists cooperate with other professionals in order to serve their patients or clients effectively and appropriately.

(c) Psychologists' referral practices are consistent with law.

1.21 Third-Party Requests for Services

(a) When a psychologist agrees to provide services to a person or entity at the request of a third party, the psychologist clarifies to the extent feasible, at the outset of the service, the nature of the relationship with each party. This clarification includes the role of the psychologist (such as therapist, organizational consultant, diagnostician, or expert witness), the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality.

(b) If there is a foreseeable risk of the psychologist's being called upon to perform conflicting roles because of the involvement of a third party, the psychologist clarifies the nature and direction of his or her responsibilities, keeps all parties appropriately informed as matters develop, and resolves the situation in accordance with this Ethics Code.

1.22 Delegation to and Supervision of Subordinates

(a) Psychologists delegate to their employees, supervisees, and research assistants only those responsibilities that such persons can reasonably be expected to perform competently, on the basis of their education, training, or experience, either independently or with the level of supervision being provided.

(b) Psychologists provide proper training and supervision to their employees or supervisees and take reasonable steps to see that such persons perform services responsibly, competently, and ethically.

(c) If institutional policies, procedures, or practices prevent fulfillment of this obligation, psychologists attempt to modify their role or to correct the situation to the extent feasible.

1.23 Documentation of Professional and Scientific Work

(a) Psychologists appropriately document their professional and scientific work in order to facilitate provision of services later by them or by other professionals, to ensure accountability, and to meet other requirements of institutions or the law.

(b) When psychologists have reason to believe that records of their professional services will be used in legal proceedings involving recipients of or participants in their work, they have a responsibility to create and maintain documentation in the kind of detail and quality that would be consistent with reasonable scrutiny in an adjudicative forum. (See also Standard 7.01, Professionalism, under Forensic Activities.)

1.24 Records and Data

Psychologists create, maintain, disseminate, store, retain, and dispose of records and data relating to their research, practice, and other work in accordance with law and in a manner that permits compliance with the requirements of this Ethics Code. (See also Standard 5.04, Maintenance of Records.)

1.25 Fees and Financial Arrangements

(a) As early as is feasible in a professional or scientific relationship, the psychologist and the patient, client, or other appropriate recipient of psychological services reach an agreement specifying the compensation and the billing arrangements.

(b) Psychologists do not exploit recipients of services or payors with respect to fees.

(c) Psychologists' fee practices are consistent with law.

(d) Psychologists do not misrepresent their fees.

(e) If limitations to services can be anticipated because of limitations in financing, this is discussed with the patient, client, or other appropriate recipient of services as
early as is feasible. (See also Standard 4.08, Interruption of Services.)

(f) If the patient, client, or other recipient of services does not pay for services as agreed, and if the psychologist wishes to use collection agencies or legal measures to collect the fees, the psychologist first informs the person that such measures will be taken and provides that person an opportunity to make prompt payment. (See also Standard 5.11, Withholding Records for Nonpayment.)

1.26 Accuracy in Reports to Payors and Funding Sources

In their reports to payors for services or sources of research funding, psychologists accurately state the nature of the research or service provided, the fees or charges, and where applicable, the identity of the provider, the findings, and the diagnosis. (See also Standard 5.05, Disclosures.)

1.27 Referrals and Fees

When a psychologist pays, receives payment from, or divides fees with another professional other than in an employer-employee relationship, the payment to each is based on the services (clinical, consultative, administrative, or other) provided and is not based on the referral itself.

2. Evaluation, Assessment, or Intervention

2.01 Evaluation, Diagnosis, and Interventions in Professional Context

(a) Psychologists perform evaluations, diagnostic services, or interventions only within the context of a defined professional relationship. (See also Standard 1.03, Professional and Scientific Relationship.)

(b) Psychologists' assessments, recommendations, reports, and psychological diagnostic or evaluative statements are based on information and techniques (including personal interviews of the individual when appropriate) sufficient to provide appropriate substantiation for their findings. (See also Standard 7.02, Forensic Assessments.)

2.02 Competence and Appropriate Use of Assessments and Interventions

(a) Psychologists who develop, administer, score, interpret, or use psychological assessment techniques, interviews, tests, or instruments do so in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.

(b) Psychologists refrain from misuse of assessment techniques, interventions, results, and interpretations and take reasonable steps to prevent others from misusing the information these techniques provide. This includes refraining from releasing raw test results or raw data to persons, other than to patients or clients as appropriate, who are not qualified to use such information. (See also Standards 1.02, Relationship of Ethics and Law, and 1.04, Boundaries of Competence.)

2.03 Test Construction

Psychologists who develop and conduct research with tests and other assessment techniques use scientific procedures and current professional knowledge for test design, standardization, validation, reduction or elimination of bias, and recommendations for use.

2.04 Use of Assessment in General and With Special Populations

(a) Psychologists who perform interventions or administer, score, interpret, or use assessment techniques are familiar with the reliability, validation, and related standardization or outcome studies of, and proper applications and uses of, the techniques they use.

(b) Psychologists recognize limits to the certainty with which diagnoses, judgments, or predictions can be made about individuals.

(c) Psychologists attempt to identify situations in which particular interventions or assessment techniques or norms may not be applicable or may require adjustment in administration or interpretation because of factors such as individuals' gender, age, race, ethnicity, national origin, religion, sexual orientation, disability, language, or socioeconomic status.

2.05 Interpreting Assessment Results

When interpreting assessment results, including automated interpretations, psychologists take into account the various test factors and characteristics of the person being assessed that might affect psychologists' judgments or reduce the accuracy of their interpretations. They indicate any significant reservations they have about the accuracy or limitations of their interpretations.

2.06 Unqualified Persons

Psychologists do not promote the use of psychological assessment techniques by unqualified persons. (See also Standard 1.22, Delegation to and Supervision of Subordinates.)

2.07 Obsolete Tests and Outdated Test Results

(a) Psychologists do not base their assessment or intervention decisions or recommendations on data or test results that are outdated for the current purpose.

(b) Similarly, psychologists do not base such decisions or recommendations on tests and measures that are obsolete and not useful for the current purpose.

2.08 Test Scoring and Interpretation Services

(a) Psychologists who offer assessment or scoring procedures to other professionals accurately describe the purpose, norms, validity, reliability, and applications of the
procedures and any special qualifications applicable to their use.

(b) Psychologists select scoring and interpretation services (including automated services) on the basis of evidence of the validity of the program and procedures as well as on other appropriate considerations.

(c) Psychologists retain appropriate responsibility for the appropriate application, interpretation, and use of assessment instruments, whether they score and interpret such tests themselves or use automated or other services.

2.09 Explaining Assessment Results

Unless the nature of the relationship is clearly explained to the person being assessed in advance and precludes provision of an explanation of results (such as in some organizational consulting, preemployment or security screenings, and forensic evaluations), psychologists ensure that an explanation of the results is provided using language that is reasonably understandable to the person assessed or to another legally authorized person on behalf of the client. Regardless of whether the scoring and interpretation are done by the psychologist, by assistants, or by automated or other outside services, psychologists take reasonable steps to ensure that appropriate explanations of results are given.

2.10 Maintaining Test Security

Psychologists make reasonable efforts to maintain the integrity and security of tests and other assessment techniques consistent with law, contractual obligations, and in a manner that permits compliance with the requirements of this Ethics Code. (See also Standard 1.02, Relationship of Ethics and Law.)

3. Advertising and Other Public Statements

3.01 Definition of Public Statements

Psychologists comply with this Ethics Code in public statements relating to their professional services, products, or publications or to the field of psychology. Public statements include but are not limited to paid or unpaid advertising, brochures, printed matter, directory listings, personal resumes or curricula vitae, interviews or comments for use in media, statements in legal proceedings, lectures and public oral presentations, and published materials.

3.02 Statements by Others

(a) Psychologists who engage others to create or place public statements that promote their professional practice, products, or activities retain professional responsibility for such statements.

(b) In addition, psychologists make reasonable efforts to prevent others whom they do not control (such as employers, publishers, sponsors, organizational clients, and representatives of the print or broadcast media) from making deceptive statements concerning psychologists' practice or professional or scientific activities.

(c) If psychologists learn of deceptive statements about their work made by others, psychologists make reasonable efforts to correct such statements.

(d) Psychologists do not compensate employees of press, radio, television, or other communication media in return for publicity in a news item.

(e) A paid advertisement relating to the psychologist's activities must be identified as such, unless it is already apparent from the context.

3.03 Avoidance of False or Deceptive Statements

(a) Psychologists do not make public statements that are false, deceptive, misleading, or fraudulent, either because of what they state, convey, or suggest or because of what they omit, concerning their research, practice, or other work activities or those of persons or organizations with which they are affiliated. As examples (and not in limitation) of this standard, psychologists do not make false or deceptive statements concerning (1) their training, experience, or competence; (2) their academic degrees; (3) their credentials; (4) their institutional or association affiliations; (5) their services; (6) the scientific or clinical basis for, or results or degree of success of, their services; (7) their fees; or (8) their publications or research findings. (See also Standards 6.15, Deception in Research, and 6.18, Providing Participants With Information About the Study.)

(b) Psychologists claim as credentials for their psychological work only degrees that (1) were earned from a regionally accredited educational institution or (2) were the basis for psychology licensure by the state in which they practice.

3.04 Media Presentations

When psychologists provide advice or comment by means of public lectures, demonstrations, radio or television programs, prerecorded tapes, printed articles, mailed material, or other media, they take reasonable precautions to ensure that (1) the statements are based on appropriate psychological literature and practice, (2) the statements are otherwise consistent with this Ethics Code, and (3) the recipients of the information are not encouraged to infer that a relationship has been established with them personally.

3.05 Testimonials

Psychologists do not solicit testimonials from current psychotherapy clients or patients or other persons who because of their particular circumstances are vulnerable to undue influence.

3.06 In-Person Solicitation

Psychologists do not engage, directly or through agents, in an uninvited in-person solicitation of business from actual or potential psychotherapy patients or clients or other persons who because of their particular circumstances are vulnerable to undue influence. However, this does not preclude attempts...
4. **Therapy**

4.01 **Structuring the Relationship**

(a) Psychologists discuss with clients or patients as early as is feasible in the therapeutic relationship appropriate issues, such as the nature and anticipated course of therapy, fees, and confidentiality. (See also Standards 1.25, Fees and Financial Arrangements, and 5.01, Discussing the Limits of Confidentiality.)

(b) When the psychologist's work with clients or patients will be supervised, the above discussion includes that fact, and the name of the supervisor, when the supervisor has legal responsibility for the case.

(c) When the therapist is a student intern, the client or patient is informed of that fact.

(d) Psychologists make reasonable efforts to answer patients' questions and to avoid apparent misunderstandings about therapy. Whenever possible, psychologists provide oral and/or written information, using language that is reasonably understandable to the patient or client.

4.02 **Informed Consent to Therapy**

(a) Psychologists obtain appropriate informed consent to therapy or related procedures, using language that is reasonably understandable to participants. The content of informed consent will vary depending on many circumstances: however, informed consent generally implies that the person (1) has the capacity to consent, (2) has been informed of significant information concerning the procedure, (3) has freely and without undue influence expressed consent, and (4) consent has been appropriately documented.

(b) When persons are legally incapable of giving informed consent, psychologists obtain informed permission from a legally authorized person, if such substitute consent is permitted by law.

(c) In addition, psychologists (1) inform those persons who are legally incapable of giving informed consent about the proposed interventions in a manner commensurate with the persons’ psychological capacities, (2) seek their assent to those interventions, and (3) consider such persons’ preferences and best interests.

4.03 **Couple and Family Relationships**

(a) When a psychologist agrees to provide services to several persons who have a relationship (such as husband and wife or parents and children), the psychologist attempts to clarify at the outset (1) which of the individuals are patients or clients and (2) the relationship the psychologist will have with each person. This clarification includes the role of the psychologist and the probable uses of the services provided or the information obtained. (See also Standard 5.01, Discussing the Limits of Confidentiality.)

(b) As soon as it becomes apparent that the psychologist may be called on to perform potentially conflicting roles (such as marital counselor to husband and wife, and then witness for one party in a divorce proceeding), the psychologist attempts to clarify and adjust, or withdraw from, roles appropriately. (See also Standard 7.03, Clarification of Role, under Forensic Activities.)

4.04 **Providing Mental Health Services to Those Served by Others**

In deciding whether to offer or provide services to those already receiving mental health services elsewhere, psychologists carefully consider the treatment issues and the potential patient's or client's welfare. The psychologist discusses these issues with the patient or client, or another legally authorized person on behalf of the client, in order to minimize the risk of confusion and conflict, consults with the other service providers when appropriate, and proceeds with caution and sensitivity to the therapeutic issues.

4.05 **Sexual Intimacies With Current Patients or Clients**

Psychologists do not engage in sexual intimacies with current patients or clients.

4.06 **Therapy With Former Sexual Partners**

Psychologists do not accept as therapy patients or clients persons with whom they have engaged in sexual intimacies.

4.07 **Sexual Intimacies With Former Therapy Patients**

(a) Psychologists do not engage in sexual intimacies with a former therapy patient or client for at least two years after cessation or termination of professional services.

(b) Because sexual intimacies with a former therapy patient or client are so frequently harmful to the patient or client, and because such intimacies undermine public confidence in the psychology profession and thereby deter the public's use of needed services, psychologists do not engage in sexual intimacies with former therapy patients and clients even after a two-year interval except in the most unusual circumstances. The psychologist who engages in such activity after the two years following cessation or termination of treatment bears the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including (1) the amount of time that has passed since therapy terminated, (2) the nature and duration of the therapy, (3) the circumstances of termination, (4) the patient's or client's personal history, (5) the patient's or client's current mental status, (6) the likelihood of adverse impact on the patient or client and others, and (7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a posttermination sexual or romantic relationship with the patient or client. (See also Standard 1.17, Multiple Relationships.)
4.08 Interruption of Services
(a) Psychologists make reasonable efforts to plan for facilitating care in the event that psychological services are interrupted by factors such as the psychologist’s illness, death, unavailability, or relocation or by the client’s relocation or financial limitations. (See also Standard 5.09, Preserving Records and Data.)
(b) When entering into employment or contractual relationships, psychologists provide for orderly and appropriate resolution of responsibility for patient or client care in the event that the employment or contractual relationship ends, with paramount consideration given to the welfare of the patient or client.

4.09 Terminating the Professional Relationship
(a) Psychologists do not abandon patients or clients. (See also Standard 1.25e, under Fees and Financial Arrangements.)
(b) Psychologists terminate a professional relationship when it becomes reasonably clear that the patient or client no longer needs the service, is not benefiting, or is being harmed by continued service.
(c) Prior to termination for whatever reason, except where precluded by the patient’s or client’s conduct, the psychologist discusses the patient’s or client’s views and needs, provides appropriate pretermination counseling, suggests alternative service providers as appropriate, and takes other reasonable steps to facilitate transfer of responsibility to another provider if the patient or client needs one immediately.

5. Privacy and Confidentiality
These Standards are potentially applicable to the professional and scientific activities of all psychologists.

5.01 Discussing the Limits of Confidentiality
(a) Psychologists discuss with persons and organizations with whom they establish a scientific or professional relationship (including, to the extent feasible, minors and their legal representatives) (1) the relevant limitations on confidentiality, including limitations where applicable in group, marital, and family therapy or in organizational consulting, and (2) the foreseeable uses of the information generated through their services.
(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.
(c) Permission for electronic recording of interviews is secured from clients and patients.

5.02 Maintaining Confidentiality
Psychologists have a primary obligation and take reasonable precautions to respect the confidentiality rights of those with whom they work or consult, recognizing that confidentiality may be established by law, institutional rules, or professional or scientific relationships. (See also Standard 6.26, Professional Reviewers.)

5.03 Minimizing Intrusions on Privacy
(a) In order to minimize intrusions on privacy, psychologists include in written and oral reports, consultations, and the like, only information germane to the purpose for which the communication is made.
(b) Psychologists discuss confidential information obtained in clinical or consulting relationships, or evaluative data concerning patients, individual or organizational clients, students, research participants, supervisees, and employees, only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters.

5.04 Maintenance of Records
Psychologists maintain appropriate confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium. Psychologists maintain and dispose of records in accordance with law and in a manner that permits compliance with the requirements of this Ethics Code.

5.05 Disclosures
(a) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose, such as (1) to provide needed professional services to the patient or the individual or organizational client, (2) to obtain appropriate professional consultations, (3) to protect the patient or client or others from harm, or (4) to obtain payment for services, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose.
(b) Psychologists also may disclose confidential information with the appropriate consent of the patient or the individual or organizational client (or of another legally authorized person on behalf of the patient or client), unless prohibited by law.

5.06 Consultations
When consulting with colleagues, (1) psychologists do not share confidential information that reasonably could lead to the identification of a patient, client, research participant, or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and (2) they share information only to the extent necessary to achieve the purposes of the consultation. (See also Standard 5.02, Maintaining Confidentiality.)
5.07 Confidential Information in Databases

(a) If confidential information concerning recipients of psychological services is to be entered into databases or systems of records available to persons whose access has not been consented to by the recipient, then psychologists use coding or other techniques to avoid the inclusion of personal identifiers.

(b) If a research protocol approved by an institutional review board or similar body requires the inclusion of personal identifiers, such identifiers are deleted before the information is made accessible to persons other than those of whom the subject was advised.

(c) If such deletion is not feasible, then before psychologists transfer such data to others or review such data collected by others, they take reasonable steps to determine that appropriate consent of personally identifiable individuals has been obtained.

5.08 Use of Confidential Information for Didactic or Other Purposes

(a) Psychologists do not disclose in their writings, lectures, or other public media, confidential, personally identifiable information concerning their patients, individual or organizational clients, students, research participants, or other recipients of their services that they obtained during the course of their work, unless the person or organization has consented in writing or unless there is other ethical or legal authorization for doing so.

(b) Ordinarily, in such scientific and professional presentations, psychologists disguise confidential information concerning such persons or organizations so that they are not individually identifiable to others and so that discussions do not cause harm to subjects who might identify themselves.

5.09 Preserving Records and Data

A psychologist makes plans in advance so that confidentiality of records and data is protected in the event of the psychologist’s death, incapacity, or withdrawal from the position or practice.

5.10 Ownership of Records and Data

Recognizing that ownership of records and data is governed by legal principles, psychologists take reasonable and lawful steps so that records and data remain available to the extent needed to serve the best interests of patients, individual or organizational clients, research participants, or appropriate others.

5.11 Withholding Records for Nonpayment

Psychologists may not withhold records under their control that are requested and imminently needed for a patient’s or client’s treatment solely because payment has not been received, except as otherwise provided by law.

6. Teaching, Training Supervision, Research, and Publishing

6.01 Design of Education and Training Programs

Psychologists who are responsible for education and training programs seek to ensure that the programs are competently designed, provide the proper experiences, and meet the requirements for licensure, certification, or other goals for which claims are made by the program.

6.02 Descriptions of Education and Training Programs

(a) Psychologists responsible for education and training programs seek to ensure that there is a current and accurate description of the program content, training goals and objectives, and requirements that must be met for satisfactory completion of the program. This information must be made readily available to all interested parties.

(b) Psychologists seek to ensure that statements concerning their course outlines are accurate and not misleading, particularly regarding the subject matter to be covered, bases for evaluating progress, and the nature of course experiences. (See also Standard 3.03, Avoidance of False or Deceptive Statements.)

(c) To the degree to which they exercise control, psychologists responsible for announcements, catalogs, brochures, or advertisements describing workshops, seminars, or other non-degree-granting educational programs ensure that they accurately describe the audience for which the program is intended, the educational objectives, the presenters, and the fees involved.

6.03 Accuracy and Objectivity in Teaching

(a) When engaged in teaching or training, psychologists present psychological information accurately and with a reasonable degree of objectivity.

(b) When engaged in teaching or training, psychologists recognize the power they hold over students or supervisees and therefore make reasonable efforts to avoid engaging in conduct that is personally demeaning to students or supervisees. (See also Standards 1.09, Respecting Others, and 1.12, Other Harassment.)

6.04 Limitation on Teaching

Psychologists do not teach the use of techniques or procedures that require specialized training, licensure, or expertise, including but not limited to hypnosis, biofeedback, and projective techniques, to individuals who lack the prerequisite training, legal scope of practice, or expertise.

6.05 Assessing Student and Supervisee Performance

(a) In academic and supervisory relationships, psychologists establish an appropriate process for providing feedback to students and supervisees.
(b) Psychologists evaluate students and supervisees on the basis of their actual performance on relevant and established program requirements.

6.06 Planning Research

(a) Psychologists design, conduct, and report research in accordance with recognized standards of scientific competence and ethical research.

(b) Psychologists plan their research so as to minimize the possibility that results will be misleading.

(c) In planning research, psychologists consider its ethical acceptability under the Ethics Code. If an ethical issue is unclear, psychologists seek to resolve the issue through consultation with institutional review boards, animal care and use committees, peer consultations, or other proper mechanisms.

(d) Psychologists take reasonable steps to implement appropriate protections for the rights and welfare of human participants, other persons affected by the research, and the welfare of animal subjects.

6.07 Responsibility

(a) Psychologists conduct research competently and with due concern for the dignity and welfare of the participants.

(b) Psychologists are responsible for the ethical conduct of research conducted by them or by others under their supervision or control.

(c) Researchers and assistants are permitted to perform only those tasks for which they are appropriately trained and prepared.

(d) As part of the process of development and implementation of research projects, psychologists consult those with expertise concerning any special population under investigation or most likely to be affected.

6.08 Compliance With Law and Standards

Psychologists plan and conduct research in a manner consistent with federal and state law and regulations, as well as professional standards governing the conduct of research, and particularly those standards governing research with human participants and animal subjects.

6.09 Institutional Approval

Psychologists obtain from host institutions or organizations appropriate approval prior to conducting research, and they provide accurate information about their research proposals. They conduct the research in accordance with the approved research protocol.

6.10 Research Responsibilities

Prior to conducting research (except research involving only anonymous surveys, naturalistic observations, or similar research), psychologists enter into an agreement with participants that clarifies the nature of the research and the responsibilities of each party.

6.11 Informed Consent to Research

(a) Psychologists use language that is reasonably understandable to research participants in obtaining their appropriate informed consent (except as provided in Standard 6.12, Dispensing With Informed Consent). Such informed consent is appropriately documented.

(b) Using language that is reasonably understandable to participants, psychologists inform participants of the nature of the research; they inform participants that they are free to participate or to decline to participate or to withdraw from the research; they explain the foreseeable consequences of declining or withdrawing; they inform participants of significant factors that may be expected to influence their willingness to participate (such as risks, discomfort, adverse effects, or limitations on confidentiality, except as provided in Standard 6.15, Deception in Research); and they explain other aspects about which the prospective participants inquire.

(c) When psychologists conduct research with individuals such as students or subordinates, psychologists take special care to protect the prospective participants from adverse consequences of declining or withdrawing from participation.

(d) When research participation is a course requirement or opportunity for extra credit, the prospective participant is given the choice of equitable alternative activities.

(e) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) obtain the participant's assent, and (3) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted by law.

6.12 Dispensing With Informed Consent

Before determining that planned research (such as research involving only anonymous questionnaires, naturalistic observations, or certain kinds of archival research) does not require the informed consent of research participants, psychologists consider applicable regulations and institutional review board requirements, and they consult with colleagues as appropriate.

6.13 Informed Consent in Research Filming or Recording

Psychologists obtain informed consent from research participants prior to filming or recording them in any form, unless the research involves simply naturalistic observations in public places and it is not anticipated that the recording will be used in a manner that could cause personal identification or harm.

6.14 Offering Inducements for Research Participants

(a) In offering professional services as an inducement to obtain research participants, psychologists make clear the nature of the services, as well as the risks, obligations, and
limitions. (See also Standard 1.18, Barter [With Patients or Clients].)

(b) Psychologists do not offer excessive or inappropriate financial or other inducements to obtain research participants, particularly when it might tend to coerce participation.

6.15 Deception in Research

(a) Psychologists do not conduct a study involving deception unless they have determined that the use of deceptive techniques is justified by the study's prospective scientific, educational, or applied value and that equally effective alternative procedures that do not use deception are not feasible.

(b) Psychologists never deceive research participants about significant aspects that would affect their willingness to participate, such as physical risks, discomfort, or unpleasant emotional experiences.

(c) Any other deception that is an integral feature of the design and conduct of an experiment must be explained to participants as early as is feasible, preferably at the conclusion of their participation, but no later than at the conclusion of the research. (See also Standard 6.18, Providing Participants With Information About the Study.)

6.16 Sharing and Utilizing Data

Psychologists inform research participants of their anticipated sharing or further use of personally identifiable research data and of the possibility of unanticipated future uses.

6.17 Minimizing Invasiveness

In conducting research, psychologists interfere with the participants or milieu from which data are collected only in a manner that is warranted by an appropriate research design and that is consistent with psychologists' roles as scientific investigators.

6.18 Providing Participants With Information About the Study

(a) Psychologists provide a prompt opportunity for participants to obtain appropriate information about the nature, results, and conclusions of the research, and psychologists attempt to correct any misconceptions that participants may have.

(b) If scientific or humane values justify delaying or withholding this information, psychologists take reasonable measures to reduce the risk of harm.

6.19 Honoring Commitments

Psychologists take reasonable measures to honor all commitments they have made to research participants.

6.20 Care and Use of Animals in Research

(a) Psychologists who conduct research involving animals treat them humanely.

(b) Psychologists acquire, care for, use, and dispose of animals in compliance with current federal, state, and local laws and regulations, and with professional standards.

(c) Psychologists trained in research methods and experienced in the care of laboratory animals supervise all procedures involving animals and are responsible for ensuring appropriate consideration of their comfort, health, and humane treatment.

(d) Psychologists ensure that all individuals using animals under their supervision have received instruction in research methods and in the care, maintenance, and handling of the species being used, to the extent appropriate to their role.

(e) Responsibilities and activities of individuals assisting in a research project are consistent with their respective competencies.

(f) Psychologists make reasonable efforts to minimize the discomfort, infection, illness, and pain of animal subjects.

(g) A procedure subjecting animals to pain, stress, or privation is used only when an alternative procedure is unavailable and the goal is justified by its prospective scientific, educational, or applied value.

(h) Surgical procedures are performed under appropriate anesthesia; techniques to avoid infection and minimize pain are followed during and after surgery.

(i) When it is appropriate that the animal's life be terminated, it is done rapidly, with an effort to minimize pain, and in accordance with accepted procedures.

6.21 Reporting of Results

(a) Psychologists do not fabricate data or falsify results in their publications.

(b) If psychologists discover significant errors in their published data, they take reasonable steps to correct such errors in a correction, retraction, erratum, or other appropriate publication means.

6.22 Plagiarism

Psychologists do not present substantial portions or elements of another's work or data as their own, even if the other work or data source is cited occasionally.

6.23 Publication Credit

(a) Psychologists take responsibility and credit, including authorship credit, only for work they have actually performed or to which they have contributed.

(b) Principal authorship and other publication credits accurately reflect the relative scientific or professional contributions of the individuals involved, regardless of their relative status. Mere possession of an institutional position, such as Department Chair, does not justify authorship credit. Minor contributions to the research or to the writing for publications are appropriately acknowledged, such as in footnotes or in an introductory statement.

(c) A student is usually listed as principal author on any multiple-authored article that is substantially based on the student's dissertation or thesis.

Standard 6.15—Standard 6.23 • 13
6.24 Duplicate Publication of Data

Psychologists do not publish, as original data, data that have been previously published. This does not preclude republishing data when they are accompanied by proper acknowledgment.

6.25 Sharing Data

After research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release.

6.26 Professional Reviewers

Psychologists who review material submitted for publication, grant, or other research proposal review respect the confidentiality of and the proprietary rights in such information of those who submitted it.

7. Forensic Activities

7.01 Professionalism

Psychologists who perform forensic functions, such as assessments, interviews, consultations, reports, or expert testimony, must comply with all other provisions of this Ethics Code to the extent that they apply to such activities. In addition, psychologists base their forensic work on appropriate knowledge of and competence in the areas underlying such work, including specialized knowledge concerning special populations. (See also Standards 1.06, Basis for Scientific and Professional Judgments; 1.08, Human Differences; 1.15, Misuse of Psychologists' Influence; and 1.23, Documentation of Professional and Scientific Work.)

7.02 Forensic Assessments

(a) Psychologists' forensic assessments, recommendations, and reports are based on information and techniques (including personal interviews of the individual, when appropriate) sufficient to provide appropriate substantiation for their findings. (See also Standards 1.03, Professional and Scientific Relationship; 1.23, Documentation of Professional and Scientific Work; 2.01, Evaluation, Diagnosis, and Interventions in Professional Context; and 2.05, Interpreting Assessment Results.)

(b) Except as noted in (c), below, psychologists provide written or oral forensic reports or testimony of the psychological characteristics of an individual only after they have conducted an examination of the individual adequate to support their statements or conclusions.

(c) When, despite reasonable efforts, such an examination is not feasible, psychologists clarify the impact of their limited information on the reliability and validity of their reports and testimony, and they appropriately limit the nature and extent of their conclusions or recommendations.

7.03 Clarification of Role

In most circumstances, psychologists avoid performing multiple and potentially conflicting roles in forensic matters. When psychologists may be called on to serve in more than one role in a legal proceeding—for example, as consultant or expert for one party or for the court and as a fact witness—they clarify role expectations and the extent of confidentiality in advance to the extent feasible, and thereafter as changes occur, in order to avoid compromising their professional judgment and objectivity and in order to avoid misleading others regarding their role.

7.04 Truthfulness and Candor

(a) In forensic testimony and reports, psychologists testify truthfully, honestly, and candidly, and, consistent with applicable legal procedures, describe fairly the bases for their testimony and conclusions.

(b) Whenever necessary to avoid misleading, psychologists acknowledge the limits of their data or conclusions.

7.05 Prior Relationships

A prior professional relationship with a party does not preclude psychologists from testifying as fact witnesses or from testifying to their services to the extent permitted by applicable law. Psychologists appropriately take into account ways in which the prior relationship might affect their professional objectivity or opinions and disclose the potential conflict to the relevant parties.

7.06 Compliance With Law and Rules

In performing forensic roles, psychologists are reasonably familiar with the rules governing their roles. Psychologists are aware of the occasionally competing demands placed upon them by these principles and the requirements of the court system, and attempt to resolve these conflicts by making known their commitment to this Ethics Code and taking steps to resolve the conflict in a responsible manner. (See also Standard 1.02, Relationship of Ethics and Law.)

8. Resolving Ethical Issues

8.01 Familiarity With Ethics Code

Psychologists have an obligation to be familiar with this Ethics Code, other applicable ethics codes, and their application to psychologists' work. Lack of awareness or misunderstanding of an ethical standard is not itself a defense to a charge of unethical conduct.

8.02 Confronting Ethical Issues

When a psychologist is uncertain whether a particular situation or course of action would violate this Ethics Code, the psychologist ordinarily consults with other psychologists knowledgeable about ethical issues, with state or national
psychology ethics committees, or with other appropriate authorities in order to choose a proper response.

8.03 Conflicts Between Ethics and Organizational Demands

If the demands of an organization with which psychologists are affiliated conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and to the extent feasible, seek to resolve the conflict in a way that permits the fullest adherence to the Ethics Code.

8.04 Informal Resolution of Ethical Violations

When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved.

8.05 Reporting Ethical Violations

If an apparent ethical violation is not appropriate for informal resolution under Standard 8.04 or is not resolved properly in that fashion, psychologists take further action appropriate to the situation, unless such action conflicts with confidentiality rights in ways that cannot be resolved. Such action might include referral to state or national committees on professional ethics or to state licensing boards.

8.06 Cooperating With Ethics Committees

Psychologists cooperate in ethics investigations, proceedings, and resulting requirements of the APA or any affiliated state psychological association to which they belong. In doing so, they make reasonable efforts to resolve any issues as to confidentiality. Failure to cooperate is itself an ethics violation.

8.07 Improper Complaints

Psychologists do not file or encourage the filing of ethics complaints that are frivolous and are intended to harm the respondent rather than to protect the public.
APPENDIX B

SURVEY INSTRUMENT: PART ONE
Professional Practices Survey

1. __ Male  __ Female

2. Age: ___ <35  ___ 35-44  ___ 45-54  ___ ≥55

3. Ethnicity:  ___ African-American  ___ Asian American/Pacific Islander  ___ Caucasian  ___ Mexican-American  ___ Native American  ___ Other Hispanic/Latino  ___ Other (Specify)

4. Profession:  ___ Psychiatrist  ___ Psychologist  ___ Social Worker

5. Please specify highest degree(s) earned and date of degree:
   B.S.W. ___ Date ______  D.S.W. ___ Date ______
   Ed.D. ___ Date ______  M.D. ___ Date ______
   M.S.W. ___ Date ______  Ph.D. ___ Date ______
   Psy.D. ___ Date ______  D.O. ___ Date ______

6. Percentage of your practice that involves work with [Note: Percentages should add up to 100%]
   Adults only (18 yrs & older) ______  Minors only (17 yrs & younger) ______  Families ______

7. Primary therapeutic orientation (Check only one)
   ____ Behavioral  ____ Cognitive-Behavioral
   ____ Eclectic  ____ Existential
   ____ Gestalt  ____ Humanistic
   ____ Psychodynamic  ____ Systems
   ____ Other (Please specify) ______

8. Which one of the following choices best describes your primary work setting?
   ____ Outpatient Mental Health Clinic
   ____ Inpatient Clinic/Hospital Setting
   ____ Residential Treatment Center
   ____ Solo Private Practice
   ____ Group Private Practice
   ____ University/Academic Department
   ____ University/Medical School
   ____ Community College
   ____ Student Health Center
   ____ Public or Private School Setting
   ____ Other (Specify) ______

9. Please check below the nature of your ethics education (check all that apply)
   ____ Graduate/medical school coursework
   ____ Separate course on ethics
   ____ Ethics included as sections of other courses
   ____ Seminars/Supervision during internship
   ____ Residency/Postdoctoral Training
   ____ Continuing education courses
   ____ No formal ethics training

10. Number of years that you have been in practice ______
APPENDIX C

SURVEY INSTRUMENT: PART TWO
Professional Practices Survey

Below is a list of behaviors or activities that may arise in the clinical setting involving the provision of mental health services to children or adolescents. Please indicate the degree to which you feel each behavior is ethical and, by circling the appropriate letter, the frequency with which you believe each behavior occurs in your clinical practice.

For the purposes of this survey, a child is considered to be 11 years of age or younger, and an adolescent is considered to be 12 to 17 years of age. A minor is any person below 18 years of age.

Rating Codes:
(N) Never, (S) Sometimes, (F) Frequently, and (A) Always

<table>
<thead>
<tr>
<th>Behavior/Activity</th>
<th>Believe Event Is Ethical?</th>
<th>Frequency Of Occurrence In Your Own Practice?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Treat the child of a close friend.</td>
<td>N S F A</td>
<td>N S F A</td>
</tr>
<tr>
<td>2. Begin a social relationship with the parent/guardian of a current minor client</td>
<td>N S F A</td>
<td>N S F A</td>
</tr>
<tr>
<td>3. Become sexually involved with the parent/guardian of a current minor client</td>
<td>N S F A</td>
<td>N S F A</td>
</tr>
<tr>
<td>4. Begin a social relationship with the parent/guardian of a former minor client</td>
<td>N S F A</td>
<td>N S F A</td>
</tr>
<tr>
<td>5. Become sexually involved with the parent/guardian of a former minor client</td>
<td>N S F A</td>
<td>N S F A</td>
</tr>
<tr>
<td>6. Accept a service or product from a parent/guardian as payment for professional services rendered to a minor client</td>
<td>N S F A</td>
<td>N S F A</td>
</tr>
<tr>
<td>7. Enter into a business relationship with a parent/guardian of a current minor client (e.g., buy or sell a product, pay for a service, make a joint investment)</td>
<td>N S F A</td>
<td>N S F A</td>
</tr>
<tr>
<td>8. Enter into a business relationship with a parent/guardian of a former minor client (e.g., buy or sell a product, pay for a service, make a joint investment)</td>
<td>N S F A</td>
<td>N S F A</td>
</tr>
<tr>
<td>9. Being sexually attracted to a child client but never acting on it</td>
<td>N S F A</td>
<td>N S F A</td>
</tr>
<tr>
<td>10. Become sexually involved with a child client</td>
<td>N S F A</td>
<td>N S F A</td>
</tr>
<tr>
<td>11. Being sexually attracted to an adolescent client but never acting on it</td>
<td>N S F A</td>
<td>N S F A</td>
</tr>
<tr>
<td>12. Become sexually involved with an adolescent client</td>
<td>N S F A</td>
<td>N S F A</td>
</tr>
<tr>
<td>13. Testify in a child custody hearing in behalf of a minor who you are seeing in therapy</td>
<td>N S F A</td>
<td>N S F A</td>
</tr>
</tbody>
</table>
14. Treat the child/adolescent of an employee or colleague
15. Attend a social function at the invitation of a minor client or parent/guardian (e.g., graduation, birthday party)
16. Accept as a client a member of a youth sports team that you coach
17. Become sexually involved with a former client who is currently 18 years of age or older, and it is two years since the termination of therapy
18. Treat an adolescent's homosexuality as a form of pathology
19. Use a psychological treatment when there is not sufficient empirical evidence to support its use
20. Use a psychological treatment when you have little experience with its use
21. Treat minor clients of cultures other than your own without seeking consultation/supervision
22. Treat minor clients when you know you are too distressed to be effective
23. Treat minor clients whose values or beliefs are not consistent with your own values
24. Inform parent/guardian of a minor client's sexual orientation without client's consent
25. Perform a child custody evaluation by seeing only the child and the one parent who made the appointment
26. Perform a child custody evaluation during the time that you are also the child's therapist
27. Perform a child custody evaluation within a two year period following the termination of treatment of the same child
28. Treat a child or adolescent who has a psychological problem which you do not have experience in treating, but do have an understanding of the general treatment principles
29. Inform Child Protection Services after you learn directly from the minor client that the client is being sexually abused

| N S F A | N S F A | N S F A | N S F A | N S F A | N S F A | N S F A | N S F A |
| N S F A | N S F A | N S F A | N S F A | N S F A | N S F A | N S F A | N S F A |
| N S F A | N S F A | N S F A | N S F A | N S F A | N S F A | N S F A | N S F A |
| N S F A | N S F A | N S F A | N S F A | N S F A | N S F A | N S F A | N S F A |
| N S F A | N S F A | N S F A | N S F A | N S F A | N S F A | N S F A | N S F A |
| N S F A | N S F A | N S F A | N S F A | N S F A | N S F A | N S F A | N S F A |
| N S F A | N S F A | N S F A | N S F A | N S F A | N S F A | N S F A | N S F A |
| N S F A | N S F A | N S F A | N S F A | N S F A | N S F A | N S F A | N S F A |
|   | 30. Inform Child Protection Services after you learn from a third party that a minor client is being sexually abused | N S F A | N S F A |
|---|----------------------------------------------------------------------------------------------------------------|--      |        |
|   | 31. Inform Child Protection Services after you learn directly from the client of past sexual abuse of the client | N S F A | N S F A |
|   | 32. Inform Child Protection Services after you learn directly from the minor client that the client is being physically abused | N S F A | N S F A |
|   | 33. Report a minor client's HIV status to other professionals (i.e., school authorities, group home leaders) | N S F A | N S F A |
|   | 34. Report an adolescent client's pregnancy to their parent/guardian | N S F A | N S F A |
|   | 35. Inform the parent/guardian of an adolescent client that the client is sexually active | N S F A | N S F A |
|   | 36. Report a child client's use of alcohol to their parent/guardian | N S F A | N S F A |
|   | 37. Report an adolescent client's use of alcohol to their parent/guardian | N S F A | N S F A |
|   | 38. Report a child client's use of marijuana to their parent/guardian | N S F A | N S F A |
|   | 39. Report an adolescent client's use of marijuana to their parent/guardian | N S F A | N S F A |
|   | 40. Break confidentiality if a minor client is homicidal | N S F A | N S F A |
|   | 41. Break confidentiality if a minor client is suicidal | N S F A | N S F A |
|   | 42. Discuss progress of therapy with parent/guardian of an adolescent client without adolescent's consent | N S F A | N S F A |
|   | 43. Discuss progress of therapy with parent/guardian of a child client without child's consent | N S F A | N S F A |

Thank you very much for completing this survey. If you would like a copy of the results of this survey, please return the enclosed card in a separate envelope to:
Kathleen Raschel, M.Ed
Richard J. Morris, Ph.D
University of Arizona
College of Education, SER
Tucson, AZ 85721
Phone: (520) 621-3086
APPENDIX D

COVER LETTER
Dear Colleague:

We are writing to request your help in surveying child-oriented mental health professionals concerning their ethical beliefs about certain practices. Specifically, we are interested in understanding what different professionals think about certain clinical practices and how frequently they feel such practices occur.

This survey is being mailed to a randomly selected national sample of members of professional associations for psychiatrists, psychologists, and social workers. Your responses will be confidential. To assure anonymity, an individual's responses will not be coded in any way and no respondent will be identified in the survey. Results will only be coded and analyzed as group data.

The enclosed form, which takes approximately 15 minutes to complete, surveys your opinion regarding the occurrence of various behaviors within your work environment, and your beliefs of the degree that you feel such behaviors are ethical.

A pre-paid and addressed envelope is enclosed to return the survey. If you would like a summary of the findings, please mail us a separate note with your name and address or, if you wish, include your name and address in the return envelope.

Please return your survey by June 6, 1997.

Thank you very much for your participation in the survey.

Sincerely,

Kathleen Rishel, M. Ed
Doctoral Candidate
School Psychology Program
(520) 621-3086

Richard J. Morris, Ph. D.
Professor and Director,
School Psychology Program
APPENDIX E

ETHICAL BEHAVIOR STATEMENTS BY DOMAIN
Multiple Relationships Domain

1. Treat the child of a close friend
2. Begin a social relationship with the parent/guardian of a current minor client
3. Become sexually involved with the parent/guardian of a current minor client
4. Begin a social relationship with the parent/guardian of a former minor client
5. Become sexually involved with the parent/guardian of a former minor client
6. Accept a service or product from a parent/guardian as payment for professional services rendered to a minor client
7. Enter into a business relationship with a parent/guardian of a current minor client (e.g., buy or sell a product, pay for a service, make a joint investment)
8. Enter into a business relationship with a parent/guardian of a former minor client (e.g., buy or sell a product, pay for a service, make a joint investment)
9. Being sexually attracted to a child client but never acting on it
10. Become sexually involved with a child client
11. Being sexually attracted to an adolescent client but never acting on it
12. Become sexually involved with an adolescent client
13. Testify in a child custody hearing in behalf of a minor client who you are seeing in therapy
14. Treat the child/adolescent of an employee or colleague
15. Attend a social function at invitation of a minor client or parent/guardian (e.g., graduation, birthday party)
16. Accept as a client a member of a youth sports team you coach
17. Become sexually involved with a former client who is currently 18 years of age or older, and it is two years since the termination of therapy

Confidentiality Domain

1. Inform Child Protection Services after you learn directly from the minor client that the client is being sexually abused
2. Inform Child Protection Services after you learn from a third party that a minor client is being sexually abused
3. Inform Child Protection Services after you learn directly from the client of past sexual abuse of the client
4. Inform Child Protection Services after you learn directly from the minor client that the client is being physically abused
5. Report a minor client’s HIV status to other professionals (i.e., school authorities, group home leaders)
6. Report an adolescent client’s pregnancy to their parent/guardian
7. Inform the parent/guardian of an adolescent client that the client is sexually active.
8. Report a child client’s use of alcohol to their parent/guardian
9. Report an adolescent client’s use of alcohol to their parent/guardian
10. Report a child client’s use of marijuana to their parent/guardian
11. Report an adolescent client’s use of marijuana to their parent/guardian
12. Break confidentiality if a minor client is homicidal
13. Break confidentiality if a minor client is suicidal
14. Discuss progress of therapy with parent/guardian of a child client without child's consent
15. Discuss progress of therapy with parent/guardian of an adolescent client without adolescent's consent
16. Inform parent/guardian of a minor client's sexual orientation without client's consent

**Competence Domain**

1. Treat an adolescent's homosexuality as a form of psychopathology
2. Use a psychological treatment when there is not sufficient empirical evidence to support its use
3. Use a psychological treatment when you have little experience with its use
4. Treat minor clients of cultures other than your own without seeking consultation/supervision
5. Treat minor clients when you know you are too distressed to be effective
6. Treat minor clients whose values or beliefs are not consistent with your own values
7. Perform a child custody evaluation by seeing only the child and the one parent who made the appointment
8. Perform a child custody evaluation during the time that you are also the child's therapist
9. Perform a child custody evaluation within a two year period following the termination of treatment of the same child
10. Treat a child or adolescent who has a psychological problem which you do not have experience in treating, but do have an understanding of the general treatment principles
APPENDIX F

QUALITATIVE STATEMENTS
Treat the child of a close friend.

- I treated a child of a friend who wasn’t close – only Spanish speaker who would see her. Later our friendship continued and became closer but we are not intimate friends.
- Eval only.
- Never – unless geographical impossibility to find another person to do it.
- As a military Dr. I may be the only one available, e.g. in Japan/Germany
- Depends on type of treatment or involvement.
- Small town setting.
- Never treat. Will provide psychoeducational assessment to send to schools such as gifted or LD eval.
- Medical term – I don’t “treat” anyone.

Accept a service or product from a parent/guardian as payment for professional services rendered to a minor client.

- Per IRS obligatory.

Begin a social relationship with the parent/guardian of a former minor client.

- I am in some activities where this can’t be avoided, but very superficial social interactions.
- If at same school etc. Sometimes comes up casually. In school my children attend. Would not pursue social relationship but would be cordial.
- If distant.
- In the military overseas bases have a smaller population. It is difficult not to see clients after hours.
- At least 5-7 years post-termination (marked never)
- After 2 years case closed.
- How former? 20 years later? It would depend on the specifics – probably never, but possibly.
- After minor is adult and independent.
- Limited social relation by nature of small town practice.

Accept a service or product from a parent/guardian as payment for professional services rendered to a minor client.

- To pay off bill after discontinued treatment.
- If patient cannot pay
- No for service – maybe for product.
- Fair exchange is allowed.
- A self-pay parent paid me in “bicycles” that I would have bought. I credited full price and reported it.
- Depends on area of country, also if urban/rural.
- For low-income clients I sometimes have them do community service to “balance” the fee.

Enter into a business relationship with a parent/guardian of a current minor client.

- Only if no other source for service is available (i.e., rural area).
- May be impossible to avoid in small community.
- I live in a very rural area – sometimes clients are the only ones providing the service in the area.
- If fellow town person has service that is needed.

Enter into a business relationship with a parent/guardian of a current minor client.

- I have done this once. It worked out well. I will probably never do it again.
- In a small town a parent may own a store where minor purchases are made – this is what I mean by sometimes (e.g., only florist in town).
• Depends. I would buy hay from parents of former clients at market rate, but would not enter into joint business venture, ever.
• Actually, he became a client after a previous established business relationship.

Being sexually attracted to a child client but never acting on it. (#9)
Being sexually attracted to an adolescent client but never acting on it. (#11)
• Confusing question.
• Never acting is always ethical!
• Might happen as countertransference to someone, but would need treatment!
• Ethics is not really the issue here, is it?
• The case for supervision and countertransference.
• Not an issue of ethics (#11 only).
• Not ethical but it happens!
• If sexually attracted to client should refer pt to someone else.
• Tough to see as ethical but may not be unusual.
• Not an ethical question but a state.
• Not applicable.
• Why attracted to child needs to be explored with third party.
• Attraction is human – acting on it unethical (#11 only).
• Never ethical assuming it’s more than a passing thought every few months.
• Confusing item.
• Terminate treatment.
• Not a matter of ethics.
• Not a question of ethics.
• Not a question of ethics.
• Not an ethical issue!
• This isn’t an ethical issue.
• Silly question.
• Not applicable to ethics.
• This is not a question that can be answered as an “ethical event”.
• These questions are not describing an action taken but a state of awareness. Do I act on my awareness? Do I act awareness? Use factor analysis on these questions to see if these questions lump.
• Attraction is not an “event”.
• Nothing to do with ethics.
• Strange mix of feelings and ethics.
• Always ethical, but get help.
• I do not think this is a question of ethics – it is a feeling which is not right or wrong. Patient should be referred to another therapist if therapist is not managing feelings effectively.
• A feeling has nothing to do with ethics.
• Rating scale not adequate for this question.
• Don’t think feelings per se are ethical or not.
• Not a behavior.
• You can’t help how you feel, but you can control your actions.
• This has nothing to do with being ethical or unethical.
• It is ethical to have feelings, but especially for #9, shouldn’t be in this setting if occurs more than once every couple years.
• Feelings in and of themselves are neither ethical nor unethical.
• Ambiguous.
• What are the ethics of sexual attraction?
• Sexual attraction is not an ethical issue.
• Isn’t “attraction” outside of voluntary control? How do you judge this?
• This is not a behavior.
• This does not seem to be an ethics issue. If you were attracted it would denote a feeling (albeit a dangerous one). Getting supervision would be important.
• I don’t think feelings are an ethical issue. They just happen.
• Countertransference issue.
• Thoughts are thoughts!
• I do not consider this to be an ethical issue! If attraction occurs, it is a “natural phenomenon,” not an ethical issue.
• “Sexual attraction” is a passive action (as a choice to experience or not) as distinguished from “awareness” that someone may be charismatic, precocious, et al., and therefore a sexual object for peers.
• The attraction a person may not have control over, their behavior they do.
• Attraction is a feeling, thus having no ethical consequence, although definitely PATHOLOGICAL.

Testify in a child custody hearing in behalf of a minor who you are seeing in therapy.
• Only if assessing parents as well.
• Rare, but subpoenas happen.
• Difficult therapeutically – best avoided. But not unethical.
• Only in regards to treatment. Not to give opinion on custody.
• When subpoena comes, but usually family courts are willing to defer.
• Frequently called to testify in various cases, including custody, or to condition of child. I testify free of charge as advocate for child.
• Testing. Not as custody evaluator.
• Limited to Rx issues – not custody recommendations.
• May not have a choice.
• To testify about child, not about parents and their capacities, when subpoenaed.
• Only if client and parents agree to disclosures prior to establishing therapeutic relationship.
• With consent and/or subpoena.
• Have never done one – I might if I felt child was in potential danger and I was subpoenaed.
• Not in terms of recommendation for custody, only in terms of mental health of that child.
• I refer these out and make no testimony part of my Rx contract and Tx.
• Court ordered situations require this.

Treat the child/adolescent of an employee or colleague.
• Another physician.
• Did this once, will not do it again.
• Never with employee, sometimes with colleague.
• Don’t know if this is unethical – but it’s fraught with problems.
• Sometimes is unavoidable in a small military community.
• Depends on relationship (colleague). If you are the only psychiatrist you may have no choice; necessary treatment may not otherwise be available. Obviously not the best.
• Not unless you were the only treatment resource within 4 hour or 200 mile radius.
• No for employee. Frequently ethical if you don’t know or work with the colleague.
• Depends on relationship.
• Employee no – colleague yes.
• Big difference between employee and colleague.
• Employee of the school district that I personally do not know.
• Never for employee, sometimes for colleague.
• Small town setting.
• Two very different categories.
• We are in a rural area—sometimes only source.
• Never treat. Will provide psychoeducational evals to school, gifted eval, LD eval.
• May depend on what type of colleague.
• Through our internal EAP.
• I did, twice, two years ago—would no longer consider this with what I know now.
• Not formal, but would offer advice if solicited.
• In the military overseas bases it is difficult not to see a client after hours. (Same for 15-16)
• How do you define colleague?
• I think an employee is a different relationship from a colleague and this should be two separate questions.

Attend a social function at the invitation of a minor client or parent/guardian.
• I would do this only for rare and therapeutic indications. Never for the social aspect.
• Did once after termination of client.
• Sometimes—especially for cultural-different client situation.
• This could be psychologically valuable to patient.
• I went to a school play to see an adolescent client with performance anxiety.
• Funeral.
• A few times for long-term client. Wedding or graduation.
• Especially for disabled kids.
• Formal ceremony, not socialization.
• Foster child graduation or big event.

Accept as a client a member of a youth sports team that you coach.
• Too difficult therapeutically.
• At end of season.
• I live in a rural area. Sometimes no other coach is available.
• After season’s over.
• Probably not a good idea, but in some small towns there may not be options.
• Only as related to sponsoring girls’ softball team which I do not coach.

Become sexually involved with a former client who is currently 18 years of age or older, and it is two years since the termination of therapy.
• What is age of therapist?
• We’re now married!

Treat an adolescent’s homosexuality as a form of pathology.
• This is not a question of ethics.
• Depends on whether it’s ego systemic or ego dystonic.
• If ego dystonic
• Thank you for this question!
• Doesn’t seem an ethical issue—more an orientation issue.
• It generally isn’t.
• If patient regards it as such.
• If situational— not fixed.
• Is it pathological to the adolescent?
• Is poor practice.
• Need more info. Vague question.
• Sometimes ethical - when patient sees it as such due to his/her religious beliefs.
• It could depend on whether client views it as ego-alien or not.
• If ego dystonic
• What does this mean?
• Rarely: only if client believes, feels it is problematic.
• If ego dystonic.
• Not ethic question. Not according to DSM IV. Practice question.
• Depends on what he/she is doing.

Use a psychological treatment when there is not sufficient empirical evidence to support its use
• If you inform client of such.
• What is empirical evidence?
• If benign.
• What is meant by psychological treatment?
• May have no such information.
• If you’ve tried everything else.
• Supportive treatment, prevention.
• Empirical evidence follows treatment.
• Sometimes – if you mean something that works but has not yet been proven.
• Depends on treatment, i.e., if it isn’t likely to hurt patient it could be ok.
• Psychodynamic psychotherapy!
• Not able to answer this question.
• Where is the empirical evidence for anything except drugs?
• Empirical evidence comes from data collected in treatment … the new brief therapy treatments fit this.
• When is there sufficient evidence?
• In conjunction with other treatment
• I have made many mistakes in my 32 years. I hope I have learned and work hard not to do this.
• Gathered by whom?
• EMDR is not supported in my view. What is? Never use questionable treatment.
• I don’t know what this means.
• Hardly any have “enough evidence.”
• Is there ever “sufficient empirical evidence?”
• As part of Rx, not as entire base of treatment.
• This is difficult for older therapists who were trained in the psychoanalytic school – no evidence.
• EMDR is still being investigated.
• Too vague to answer. Psychotropic? EMDR? Paradoxical?

Use a psychological treatment when you have little experience with its use.
• As a medical student.
• With supervision.
• Does one seminar qualify?
• In family.
• With supervision.
• In training.
• In training.
• Experience may be gained in training and workshop settings.
• Depends entirely on type of treatment.
• Only new ones.
• Only with supervision.
• I would do this, though I would also seek consultation/supervision; would not attempt
treatment without this backup.
• With consultation/supervision.
• With supervision.
• With supervision.
• With supervision and/or consultation.
• With consultation.
• With supervision.
• With consultation.
• With or without consultation?
• With consultation and/or supervision.
• If supervised.
• We start at zero with everything.
• More often in the beginning of my career.
• When learning a new technique.
• Had to start sometime after learning new techniques.
• Every therapist does this at first.
• We are all beginners at some point!

Treat minor clients of cultures other than your own without seeking consultation/supervision.
• Did literature search/self education.
• If educated and sensitized to cultural issues.
• I'm of minority status.
• Occasionally if no local consultation available, plus some patients can suggest resources.
  Generally not a good idea.
• You may be experienced.
• Can learn from books.
• I think it is necessary to get some education but not specific supervision.
• Lit review.
• Depends on experience with culture.
• How different is the culture?
• Rural area – may be no consultants available
• Self study.
• Depends on your own knowledge of these cultures.
• In my practice supervision is always available if needed.
• There are very few sources of multi-cultural supervision in my present professional
  community – rural.
• Sometimes there are no knowledgeable consultants re specific culture.
• Clients can be “supervisors.”

Treat minor clients when you know you are too distressed to be effective.
• One should not go to office unless prepared to be maximally effective
• Temporary grief but can’t abandon.
• Sometimes – if distress of child would be worse if I didn’t treat.
• Don’t understand question.
• If I have a migraine today or I am suicidal every day?
• Only if only source of last hope.
• When there is no other option.
Treat minor clients whose values or beliefs are not consistent with your own values.
- This requires constant vigilance and awareness. I do not treat patients when I feel distaste for their values.
- This applies to all teenagers.
- Most people under 30 don’t share my beliefs.
- I personally cannot treat a minor child whose parents’ ideas and values are in conflict with mine.
- It’s my job to keep these separate.
- Need to always keep own values as own, not impose own values on client.

Inform parent/guardian of a minor client’s sexual orientation without client’s consent.
- Based on age of minor.
- Sometimes, if below age 14. Never, if 14 or older.
- Depends on circumstances.
- If related to unsafe behavior.

Perform a child custody evaluation by seeing only the child and the one parent who made the appointment.
- It was a big mistake. Only one. Paid for my mistake.
- When other parent refuses participation.
- Only if we were unable to get other parent to cooperate and it would be detrimental not to testify.
- Once father refused to testify. Made known to the court.
- Depends on nature of treatment.
- That wouldn’t meet my definition of a child custody evaluation.
- Will do a consultation on issues but can’t make a specific recommendation.
- We don’t do child custody evals due to the ethical problems.
- Estranged parents sometimes refuse. Usually I obtain court order.
- What if parent refused to be seen?
- Sometimes – but cannot recommend one parent over the other without seeing both parents.
- Are you referring to a court ordered or private referral or both? If you are court ordered and only one parent shows up for interviews...
- Except where other parent refuses to participate – then custody evaluation will be limited and full recommendations cannot be made.
- If other parent is totally unavailable.
- Sometimes court or circumstances don’t give the option.
- Parent sometimes refuses.

Perform a child custody evaluation during the time that you are also the child’s therapist.
- Depends on who else is available geographically.
- Court needs to be informed.
- Custody eval is often part of treatment.

Perform a child custody evaluation during the time that you are also the child’s therapist.
- I think the idea that someone is no longer your patient after a period of time is arbitrary.

Treat a child or adolescent who has a psychological problem which you do not have experience in treating, but do have an understanding of the general treatment principles.
- In training, with supervision.
- But only with supervision and/or consultation on that problem.
• If the child won't get treatment if you don't help them then what is the lessor of 2 evils?
• Experience and/or supervision is necessary to safeguard patients' therapeutic experience.
• In training.
• With supervision.
• Necessary for newly trained people.
• Sometimes – if no one more experienced is available.
• With supervision.
• Not without supervision/consultation.
• With peer consultation.
• This is a small community. There is sometimes not a great deal of choice in providers.
• With consultation. Did this a couple of times while a civilian psychologist for the U.S. Army in Europe for 5 years.
• With supervision.
• If supervised.
• Applies to every group practitioner.
• Sometimes, because of managed care lists, there are no experts available.
• Would seek consultation.

Inform Child Protection Services after you learn directly from the minor client that the client is being sexually abused.
• Required by state law.
• Depends on social class of client.
• By law required.
• It's the law!
• I usually interview patient myself if someone on staff suspects abuse.
• Only if minor client call CPS from office and asks for immediate protection. Police Dept. called first.
• In a Residential Treatment Center where children are committed, reporting rules are more complex than your questionnaire allows.
• Without telling the parents?
• Also, however, further investigation is mandatory.
• It's the law of the state. (same for 30-32)
• Not an option in Oregon – therapists must report. Clients are always informed of this at the beginning of treatment. (same for 30)
• Can't answer. Question doesn't clarify if other means were exhausted first (such as convincing parents to notify CPS). (same for 30-32)
• Only after speaking with client.

Inform Child Protection Services after you learn from a third party that a minor client is being sexually abused.
• Required by state law.
• Talk with child first.
• Need more info/name
• Urge third party to report.
• This is our state law. (same for 31, 32, 33)
• Not required by law but if any question I do report.
• Depends on reliability.
• Certainly if you believe it.
• This is hearsay, but the duty to inform requires only the suspicion or possibility of abuse.
• This is hard. How valid is third party report?
• Military falsely accuse.
• Advise them to call better.
• Could be necessary.
• If third party unable/unwilling.
• If third party has not called and third party reliable.
• Call local police dept. (same for 31)
• Call to consult.
• Always - If third party is related to child or is the abuser (not a neighbor telling me about a child I don’t know.)
• Only with some evidence!
• Not required in state.
• Try to get third party to report.
• Depends on informant.
• Mandated. (same for 31-32)

Inform Child Protection Services after you learn directly from the client of past sexual abuse of the client.
• Depends on age of patient.
• Depends on if it is an adult.
• If child is in danger.
• Report if possible. Most adults I’ve treated will not give names, or perp is already in jail.
• Question not specific enough.
• Only if not previously reported.
• If the data is there, i.e., patient may not know who molester was – as in a rape by a stranger.
• How far past?
• If perp still has contact.
• With child’s consent?
• If client is still a minor, it’s the law. If the perp has access to minors I report to have it on the record.
• Depends on age. If over 18, no, or if already reported, no. (same for 32)
• Always – if client is a minor and it has not already been reported and if threat if still present.
• Useless question.
• Depends on potential for recurrence.
• Depends on age and circumstances.
• How far past?
• If the client is still at risk or other children at risk. Perpetrator in the home.
• Adult no, child yes.
• Only if client is still under 18 will I always do this.
• Depends on safety issues. (same for 32)
• Depends if it’s past statute of limitations.
• Couldn’t answer. Would need to know situation directly.
• Depends on age of client and risk to others.

Inform Child Protection Services after you learn directly from the minor client that the client is being physically abused.
• Required by state law.
• After discussing with client and notifying parents.
• False accusation military.
• Inform client first.
• Need to verify.
• State law.
• Depends on whether it is something reportable vs something I know Prot-Services will not take a report on.

Report a minor client's HIV status to other professionals.
• Never without informed consent/authorization.
• Only as required by law.
• With permission only.
• Only with permission and only as required.
• Medical authorities – for treatment and public health reasons.
• If child aggressive, danger to others.
• Depends.
• Not without consent. (same 34 and 35)
• Federal law pertains here even though law is very shortsighted.
• Never without permission. Sometimes with permission and a good reason.
• This is being tested – not clear in state statute – what is considered duty to warn?

Report an adolescent client's pregnancy to their parent/guardian.
• I try to have clients tell parent themselves.
• Encourage client to tell.
• With consent or health endangerment.
• Usually after discussing and encouraging child or adolescent to share with parents, facilitate in session (same comment for 35-39).
• With client's knowledge/consent (same comment for 35-39).
• Only as required by law.
• Patients end up reporting it themselves.
• I specifically tell them I won't tell parents. I encourage them to do so, often in my presence. (same comment for 35-39)
• With permission of client. (same 36-39)
• I discuss these boundaries with parents and minors prior to beginning Tx – usually encourage minors to tell parents about these issues during a family session. At outset I tell minors that if I believe their behaviors are self-endangering I will break confidentiality.
• Under certain circumstances – i.e. diabetic.
• I help the adolescent to tell, often in my office.
• Not without consent.
• Depends on age, i.e., 13-y-o is different from 17-y-o. (same for 35, 37, 39)
• Only at request of patient in a joint session.
• Usually with consent of patient. (same for 35)
• Encourage client to tell parent/guardian if appropriate.
• Only with consent. If she won't give it I have to tell.
• Always help patient tell parents with all of us together. Have never had a child or adolescent request this be kept from parent. (same for 35-39).
• Always below 14, never above 14.
• I encourage the adolescent to tell the parent themselves.
• If the child won't, I will.
• Invite parent to session in which client reveals nature of problem to parent. (same for 35-38)
• If unsafe behavior and have told teen. (same for 35-37)
• After discussion with the adolescent. (same for 35)
• Current law in state.
Inform the parent/guardian of an adolescent client that the client is sexually active.

- After consult with client.
- Never if patient isn't endangering self.
- I specifically tell parents I will only inform for imminent danger and explicitly exclude sexual behavior and therapy content.
- Not without permission.
- With client present. (same for 36-39)
- If danger to self or others.
- Is IQ relevant?
- Only with client present.
- If demanded.
- Only if dangerous, e.g., with AIDS patient and no other way to deal with the danger.

Report a child client's use of alcohol to their parent/guardian.

- If dangerous.
- Never, unless patient agrees. (same for 37 and 38)
- Family therapy would be used to help child or adolescent disclose to parent/guardian. (same for 37-39)
- Will inform client of intent first. (same for 37 and 38)
- Inform client of what I intend to do and why. (same for 37)
- If addicted.
- Depends on level of use.
- Only if imminent danger.
- Only if I believe child's life is in danger. (same for 37)
- Tell the child that I will talk to parent. (same for 38)
- I would tell the kid that the parent needs to know first.
- After telling them I would do so.
- If at abuse level. (same for 37-39)

Report an adolescent client's use of alcohol to their parent/guardian.

- I try to have clients tell parent themselves.
- Usually get adolescents to do it themselves.
- We work towards their sharing it with therapist present unless it's life threatening — then it's reported. (same for 38-39)
- If addicted.
- If danger.
- Is IQ relevant?
- Depends on extent of abuse. (same for 39)
- Always have been able to get client to do so.
- I help the teen to tell. (same for 38)
- If endangerment issue.

Report an adolescent client's use of marijuana to their parent/guardian.

- I try to have clients tell parent themselves.
- Usually adolescents helped to do it themselves.
- If I believe there is danger.
- I help the teen to talk about it with the parents.
- After telling them I would do so.
Break confidentiality if a minor client is homicidal.
- Has never happened but I would not hesitate!
- I always inform patients that certain things cannot be confidential (and explain what that means in terms of health and safety) — but that if/when I have to tell parents they will know and can be present.
- If necessary to save minor's life.
- Mandated.
- Tell client first.
- If plan, means, identified victim(s).
- Law in Oregon.
- Generally violent or specific target?
- It's the law.
- Damned either way.
- Legally required.
- Required by law. Duty to report.
- Yes: duty to warn/Tarasoff rule if victim is deemed to be in imminent danger.
- I define confidentiality to clients at onset of treatment and these two are clearly defined as times I report to parents/authorities. (same for 41)
- Michigan law. (same for 41)

Break confidentiality if a minor client is suicidal.
- Legally required.
- If life threatening.

Discuss progress of therapy with parent/guardian of an adolescent client without adolescent's consent.
- I always get consent at start of therapy for an "update".
- Without informing details.
- Progress not specifics.
- Always inform child I will be talking to parent and about what and encourage or give the client the opportunity to talk with parents first with my help or coaching.
- Would normally be a condition of treatment unless some danger existed. (same for 43)
- In general terms, usually based on info from parents. (same for 43)
- Always get consent for general discussion up front.
- In general terms, not private information. (same for 43)
- Progress but not content. I don't get consent but I inform them that a general picture of therapy will be made, but no details without permission with exception of suicidal, homicidal, and abuse.
- Only in general terms — depends. (same for 43)
- In general terms.
- Without breaking confidentiality — general terms.
- Non-issue — they always consent and are present. (same for 43)
- Meaningless to me. Goals of therapy are agreed upon/signed by patient and family — both report and are aware of progress.
- Carefully overview. No details!
- I would not enter into treatment if I was forbidden by adolescent to discuss with parents.
- In generality, not specifics.
- Poorly worded question.
- Usually covered initially.
- In general terms.
• I always have consent to discuss treatment with parent. May not discuss certain details. This issue is in my original authorization for services form.
• Treatment contract requires minor’s consent to apprise parent.
• Without specific details.
• Set up with consent prior to treatment. (same for 43)
• Only in general terms. I’ve always received such consent from minor patients.
• Depends on age of adolescent.
• If demanded. (same for 43)
• Usually done in a conjoint session. (same for 43)
• In general terms.
• In general.
• Parent has legal access to record so adolescent must be informed of this limit to confidentiality. Then it is a moot point and I believe it is ethical and I would be able to discuss with parent.

Discuss progress of therapy with parent/guardian of a child client without child’s consent.
• What is a child’s consent? I tell the kids roughly what I will tell their parent.
• No child has ever not consented.
• Frequently – but with explanation.
• With child’s awareness.
• In general terms.
• Children usually expect this and then guess at what you have said. Therefore I tell the child up front what I will say after without child present.
• Depends on age of child.
• Always explained to child at outset.
• I can discuss general progress of treatment without breaking confidentiality.
• Young children don’t expect the same level of confidentiality that adolescents expect. They expect that their parents know what’s going on. We talk at length about what I want to say to parents and why. Usually I have consent. If they feel strongly about something that doesn’t involve safety of self or others, I keep that secret.
• Consent desired but not legally necessary so I always inform minors of this fact and then discuss as little as necessary and try to keep minor informed about what will be said.
• Usually with child’s knowledge, with child in room or by sharing with child what I’ll be sharing with parents.
• Always include child.
• General terms only.
• Parents are included in therapy always.
• Depending on age and child understanding.
• In general terms with the child’s approval and after discussing it with the child – we do family session to address this.

General:
• Are you trying to find out if practitioners follow what they believe to be ethical – or if such issues have never been raised in therapy?
• In a small town – no other treater available, social contact unavoidable
• Please note a rural practice affects the ethics considerably!
• Questions’ usefulness is severely limited by not specifying conditions under which certain decisions/actions are taken (which always should be noted in patient’s record).
• I wish you would have defined “ethical”.
• Note: 15 minutes of my time is a lot! If I extend myself to you in this way, not even knowing you… is it ethical for you to intrude and impose, especially with a problematic instrument.
• You didn’t cover touching in child therapy. I used to frequently. Not sexually abusive but now I don’t. I cringe when they hug or touch me. Main difference is they used to improve faster.
• Real life clinical practice is not as neat as this questionnaire reflects.
• There is a big ethical conflict present in rural areas not present elsewhere: What do you do if you are the only feasible resource to avert likely tragedy, when possible clients have no other reasonable option? In 1985-90 in WI I refused to treat once with tragic results, later treated – success. APA later loosened up standards for rural areas.
• Please understand that I live in a small town where few other highly qualified resources are available, so I may on rare occasion treat the child of a friend, but if there were someone else I would refer to someone else. Other questions would be answered differently also. In a small town you can’t shun every one you have ever had professional contact with.
• We are required by state law to notify child protective services and/or law enforcement of suspected child abuse and homicidal threats. I inform clients of this in first session.
• Those of us in the Armed Forces on overseas assignments must sometimes treat friends’ kids – because we are the only providers – not because we want to.
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