HANDOUTS

Positive Ethics with the Most Difficult Clients

Presented by

Mitchell M. Handelsman, Ph.D.

Department of Psychology – Campus Box 173
University of Colorado at Denver and Health Sciences Center
P.O. Box 173364
Denver, CO 80217-3364
303-556-2672
mitchell.handelsman@cudenver.edu

AGENDA

8:30 Positive Ethics in Context

- Levels of awareness that form the basis of ethical practice— *personal, professional, and political*
- Practical implications for **borderline, suicidal, angry, abusive, court-ordered, seductive, non-compliant, and other "difficult" clients**

9:50 Break (coffee and tea)

10:05 **What Makes Difficult Clients So Difficult?**

- Therapist reactions to difficult clients
- Ethical acrobatics: Balancing the personal and professional, clinical, and legal
- Maintaining the right mix of detachment and involvement
- Prevention vs. reaction: Applying positive principles to avoid ethical pitfalls

11:30 p.m. Lunch (on your own)

12:45 **Strategies and Tactics**

- Ethical reasoning in difficult circumstances
- How to inform clients
- What to document
- When to consult and with whom to consult
- When to refer and how to terminate

2:00 Break (coffee, tea, soda, snack)

2:15 **Putting It All Together**

- Ongoing strategies to prevent ethical problems
- Case Examples

3:45 Adjournment (pick up CE certificates)

Sponsored by
J&K Seminars, *LLC*
1861 Wickersham Lane
Lancaster, PA 17603-2327
(800) 801-5415
jk@jkseminars.com
www.jkseminars.com

NOTES
Positive Ethics with the Most Difficult Clients

INTRODUCTION –Potential Benefits and Risks of the Workshop

I. Potential Benefits

A. New ways of thinking about ethics that avoid as much paranoia as possible

B. Specific techniques and strategies

C. Confirmation and support for what we're doing
   1. There is no difference between positive ethics and risk management!
   2. The best malpractice protection is doing good work.

D. Appreciation of the cognitive, emotional, and behavioral mistakes we are prone to

E. Inspiration to re-read your code, and perhaps some others

F. Realization: Difficult clients can bring out our *best*.

II. Risks (frustrations)

A. Nothing new

B. No short cuts

C. Lack of specifics

D. Diatribes

E. Realization: Difficult clients can bring out our *worst*.

F. Paper cuts!

Positive Ethics in Context

I. Levels of Awareness That Form the Basis of Ethical Practice — *personal, professional, political (global)* (Handelsman, Knapp, & Gottlieb, 2002, in press; Knapp & VandeCreek, 2006)

A. Goal of positive ethics: to encourage psychotherapists to aspire to, and achieve, their highest ethical ideals, rather than only trying to avoid punishment.

B. Implications of positive ethics

1. Consider personal bases for actions that are consistent with professional obligations
2. Expand our awarenes
3. Develop greater openness
   a) Reading: Pope, Sonne, & Greene (2006)

C. Themes (and Variations) of positive ethics

1. Personal – self-awareness

a) Values and motives

b) Ethical sensitivity

(1) Tjeltveit (1999, p. 272): "Ethical Acuity"

(2) Knapp & VandeCreek (2006): Supererogatory obligations

c) Self-care: GET A LIFE!

d) Virtues: "Who should I be?"

2. Professional Awareness

   a) Ethical acculturation

   b) Ethical reasoning

      (1) Reading: Cottone & Claus (2000)

      (2) Basic principles (Beauchamp & Childress, 1994; Kitchener, 1984, 2000):
         (a) Autonomy (respect)
         (b) Beneficence (do good)
         (c) Nonmaleficence (do no harm)
         (d) Justice (fairness)
         (e) Fidelity (keep promises)

   c) Moral traditions of the professions

      (1) Virtue ethics, utility, foundational principles, ethics of care, feminist ethics

      (2) Tjeltveit (1999): "ethical sources"

   d) Prevention
      (1) Creating policies in NON-CRISIS situations
      (2) "Customer handling techniques" ("Bedside manner")

3. Political (Global) Awareness

   a) Multicultural awareness

   b) Agency policy

   c) Professional associations

   d) Laws and regulations

II. Practical implications for working with "difficult" clients

A. Positive ethics is consistent with good therapy, which is good risk management.

1. Guthiel (1994): "The only sound and valid risk management principles rest upon a rock-solid clinical foundation…. Sound risk management is also not antithetical to spontaneity, warmth, humanitarian concerns, or flexibility of approach" (p. 295).

2. At the heart of the matter is being an excellent therapist.

B. We need a comprehensive SYSTEM, including elements of all three levels of awareness.

1. Consistent with this systemic approach, Roberts & Dyer (2004) present a table (9.1) of eight steps in responding therapeutically to difficult clients. (These are all quotes from p. 162):
   a) Understand yourself
   b) Understand your patient
   c) Think, don't react
   d) Form an alliance
   e) Treat whatever is treatable
   f) Avoid the traps
      (1) Of wanting to save the patient and be idealized
      (2) Of wanting to reject the patient and not be hurt
      (3) Of wanting to punish the patient
      (4) Of doing anything to help the patient so he won't hurt himself
   g) Get help
   h) Handle your emotions

C. Positive ethics can drive practical suggestions.

D. It takes time to implement a system.

What Makes Difficult Clients So Difficult?

I. Therapist reactions to difficult clients

A. Definition of Difficult Clients: "There are patients and there are patients. The difficult ones can be 'demanding,' 'noncompliant,' 'whiny,' 'entitled,' or 'manipulative.' They can be too different from or too similar to the clinician, too seductive, too unclean, too smart, too fat, too thin, or too anxiety-provoking" (Roberts & Dyer, 2004, p. 153).

1. Difficulty has clinical, legal, and ethical components.

B. Stressful Client Behaviors: Deutsch's survey of psychotherapists found that they rate the following as the most stressful client behaviors (all from p. 837):
   1. "Client's suicidal statements"
   2. "Inability to help an acutely distressed client"
   3. "Client expression of anger toward you"
   4. "Lack of observable progress"
   5. "Severely depressed client"
   6. "Apparent apathy or lack of motivation in client"

C. Challenges to our professional identity
   1. Failure [Reading: Duncan, Hubble, & Miller (1997)]
      a) "Intrusive family members who are clearly worried but have difficulty with boundaries—especially when it concerns children."
      b) "Clients who sabotage theirs or their child's treatments by not following the rules, the treatment plans, etc."
      c) "Extremely passive/lethargic."
      d) "Clients who relapse repeatedly at outpatient setting."
      e) "They will make appointments but not keep those appointments. They only respond or show up when they are threatened with being discharged or DSS is involved."

2. Violation or Disruption of our values

    a) Professional values

        (1) Koekkock, van Meijel, & Hutschemackers (2006): "Good patients were described as reasonable and thankful; difficult patients were described as unreasonable, selfish, and not able to appreciate the value of given care. Power struggles arose easily with the latter category" (p. 797).

    b) Personal values

D. Disruption or invasion of personal dynamics

1. "Some authors pointed out that some personality traits may increase the risk of difficult relationships with patients: a strong wish to cure, a great need to care, trouble with accepting defeat, and a confrontational and blaming attitude" (Koekkock, van Meijel, & Hutschemackers, 2006, p. 798).

2. Professional voyeurism

3. POWER

4. Dependent clients represent the worst of both worlds. They appeal to our sense of compassion, but also twist our power against us.

E. Simple inconvenience

F. Reactions

1. Countertransference reactions

a) Roberts and Dyer (2004) discussed wanting to "rescue" the client, identifying with the client, feeling awe, feeling intimidated. "The patient who has extraordinarily severe symptoms may be perceived as a difficult patient if he evokes feelings of distress or inadequacy in the clinician" (Roberts & Dyer, 2004, p. 154).

b) Koekkock, van Meijel, & Hutschemackers (2006): "anger, guilt, helplessness, powerlessness, dislike, and disappointment" (p. 797).

c) Example: "The clients with whom I struggle the most are those with personality disorders. After initially saying I'm the best therapist they have ever had after a couple of sessions, things change. They become abusive towards me, seductive at times, suicidal at times, don't want to pay for services, which they say aren't helping."

d) Practical suggestion: *Assume* that difficult patients elicit countertransference reactions!!

2. Behavioral reactions

a) Betan & Stanton (1999) found that people who are feeling more anxious and less compassionate are less likely to do what they know they should in reaction to an ethical dilemma.

b) Impulsive actions: "Ideally, the responses of psychologists will be based on a therapeutic model and rationale, not on unproductive emotional reactions" (Knapp & VandeCreek, 2006).

c) Exceptions to policies

d) Roberts & Dyer (2004) list several ethical pitfalls when dealing with difficult clients:

(1) Therapeutic abandonment – minimal efforts to preserve the therapeutic alliance. Could be subtle.

(2) Erosion of boundaries.
(a) More self-disclosure
(b) More advice-giving
(c) Variations in informed consent procedures

(3) Confidentiality issues
(a) Because of strong feelings, a clinician may talk about the client with others in more public places, with more detail.

e) Professional equivalent of *terror management* (Pyszczynski, Solomon, & Greenberg, 2003). We disparage others, become more rigid, less human, and less therapeutic.

G. Suggestions

1. Consider reactions to clients who are not so difficult but still a bother!

2. Consultation, Supervision, Therapy

3. CLEAR, ARTICULATED POLICIES

a) Difficult clients may also be more likely to misinterpret vague policies. "Clients with histories of abuse, deprivation, or neglect may be especially vulnerable to misunderstanding their psychologists' interventions, as well as the intent and application of professional ethics codes" (Thomas, 2005, p. 427).

b) Have clear policies, in writing (See table after References).

(1) Great resource: Zuckerman (2003)

c) Clear your policies with other professionals, perhaps former clients.

d) Build anticipated exceptions into your policies.

4. Carry out your policies CONSISTENTLY.

a) How would you finish this sentence?: "I treat all my clients…."

II. Ethical acrobatics: ethical acculturation

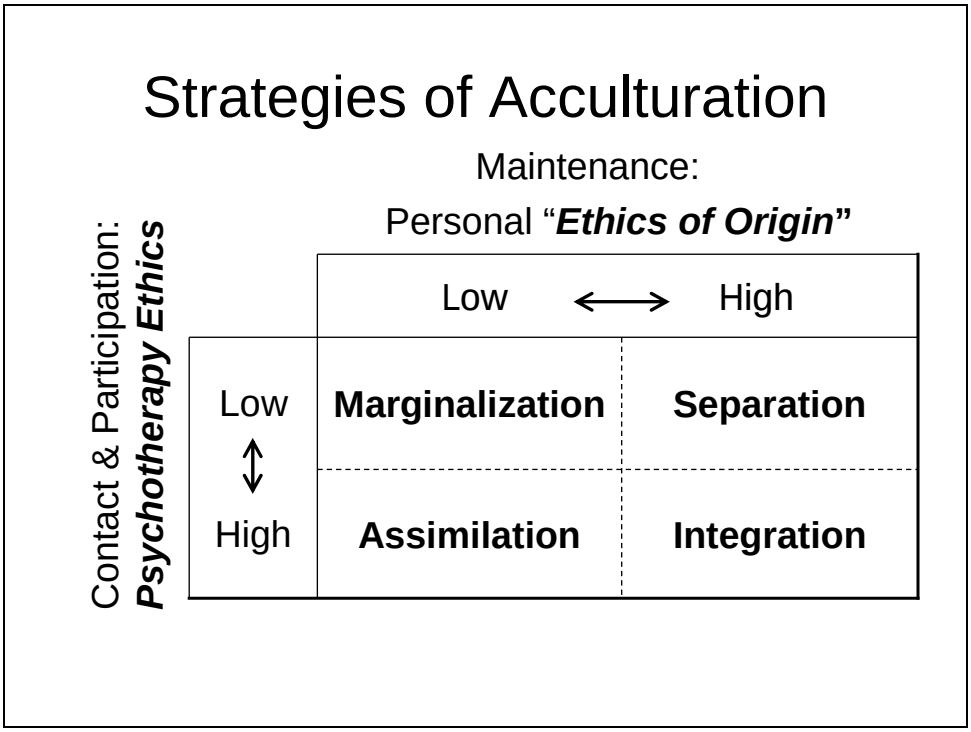
A. Berry's definition: "A set of internal psychological outcomes including a clear sense of personal and *cultural* identity, good mental health, and the achievement of personal satisfaction in the new *cultural* context" (Berry & Sam, 1997, p. 299, italics added).

B. Berry's model adapted – 2 major variables (See Handelsman, Gottlieb, & Knapp, 2005; Bashe, Anderson, Handelsman, & Klevansky, 2007)

1. *Maintenance* of culture of origin – our own moral sense

2. *Contact and participation* with new culture – of psychotherapy

C. *Strategies of acculturation* — These are not stages we go through, nor personality characteristics. They are CHOICES we make in various situations. We can adopt one strategy at one point, and other strategies at others.



1. *Integration* – The best! High maintenance, high contact

2. *Assimilation* – Low maintenance, high contact

3. *Separation* – High maintenance, low contact

4. *Marginalization* – Low maintenance, low contact

D. Acculturation is an ongoing process.

E. We need to do a careful self-assessment of our strategies of acculturation and move toward using integration.

F. EXERCISE: *If you were not perfectly using integration, what would be your preferred strategy, assimilation or separation?*

G. This quote is relevant to the issue of acculturation. "Many clinicians and ethicists have been concerned that they must assume a policelike or judicial role that is contrary to their mission as patient advocates and healers. Psychotherapists in particular may feel that the trust and confidentiality crucial to effect personal change may not be possible under current legal mandates and political pressure. For these reasons, individual clinicians must search their hearts and know their societally mandated and professionally affirmed duties to arrive at acceptable approaches to dealing with these complicated, multifaceted issues with their patients" (Roberts & Dyer, 2004, p. 93).

H. Integration takes many forms, and there are lots of dualities to this profession that we have to balance.
   1. Personal vs. professional
   2. Clinical vs. legal
   3. Helping vs. helplessness
   4. Effort vs. failure
   5. Outcome vs. process
   6. Therapy vs. other help
   7. Detachment vs. involvement
   8. Prevention vs. reaction

III. Maintaining the right mix of detachment and involvement: BOUNDARIES

A. Good readings on boundaries: Gutheil & Gabbard (1993), Epstein & Simon (1990)

B. Therapy is unique.

C. "Responding therapeutically may entail building a sense of empathy for the unlikable or otherwise off-putting patient; it may entail assuming a more professional, more objective stance with the specially charming or intriguing patient" (Roberts & Dyer, 2004, p. 161).

D. Need for consistency and clarity

1. "Boundaries—when to loosen them, when to tighten them."

E. Bolstering boundaries does not mean distance, or walls. It means preserving the intimacy of therapy while understanding the limits of the relationship.

F. "The mere experience of a healthy, autonomy-fostering relationship with clear and consistent boundaries can have important curative qualities" (Bornstein, 2005, p. 85).

IV. Prevention vs. reaction: Applying positive principles to avoid ethical pitfalls with difficult clients

A. Consistency rather than uniqueness

B. The Handelsman "Why Bother?" Rule

C. "Is it ethical for me to work with a client I can't seem to appreciate and I fear may be affecting my competence as a therapist?"

D. Ethical conduct of colleagues: "Psychologists must also commit to addressing ethics-related concerns about their colleagues' professional behavior" (Thomas, 2005, p. 432).

E. Chauvin & Remley (1996) suggestions for preventing ethical violations:

1. "It is important to keep the lines of communication open. Allowing clients to express their feelings, positive or negative, toward the counselor prevents a build-up of unreleased anger" (p. 566).
2. Practice within your competence.
3. "It is almost always unwise to sue clients for unpaid fees" (p. 566).
4. Have a good disclosure statement.
5. Get consultation.
6. In general, act professionally. "When a complaint is filed against a professional counselor, a major violation of ethical standards usually is the focal point. In the course of the proceedings, however, minor incidents that seemed perfectly innocent at the time might surface. Casual comments before a session regarding the counselor's personal life may take on the dimensions of a dual relationship. Personal notes of encouragement written by the counselor could be seen as an attempt on the professional's part to enter into a 'friendship' with the client. Frequent calls between counseling sessions can be interpreted as seductive" (p. 567).

Strategies and Tactics with Difficult Clients

I. Ethical reasoning in difficult circumstances

A. The *fundamental attribution error*: We over-attribute others' behaviors to dispositions.

1. We attribute our own behavior to situations

2. "Spread" – Wright (1983)

a) Empirical studies: "Patients given a previous diagnosis of personality disorder (PD) were seen as more difficult and less deserving of care compared with control subject who were not. The PD cases were regarded as manipulative, attention-seeking, annoying, and in control of their suicidal urges and debts" (Lewis & Appleby, 1988, p. 44).

3. Suggestion: Ask yourself this question: Who would these folks be if they didn't have that one characteristic that made them difficult?
   a) Is ALL their behavior evidence of their difficult-ness?

4. Notice that we don't talk about difficult treatment, or difficult therapists, only about difficult clients!

B. Pitfall: Attributing success to self rather than methods as we get more experienced (Handelsman, 2001b).

C. Irrational Beliefs: (Deutsch, 1984).
   1. I should always work at my peak level of enthusiasm and competence.
   2. I should be able to handle any client emergency that arises.
   3. I should be able to help every client.
   4. When a client does not progress, it is my fault.
   5. I should not take time off from work when I know that a particular client needs me.
   6. My job is my life.
   7. I should be able to work with every client.
   8. I should be a model of mental health.
   9. I am "on call" 24 hr a day.
   10. My clients' needs always come before my own.
   11. I am the most important person in my client's life.
   12. I am responsible for my client's behavior.
   13. I have the power to control my clients' lives.

D. Need to be tempered by other beliefs, such as, "I can do no good if I'm not experiencing some level of well-being," and "I cannot be all things to all clients."

E. Competence

   1. Therapy is not the only way to help.

   2. Therapy with some difficult clients may be seen as a specialty.

3. State Boards will ALWAYS ask you what your credentials are to work with a specific client.

    a) Sometimes we don't know if we're competent until it's "too late" to recognize a difficult client.

4. "The clinician's first duty in the care of the difficult patient is to understand that the aspects of the patient's presentation that make him or her 'difficult' are, in essence, clinical signs—that is, observable manifestations of the patient's underlying health and of factors affecting his or her health status" (Roberts & Dyer, 2004, p. 158).

II. How to inform clients

A. Have a conversation! Make it a process, rather than an event (Handelsman, 2001a).

B. Use written consent forms.

1. Qualities of written forms may influence first impressions, which can then influence the course of therapy (Handelsman, 2001a).

2. Make them readable.

3. Make them personalized: "You and I," versus "The therapist and the client."

4. Make them accessible in other ways: sections, double-space, etc.

5. Use a question format for additional information (Pomerantz & Handelsman, 2004).

6. Get feedback on them.

C. Don't promise what you can't deliver.

1. Dolgan, (2006): "I suggest making what a client/patient is to receive or is promised perfectly clear up front. Further, I think we should give an estimate of time to complete a report or letter and mail it back" (p. 1).

2. Promise process, not outcome.

D. Don't guarantee success.

E. Inform about Termination (Kramer, 1986).

1. Rice & Follette (2003): "Take responsibility at the beginning of a therapy contract for educating the client on how the termination process will unfold and what criteria you will be using to evaluate their progress" (p. 157).

F. Contract for a specific number of sessions.

III. What to document

A. Knapp: "Courts tend to give great deference to medical records. The general assumption is that if it is written in a medical record, then it occurred (and conversely, if it is not written down it did not occur)."

B. Koekkock, van Meijel, & Hutschemackers (2006) cite a study on inpatients that found that "Difficult patients' files were updated less thoroughly, and communication between professionals of differing treatment programs about these patients was minimal." (p. 796).

C. Commit yourself to fuller documentation.

1. Good resource: Moline, Williams, & Austin (1998)

D. Document as if these are (or will be) public records.

1. "We advise that you not keep client writings (e.g., diaries, journals), which are part of their record and could be subpoenaed. However, any correspondence the client writes directly to you (e.g., letters, greeting cards), you will want to retain" (Moline et al., 1998, p. 26).

E. Use the *BANJO* method to document ethical reasoning.

1. Principles (Beauchamp & Childress, 1994; Kitchener 1984, 2000)

    a) Beneficence – doing good, preventing harm
    b) Autonomy – respecting people's dignity, choice, privacy, etc.
    c) Nonmaleficence – not doing harm
    d) Justice – treating people fairly
    e) Others, including fidelity, veracity

F. Document competence assessment.

G. Document the consent process.

H. Document all contacts.

I. Document your self-disclosure.

1. Dangerous three-word phrases:
   a) "Let's have lunch"
   b) "Just this once"
   c) "Just between us…" followed with a self-disclosure

2. Document your BANJO reason for your self-disclosures.

   a) Hypothesis: The clients who pull most for you to self-disclose are the people who are most likely to misinterpret it.

J. Document therapeutic goals. Make them specific. Make them the minimum.

K. Document your assessment of suicide, dangerousness, etc.

L. Document the same way for everybody.

IV. When to consult and whom to consult

A. The continuum of consultation:

1. Informal “hallway” consultation

2. Ongoing supervision within an agency

3. Ongoing peer consultation

4. “Special case” consultation, including high-risk cases

5. “Post-complaint” consultation

B. Treat “special case” consultation like psychotherapy.

1. Make it official.
2. Pay for it.
3. Document it.
4. Do not consult with people you know! (Unless they don’t like you.)

5. Consult with somebody from a different theoretical orientation.

C. Deal with your own feelings. Koekkock, van Meijel, & Hutschemackers (2006): “Teamwork leads to less trouble and fewer mistakes, because countertransference issues can be shared” (p. 797).

D. Make peer consultation multidisciplinary. “Multidisciplinary meetings are suggested as a way to form a collective vision. In such meetings, staff feelings are channeled into more professional modes, and development of consistent treatment plans is endorsed” (Koekkock, van Meijel, & Hutschemackers, 2006, p. 799).

E. Make peer consultation routine.

V. When to refer and how to terminate (therapy, not clients!)

A. Balance between late termination and abandonment

B. Have a list of good referral sources.

C. It's hard to stare failure in the face.

D. Be careful of the "Transfer Syndrome" (O'Reilly, 1987): Feelings of guilt, depression, and RELIEF!

1. These feelings can lead to bad behaviors, and be highlighted by "fears of evaluation by peers or supervisors, anxiety concerning what the client might expose about him or her, and anxiety about the new placement" (Rice & Follette, 2003, p. 162).

E. Establish procedures for termination, even when you don't "need" them.

1. Pretermination counseling

2. Document the termination with a letter to your client, etc.

3. Deal with your own reactions. It's a good time for consultation!

Putting It All Together

I. Ongoing strategies to prevent ethical problems

A. Personal Strategies

1. Self-care

a) Carl Pletsch: "The first duty of a lifeguard is not to drown."

B. Professional Strategies

1. Acculturation strategies

a) Periodic ethics autobiography

2. Professional stress inoculation

3. Treat these *ethics-enhancing behaviors* as you would treat marketing efforts, or insurance payments.

4. Become more affiliative. Don't be isolated. Say things out loud. Share your policies with others and get their opinions.

a) Peer consultation. Advisory committees (external people).

C. Political-Global strategies

1. Work to make your group practice or agency more ethical.

2. Political action

II. What if you get complained against?

A. "The complaint adjudication process is stressful at every stage. Psychologists can, however, inoculate themselves by developing patience, realistically allocating time and money and availing themselves of personal and professional support" (Thomas, 2005, p. 428).

1. Complaints are part of the culture you are in.

a) A *Separation* strategy is not good! In regard to psychologists, Thomas wrote: "If they recognize the violation but disagree with the rule, they may believe their actions were justified and, therefore, may feel indignant and incredulous" (2005, p. 427).

B. Take every complaint seriously. "Failure to accurately perceive the seriousness of the allegations and the stakes involved may place psychologists at greater risk for responding impulsively, without benefit of collegial or legal consultation" (Thomas, 2005, p. 429).

C. Do not think of yourself as a victim.

D. Call your insurance carrier, and your attorney.

1. Chauvin & Remley (1996): "A first inclination of most counselors would be to call a best friend or family member and describe the details of the accusation and lament the injustice of what has been alleged. A lawyer most likely would advise against such a response…. Divulging confidential information has the potential to do more harm than good. A lawyer should be the first to hear the full details of the case" (p. 565).

2. "Counselors should be careful not to discuss issues with supervisors that they would not want repeated in court" (Chauvin & Remley, 1996, p. 565).

3. But, you might benefit from personal counseling. You need to deal with your anger and other emotional reactions.

4. *Always* get an attorney to review your response.

E. Take time for yourself.

F. Be careful of self-defeating actions.
   1. Thomas (2005) talks about impulses psychologists have
      a) to mail their license to the board,
      b) to lie to conceal errors,
      c) to contact the client to try an informal resolution,
      d) to alter records, which is a huge problem.

G. Do not pathologize the client.

H. Keep reasoning and thinking. "The ability to articulate to the board a clear understanding of mistakes and related ethical issues, and to demonstrate a commitment to rectifying problems, are likely to result in improved practices and to augment the psychologist's defense (Thomas, 2005, p. 431).

I. You need to balance compartmentalization and spread.

J. Use the proceedings as an opportunity to learn.
   1. "When the most acute distress has abated, however, many say that they had been thinking about revising their informed-consent materials, updating assessment protocols, organizing a peer consultation group, joining a professional association, or seeking continuing education in a particular area of practice. Being the subject of a complaint may provide the impetus for initiating these changes. Time and money spent on required supervision or education may feel more worthwhile to psychologists who take an active role in determining how the experience can further their professional goals" (Thomas, 2005, p. 432).

K. After the decision:

   1. "The professional counselor may be found innocent but the client or the counselor may have talked openly about the case so other people are well aware of it. Some damage to the counselor's reputation will almost always occur …. however, the counselor can and should overcome this. Discussing the situation with other clients is extremely inappropriate and, in fact, the less said to anyone the better…. Continuing to conduct oneself in the most professional manner possible is the most advantageous means of ridding oneself of any stigma from such a situation" (Chauvin & Remley, 1996, p. 566).

   2. Don't take it out on your other clients.

   3. Be careful of the effects of the case (even a dismissed one) on your clinical judgment. You run "the risk of turning unconsciously to other clients for reassurance about competence and worth" (Thomas, 2005, p. 430)

III. Case Discussion (IF TIME)

A. "What do you recommend for persons with a chronic history of lawsuits or in general, a practice of 'getting something for nothing by complaining?'"

B. Think of a difficult client, or difficult type of client. Write ONE policy, based on what we talked about, and share it with your neighbor.

C. "If owes money, can readmission into the program be denied until bill is paid in full?"

D. What do you tell clients about your willingness to be contacted between sessions?

1. Empirical study by Reitzel, Burns, Repper, Wingate, & Joiner (2004):

   a) "When therapist willingness to be called in a crisis was low, those patients with a PD initiated more nonemergency calls than patients without a PD diagnosis" (p. 293).

   b) "Therapists who were more willing to be called between sessions for mental status updates received fewer crisis intervention calls; however, the results also suggest that those therapists who verbally confirmed to their patients their willingness to be called between sessions tended to receive more crisis intervention calls" (p. 293).

   c) "Greater therapist willingness to be contacted between sessions may have been associated with fewer calls from patients because of a decrease in patients' distress through the provision of a supportive therapeutic relationship, the normalization of periodic crises, or the communication of boundaries" (p. 294).

   d) "Patients with more severe levels of interpersonal impairment and/or PD diagnoses are particularly likely to benefit from an attitude of therapist willingness to receive between-session calls" (p. 295).

e) Establish clear guidelines about between-session contact. The issue may be one of CLARITY, not necessarily the specific policy.

E. Do you apologize to a client if you made a mistake?

1. What are the parameters?

a) Effect on the client

b) Type of infraction

c) Timing: If the client has already complained, do NOT apologize.

2. Be prepared to give the money back.

References

American Association for Marriage and Family Therapy. (2001). *AAMFT Code of Ethics.* Alexandria, VA: Author.

American Counseling Association. (2005). *ACA code of ethics.* Alexandria, VA: Author.

American Psychological Association. (1991). *Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations.* Washington, DC: Author.

American Psychological Association. (2000). *Division 12, section VII report on education and training in behavioral emergencies.* Retrieved May 20, 2007, from http://www.apa.org/divisions/div12/sections/section7/tfreport.html.

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57,* 1060-1073.

Bashe, A., Anderson, S. K., Handelsman, M. M., & Klevansky, R. (2007). An acculturation model for ethics training: The ethics autobiography and beyond. *Professional Psychology: Research and Practice, 38,* 60-67.

Beauchamp, T. L., & Childress, J. F. (1994). *Principles of biomedical ethics* (4th ed.). New York: Oxford University Press.

Berry, J. W. & Sam, D. L. (1997). Acculturation and adaptation. In J. W. Berry, M. H. Siegel, & C. Kagitcibasi (Eds.), *Handbook of cross-cultural psychology* (pp. 291-326). Needham Heights, MA: Allyn & Bacon.

Betan, E. J., & Stanton, A. L. (1999). Fostering ethical willingness: Integrating emotional and contextual awareness with rational analysis. *Professional Psychology: Research and Practice, 30,* 295-301.

Bornstein, R. F. (2005). The dependent patient: Diagnosis, assessment, and treatment. *Professional Psychology: Research and Practice, 36,* 82-89.

Chauvin, J. C., & Remley, T. P., Jr. (1996). Responding to allegations of unethical conduct. *Journal of Counseling & Development, 74,* 563-568.

Cottone, R. R., & Claus, R. E. (2000). Ethical decision-making models: A review of the literature. *Journal of Counseling & Development, 78,* 275 – 283.

Deutsch, C. J. (1984). Self-reported sources of stress among psychotherapists. *Professional Psychology: Research and Practice, 15,* 835-845.

Dolgan, J. (2006, September-October). News from the State Board of Psychologist Examiners. *Colorado Psychological Association Bulletin,* p. 1.

Duncan, B. L., Hubble, M. A., & Miller, S. D. (1999). *Psychotherapy with "impossible" cases.* New York: Norton.

Epstein, R. S., & Simon, R. I. (1990). The Exploitation Index: an early warning indicator of boundary violations in psychotherapy. *Bulletin of the Menninger Clinic, 54,* 450-465. [The entire exploitation index is reprinted at http://www.oregon.gov/OBCE/publications/EMEBC_appendix_F.pdf]

Gallop, R., Lancee, W. J., & Garfinkel, P. (1989). How nursing staff respond to the label "borderline personality disorder." *Hospital and Community Psychiatry, 40,* 815-819.

Guthiel, R. (1994). Discussion of Lazarus's "How certain boundaries and ethics diminish therapeutic effectiveness." *Ethics and Behavior, 4,* 295-298.

Gutheil, T. G., & Gabbard, G. O. (1993). The concept of boundaries in clinical practice: Theoretical and risk-management dimensions. *American Journal of Psychiatry, 150,* 188-196.

Handelsman, M. M. (1997, March 14). *Colorado Grievance Board Sanctions* (Available from the Colorado State Mental Health Boards, 1560 Broadway, Suite 1370, Denver, CO 80202).

Handelsman, M. M., Knapp, S., & Gottlieb, M. C. (in press). Positive ethics: Themes and variations. In C. R. Snyder & S. J. Lopez (Eds.). *Handbook of positive psychology* (2nd ed.) . New York: Oxford University Press.

Handelsman, M. M., Knapp, S., & Gottlieb, M. C. (2002). Positive ethics. In C. R. Snyder & S. J. Lopez (Eds.). *Handbook of positive psychology* (pp. 731-744) . New York: Oxford University Press.

Handelsman, M. M. (2001a). Accurate and effective informed consent. In E. R. Welfel & R. E. Ingersoll (Eds.), *The Mental Health Desk Reference* (pp. 453-458). New York: Wiley.

Handelsman, M. M. (2001b). Learning to become ethical. In S. Walfish & A. K. Hess (Eds.), *Succeeding in graduate school: The career guide for psychology students* (pp. 189-202). Mahwah, NJ: Lawrence Erlbaum.

Handelsman, M. M. (1998). Ethics and ethical reasoning. In S. Cullari (Ed.), *Foundations of Clinical Psychology* (pp. 80-111). Needham Heights, MA: Allyn & Bacon.

Handelsman, M. M., Gottlieb, M. C., & Knapp, S. (2005). Training ethical psychologists: An acculturation model. *Professional Psychology: Research and Practice, 36,* 59-65.

Handelsman, M. M., Knapp, S., & Gottlieb, M. C. (2002). Positive ethics. In C. R. Snyder & S. J. Lopez (Eds.). *Handbook of positive psychology* (pp. 731-744) . New York: Oxford University Press.

Handelsman, M. M., Knapp, S., & Gottlieb, M. C. (in press). Positive ethics: Themes and variations. In C. R. Snyder & S. J. Lopez (Eds.). *Handbook of positive psychology* (2nd ed.) . New York: Oxford University Press.

Hubble, M., Duncan, B., & Miller, S. (1999). *The Heart & Soul of Change: What Works in Therapy*. Washington D.C.: American Psychological Association.

Kitchener, K.S. (1984). Intuition, critical evaluation and ethical principles: The foundation for ethical decisions in counseling psychology. *The Counseling Psychologist, 12*, 43-55.

Kitchener, K. S. (2000). *Foundations of ethical practice, research, and teaching in psychology.* Mahwah, NJ: Erlbaum.

Knapp, S., Gottlieb, M., Berman, J., & Handelsman, M. M. (2007). When laws and ethics collide: What should psychologists do? *Professional Psychology: Research and Practice, 38,* 54-59.

Knapp, S. J., & VandeCreek, L. D. (2006). *Practical ethics for psychologists: A positive approach.* Washington, DC: American Psychological Association.

Koekkock, B., van Meijel, B., & Hutschemackers, G. (2006). "Difficult patients" in mental health care: A review. *Psychiatric Services, 57,* 795-802.

Kramer, S. A. (1986). The termination process in open-ended psychotherapy: Guidelines for clinical practice. *Psychotherapy, 23,* 526-531.

Lewis, G., & Appleby, L. (1988). Personality disorder: The patients psychiatrists dislike. *The British Journal of Psychiatry, 153,* 44-49.

Malley, P. B., & Reilly, E. P. (1999). *Legal and ethical dimensions for mental health professionals.* Philadelphia: Taylor & Francis.

Moline, M. E., Williams, G. T., & Austin, K. M. (1998). *Documenting psychotherapy: Essentials for mental health practitioners.* Thousand Oaks, CA: Sage.

National Association of Social Workers. (1999). *Code of ethics*. Washington, DC: Author.

Pomerantz, A., & Handelsman, M. M. (2004). Informed consent revisited: An updated written question format. *Professional Psychology: Research and Practice, 35,* 201-205.

Pyszczynski, T., Solomon, S., & Greenberg, J. (2003). *In the wake of 9/11: The psychology of terror.* Washington, DC: American Psychological Association.

Pope, K. S., Sonne, J. L., & Greene, B. (2006). *What therapists don't talk about and why*. Washington, DC: American Psychological Association.

Reitzel, L. R., Burns, A. B., Repper, K. K.,Wingate, L. R., & Joiner, T. E., Jr. (2004). The effect of therapist availability on the frequency of patient-initiated between-session contact. *Professional Psychology: Research and Practice, 35,* 291-296.

Rest, J. R. (1986). *Moral development: Advances in research and theory*. New York: Praeger.

Rice, N. M., & Follette, V. M. (2003). The termination and referral of clients. In W. O'Donohue & K. Ferguson (Eds.). *Handbook of professional ethics for psychologists: Issues, questions, and controversies* (pp. 147-166). Thousand Oaks, CA: Sage.

Roberts, L. W., & Dyer, A. R. (2004). *Concise guide to ethics in mental health care*. Washington, DC: American Psychiatric Publishing.

Thomas, J. T. (2005). Licensing board complaints: Minimizing the impact n the psychologist's defense and clinical practice. *Professional Psychology: Research and Practice, 36,* 426-433.

Tjeltveit, A. C. (1999). *Ethics and values in psychotherapy.* London: Routledge.

Van Horne, B. A. (2004). Psychology licensing board disciplinary actions: The realities. *Professional Psychology: Research and Practice, 35,* 170-178.

Wright, B. A. (1983). *Physical disability--a psychosocial approach* (2nd ed.). New York: HarperCollins.

Zuckerman, E. L. (2003). *The paper office: Forms, guidelines, and resources to make your practice work ethically, legally, and profitably* (3rd ed.). New York: Guilford.

Table: POLICY AREAS

These are some of the areas in which you might want to have written policies. Each policy should be formulated with consideration given to:

- The context of your practice (agency, group private practice, etc.)
- The range of your clients (diagnosis, SES, gender, religion, ethnic group, etc.)
- The types of clients you consider difficult

1. Dress
2. Objects (pictures, diplomas, awards, political material, etc.) I display in my office
3. How to determine my competence to treat a client
4. Clients whom I am incompetent to treat
5. Forms of address
6. Pre-appointment information to send to clients, receive from them
7. Informed consent
   a. What do I tell all clients?
   b. What are the risks of my therapy?
   c. How do I tell clients the information they need to know?
   d. How do I address client questions?
   e. How do I assess what information particular clients might need to know?
   f. How do I document consent? Refusal? Assent?
   g. Contracts
8. Rights of clients
   a. Consent
   b. Termination
   c. Second opinion
   d. Asking questions
   e. Rights to records
9. How to formulate the goals of treatment
10. Coverage for vacations, weekends, other absences
11. Emergencies
12. Extra-therapy contacts
    a. Phone calls
    b. Collateral contacts
13. Invitations from clients for extra-therapy contact (social events, life events)
    a. What are my criteria for accepting and rejecting invitations?
14. Confidentiality
    a. Releases of information
    b. Privilege and other legal issues
    c. Requests for information from others
    d. How do I send records?
    e. What is my complete list of exceptions to confidentiality, including abuse reporting, court orders, and other legal requirements.

15. Records
    a. Storage – computer, files, etc.
    b. Disposal
    c. Retention of records
    d. Deleting obsolete records
    e. Sharing records with clients, colleagues
    f. Plans for moving, retiring, death
    g. What is the format of my records?
    h. What are the components of my records?
16. Accepting and giving gifts
17. Finances
    a. Fees for sessions, other contacts, emergencies, phone calls, testimony, etc.
    b. Raising fees
    c. Negotiating fees for new clients, clients who change circumstances, etc.
    d. Missed and cancelled appointments
    e. Billing and collecting fees
    f. Bartering
18. Advertising and public statements
19. Safety issues
    a. How do I deal with clients who seem to be getting angry?
    b. How do I deal with suicidal gestures, threats, behaviors?
    c. How do I deal with threats from clients, others?
20. Termination and referral
    a. How do I inform clients about the conditions under which termination and/or referral take place.
    b. How do I terminate?
    c. How do I refer?
    d. How do I conduct pre-termination (pre-referral) counseling?
21. Knowledge of unprofessional conduct by colleagues
    a. How do I talk with colleagues about concerns I have about their behavior?
    b. What is my threshold for reporting the unethical conduct of colleagues?
22. Whom to call if I am sued or complained against to an ethics committee
    a. Attorney
    b. Insurance carrier
    c. Risk management office at your agency
    d. Therapist
    e. Family
    f. Colleagues
23. Touching

Professional Psychology: Research and Practice
2005, Vol. 36, No. 1, 59–65

0735-7028/05/$12.00 DOI: 10.1037/0735-7028.36.1.59

Training Ethical Psychologists: An Acculturation Model

Mitchell M. Handelsman
University of Colorado at Denver

Michael C. Gottlieb
Dallas, Texas

Samuel Knapp
Pennsylvania Psychological Association

This article presents an approach to graduate (and professional) training that views becoming an ethical psychologist as an acculturation process. J. W. Berry's (1980, 2003) model of acculturation strategies is used as a framework for understanding *ethical acculturation*, a developmental process during which students can use several types of adaptation strategies. Students enter training with their own moral value traditions and concepts but are confronted with new ethical principles and rules, some of which may be inconsistent with their ethics of origin. The article explores several applications of the framework to ethics courses, practicum supervision, and other areas of training.

How do students develop a sense of themselves as ethical professionals? How do they develop a "professional ethical identity" as a part of the process of becoming psychologists? We ask these questions to help improve ethical behavior in our students and better prepare them to be more responsive to an increasingly complex and diverse professional world.

Becoming an ethical professional is more complex than simply following a set of rules or doing what one sees one's mentors do, and helping students become ethical psychologists involves more than teaching certain professional rules to morally upright people who will easily understand and implement them. The complexities of ethics training were recognized by the ethics workgroup of the Competencies Conference 2002 (2002; de las Fuentes, Willmuth, & Yarrow, 2003).

There are at least three reasons ethics training is not so simple. First, the rules embedded in ethics codes are sometimes vague and conflicting (Keith-Spiegel, 1994). Second, learning about the ethics of the profession of psychology by watching models is incomplete at best (Branstetter & Handelsman, 2000; Handelsman, 1986). Third, ethics is the study of right and wrong but is often taught as the study of wrong. Many ethics courses are devoted to laws, disciplinary codes, and risk management strategies and do not focus on best practices.

If ethics training is limited primarily to learning rules, then students may not appreciate the extent to which the need for sound ethical thinking will permeate their professional lives. The development of an identity as an ethical psychologist is a far more complex matter that deserves greater attention. To do so requires that ethics training be considered in a new way, as a process of acculturation.

Our assumption is that psychology, as a profession and a scientific discipline, represents a discrete culture with its own traditions, values, and methods of implementing its ethical principles. Students who choose to enter graduate training in psychology have already excelled at academic work and may already have been exposed to some of psychology's academic and professional values. However, their knowledge of the culture of psychology is incomplete at best. We believe that psychologists can continue to improve their ability to acculturate students into the ethical values and standards of the discipline.

The "culture" of psychology is larger than ethics, and an acculturation model could be used more broadly than we attempt here. We focus on ethics because it transcends all aspects of the discipline and because ethics training has been neglected relative to other aspects of professional preparation. In this article we propose that ethics training is an acculturation process, and we present some resulting implications and practical suggestions.

The Culture of Psychology

Berry and Sam (1997) defined *acculturation* as "a set of internal psychological outcomes including a clear sense of personal and cultural identity, good mental health, and the achievement of personal satisfaction in the new cultural context" (p. 299). We suggest that *ethical acculturation* can be defined by substituting the word *ethical* for the word *cultural* in the above definition. The ethical culture of psychology may differ significantly from the

MITCHELL M. HANDELSMAN earned his PhD in clinical psychology from the University of Kansas. He is currently professor of psychology and a president's teaching scholar at the University of Colorado at Denver. His research has focused on teaching and ethics.

MICHAEL C. GOTTLIEB received his PhD in counseling psychology from Texas Tech University, is board certified (American Board of Professional Psychology) in family psychology, and is an associate clinical professor at the University of Texas Southwestern Medical Center. He practices family and forensic psychology independently in Dallas, Texas. His research interests include ethics and the psychology–law interface.

SAMUEL KNAPP received his EdD in counseling from Lehigh University and is the director of professional affairs for the Pennsylvania Psychological Association. His area of professional interest is ethics.

THE OPINIONS EXPRESSED are those of the authors and do not represent the views of the Pennsylvania Psychological Association or any other institution. We thank Michael Burgan and Margie Krest for their positive influence on this article.

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Mitchell M. Handelsman, Department of Psychology—Campus Box 173, University of Colorado at Denver, P.O. Box 173364, Denver, CO 80217-3364. E-mail: mitchell.handelsman@cudenver.edu

value traditions of students, and the new cultural values may be counterintuitive for some trainees. For example, lending money to friends is often a sign of caring and reciprocation; however, lending money to a psychotherapy client may signify something much different.

The culture of psychology is complex and pluralistic but contains agreed-on values, traditions, and rituals. Among these values are scientific thinking, appreciating the complexity of behavior, scientifically informed practice, the search for truth, lifelong learning, the sharing of knowledge, improving society, tolerance for diversity, and social justice. Obviously, some of these values exist in many scientific disciplines and professions, but the particular combination of elements and the tradition of helping make psychology a distinct professional culture.

As in any profession, the acculturation of psychology students is a complex and lengthy undertaking. To improve this process, we review the highlights of a model of acculturation that may be helpful.

Berry's Model of Acculturation

Berry (1980, 2003; Berry & Sam, 1997) conceived of acculturation as a process of adaptation that includes two dimensions that lead to four possible strategies of acculturation or types of adaptation. The first dimension, which Berry and Sam (1997) called *cultural maintenance*, refers to identification with the culture of origin: "Is it considered to be of value to maintain cultural identity and characteristics?" p. 296). When people enter a new culture (either voluntarily or by force) and need to adapt, they vary in their desire to retain their original cultural values and traditions. At one end of the continuum are those who give up their culture of origin completely. At the other extreme are those who want to fully preserve their heritage.

The second dimension, *contact and participation*, refers to identification with the adopted culture: "Is it considered to be of value to maintain relationships with dominant society?" (Berry & Sam, 1997, p. 296). Individuals high in identification see great value and potential in the traditions of their new culture. Those low in identification refuse to accept a culture of which they are ignorant or in which they place little value.

According to Berry (2003; Berry & Sam, 1997), being relatively high or low in cultural maintenance and in contact and participation leads to four possible strategies of acculturation (see Figure 1). "*Attitudes* towards these four alternatives, and actual *behaviors* exhibiting them, together constitute an individual's acculturation *strategy*" (Berry & Sam, 1997, p. 297). Because educators ask students to make a transition to the culture of psychology, we believe students face the same acculturation alternatives as do immigrants. Like those who must create a new cultural identity (Atkinson, Morten, & Sue, 1998; Helms, 1995), students must create an ethical identity, which includes knowledge of the American Psychological Association (2002) Ethics Code, professional behavior, aspirational ethical principles, virtues, and values (Kitchener, 2000).

Acculturation is a dynamic process. Both individuals and cultures change over time, so acculturation is not a place where people arrive but a process on which they embark early and continue throughout life, making adaptations on a continuous basis. Our goal is not to categorize people into static categories but to understand the kinds of choices people face and the implications of those choices.

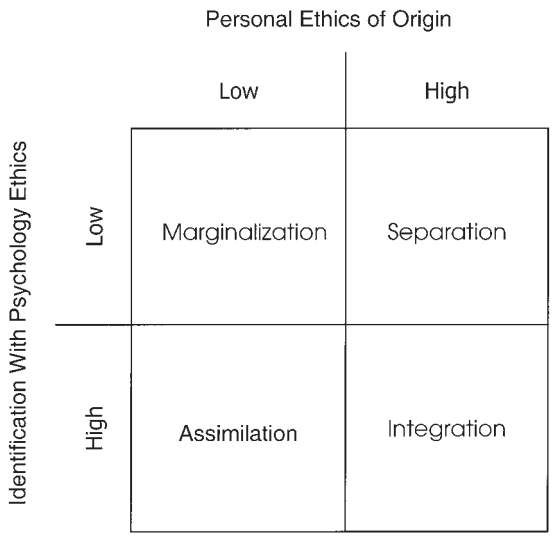


Figure 1. Berry's (1980, 2003; Berry & Sam, 1997) acculturation model applied to ethical identity.

The acculturation choices trainees make are influenced by many factors, not all of which are consciously recognized. External factors include the conditions of both the culture of origin and the new culture. For example, how supportive of cultural maintenance is a particular training program or agency? Another factor influencing adaptation is *cultural distance* (Berry & Sam, 1997, p. 307), or the degree of difference between the two cultures. Among the internal or psychological factors that influence acculturation strategies are trainees' coping styles (Berry, 2003), their sense of how voluntary their acculturation is, and their orientation to moral and ethical issues and judgment (Forsyth, 1980). In the next sections we consider each of the four strategies. Although some of the more extreme features of these strategies are presented here, it should be recognized that each strategy comprises a continuum of behaviors.

Integration

People who adopt an *integration* strategy retain important aspects of their heritage but they also adopt what their new culture has to offer. Integration appears to be the most effective acculturation strategy (Berry, 2003; Berry & Sam, 1997). "Evidence strongly supports a positive correlation between the use of this strategy and good psychological adaptation during acculturation" (Berry & Sam, 1997, p. 298). Applied to ethical acculturation, people choosing integration would adopt the ethical values of psychology while understanding and maintaining their own value tradition. They may be in a better position to do what Gardner, Csikszentmihalyi, and Damon (2001) called "good work," that is, combining technical expertise with a firm ethical sense. For example, they may look for areas of consistency between their personal notion of respect and the ways professionals show respect for clients and others. They may have a richer, more sophisticated appreciation for the underlying principles of both cultures. This is not to say that these psychologists will encounter no conflicts;

instead, they tend to be aware of these strains and work to resolve them in ways that foster greater integration.

Students and psychologists who often choose among the remaining three strategies may be susceptible to alienation or professional and ethical problems, or both. These strategies may be associated with some implicit misconceptions that we describe. Some, who find themselves with unacceptable value conflicts, may choose to pursue other professions more consistent with their values. Others may continue in the profession but struggle with conflicts that may result in ethical problems.

Assimilation

Berry (2003; Berry & Sam, 1997) called the strategy of relatively high contact and relatively low cultural maintenance *assimilation*. At the extreme of the assimilation strategy, the new culture is adopted totally, and the values and traditions from the culture of origin are discarded. In this mode, students adopt professional standards but do so with little personal sense of a moral base.

Assimilation may be dangerous for students, although it may not be immediately apparent. Trainees may feel so strongly motivated to develop a professional identity that they divorce themselves from the values that had previously guided their personal lives. Perhaps they did not start with a strong personal sense of ethics, or, somewhere in the professional socialization process they may have acquired the belief that their personal values were not relevant to or necessary in their professional lives.

When pursuing an assimilation strategy, external trappings may become more important than substance; this can lead to a false sense of competence. The degree, license, and well-furnished office all signify entry into the profession. Certificates, memberships, and offices in professional associations may be sought because of the purely personal satisfaction they bring rather than the professional accomplishments they are supposed to represent. These outward signs are meaningless and potentially harmful without a firm personal grounding in and an appreciation for the ethics and value traditions of the professional culture.

A misconception implicit in the assimilation strategy might be that "the APA Ethics Code contains all I need to know to practice (teach, do research) ethically." Psychologists may attempt to abide by and apply APA standards or state law without understanding the general principles behind them or without appreciating that the code is not a comprehensive guide for living one's life. This strategy is akin to building a strong structure on a shaky foundation, and it may lead to empty, legalistic, and overly simplistic applications of our ethical principles.

Separation

The *separation* strategy describes relatively high cultural maintenance and relatively low contact and participation. Applied to psychology training, students might have a well-developed ethical sense from their own upbringing, or the values of other professions to which they may have belonged, but they do not identify as strongly with the values of psychology. Those choosing the separation strategy may feel that their own way of expressing their morals, ideals, and compassion are sufficient for helping others or doing good research and that they do not need additional rules (for further information, see Bucher & Stelling, 1977, who discussed what they called *socialization failures*).

An implicit misconception of those using the separation strategy may be that "the way I express my personal morality translates into virtuous professional behavior in all circumstances." For example, a psychologist has a patient who becomes pregnant and decides to seek an abortion. The psychologist allows her personal beliefs regarding abortion to override her professional ethical obligation to respect the autonomous decision making of her patient and finds herself slanting her comments accordingly. Another psychologist decides to give two of his single clients each other's phone numbers because he thinks they would be compatible. This seems to the psychologist to be a kind gesture, but he is oblivious to his professional obligations regarding confidentiality.

People may exhibit several variations within the separation strategy. Some inadequately trained students may simply be uninformed about the differences between the two cultures. Others may feel openly hostile to and denigrate the constraints of their new professional responsibilities. They may create the illusion that contact with the professional culture is unnecessary because their own values (perhaps from previous professions) trump those of psychology. Others may feel that the APA Ethics Code is simply a collection of arbitrary rules that represent narrow political interests and not their own compassion or values.

Problems are easy to foresee for those who actively reject large portions of psychology's professional and ethical culture. Although they may have a very strong personal code of ethics and be very well intentioned, these students may also be unaware of the potential harm that may come from acting on a set of principles or virtues that are inconsistent with the professional context.

Marginalization

Marginalization is the most problematic acculturation strategy, comprising low identification with both cultures. Sometimes this may be a temporary strategy—for example, when people move to a new culture and give up their culture of origin before they attempt to adopt the new culture. However, marginalization may also constitute an enduring state of alienation, or a failure of attempts at other strategies (Berry, 2003). In terms of ethics, psychologists using the marginalization strategy do not have a well-developed personal moral sense; neither have they (yet) internalized a sense of professional ethics. Such persons may be at greatest risk for ethical infractions. The extreme of this dimension is represented by psychopaths, although such persons represent a very small percentage of psychologists. Unfortunately, there seem to be numerous other, less extreme examples.

Unlike psychologists exhibiting integration or assimilation, those exhibiting marginalization will obey ethical standards out of personal convenience rather than a sense of moral commitment. A general misconception implicit in this strategy may be the belief that all ethics codes and standards are equally arbitrary and oppressive. This perspective is exemplified by the psychologist who is an adequate clinician but falsifies his time sheets whenever he believes he can do so without detection.

Another type of marginalization may arise when individuals are disturbed or impaired such that enduring relationships or adequate socialization are not achieved. For example, a practicum supervisor may have such a poor sense of relational boundaries that he uses students for his own emotional needs regardless of feedback from colleagues that such behavior is inappropriate.

Implications and Applications of an Acculturation Model for Instructors and Supervisors

Berry's (2003, Berry & Sam, 1997) model of acculturation and adaptation provides a framework for ethics education that may allow one more effectively to understand the transition from person to professional. Although a full explication of Berry's model is beyond the scope of this article, in this section we explore how viewing ethics training as an acculturation process may help those who train psychologists, and we provide some specific suggestions.

Two major ideas underlie an acculturation approach to ethics training. The first is that an acculturation model may provide a more positive approach to teaching ethics. An explicit focus on acculturation in the classroom or supervision may make it easier to see that trainees' decisions and disagreements with instructors and supervisors about appropriate courses of action can be considered and discussed as an acculturation task (or stress) rather than evidence of inadequate learning. The educational task may be more easily viewed as one of helping students make transitions; thus, some of the problems of indoctrination may be avoided or mitigated. Exploring the gap between students' two (or more) cultures respects their personhood and may allow them to be more receptive to altering their judgments without feeling like they are giving up parts of themselves. Trainees will be engaged in active integration.

Integration may best occur when instructors and supervisors view ethics not only as a set of prohibitions but also as a way to actualize students' visions of what it means to be a psychologist. Codes of conduct, licensing board rules, and other disciplinary documents are certainly necessary, but they represent only the ethical *floor,* or minimum standards. Teaching these documents by themselves may lead students to separation choices; they may feel that the codes and rules are external to their sense of ethical identity. (After all, applicants do not say they want to become psychologists so they can obey the law.) Taking a positive approach to ethics (Handelsman, Knapp, & Gottlieb, 2002) includes helping students appreciate that ethics is more than the minimum—that ethics means becoming a full member of the culture of psychology.

The second underlying idea is that acculturation is a long-term developmental process. Developmental models have been created to understand and improve the inculcation of clinical skills (Skovholt & Rønnestad, 1992; Stoltenberg & Delworth, 1987; Worthington, 1987), teaching ability (Marincovich, Prostko, & Stout, 1998), and a variety of other professional behaviors (Bucher & Stelling, 1977). We believe that becoming an ethical professional is also a developmental process (de las Fuentes et al., 2003). In regard to acculturation, Berry and Sam (1997) noted that "during the course of development (and even in later life) individuals explore various strategies, eventually settling on one that is more useful and satisfying than the others" (p. 297). In regard to ethics, faculty who select and teach graduate students, and clinical supervisors, can periodically assess and facilitate the acculturation of students. The fact that acculturation is a lifelong adaptation means that continuing education can also be viewed as part of the process.

Selection of Trainees

First-year graduate students cannot know all that will be expected of them. Students who enter psychology only "because I want to help people" may be especially shocked at the range of values and principles psychologists hold that are irrelevant to, only tangentially related to, or seemingly antithetical to their value of helping. An acculturation framework might help training programs select applicants who are better able to adapt to a new ethical culture. For example, programs could ask applicants to write essays about their preexisting expectations of the ethical culture they are about to enter, their willingness to adopt a new set of values and traditions, or evidence of prior accomplishments that actualize their moral values and indicate their adaptability. These essays or other assessment methods would not be predictors of ethical behavior during one's career; instead, these methods would be more similar to trainability tests (Robertson & Downs, 1979) that may help predict the ability of applicants to learn and adapt to a new ethical culture during graduate training.

First Stages of Ethical Acculturation

New graduate students vary widely in their knowledge and appreciation of psychology ethics. Some students, perhaps those with psychologist friends or relatives, may have a more accurate picture of the field and its ethical expectations. However, many may not realize that a professional body of ethical standards, literature, and practice exists. These students may experience acculturation stress as they confront the values, traditions, and behaviors of their new culture. "If conflict and tension do appear, a highly stressful *crisis* phase may then occur, in which the conflict comes to a head, and a resolution is required" (Berry & Kim, 1988, p. 210). At this time, students might choose an initial acculturation strategy as an adaptation to the crisis or conflict. This choice of strategy may represent a transition to ultimate integration or to one of the other three strategies.

Acculturation entails many sources of tension and stress. Berry and Sam (1997) identified several factors that may influence acculturation strategies and exacerbate the stress of the process, including personal, economic, or political difficulties people had in their culture of origin; gender; cultural distance; inadequate social support; poor training; and a lack of role models in the new culture. Any one or combination of these stressors may leave students more likely to choose marginalization, assimilation, or separation. Knowledge of these stressors may help students move toward integration and may help instructors better understand their students.

One technique that instructors and supervisors can use with trainees in this early acculturation stage is to ask these questions: "What was the most counterintuitive, shocking, surprising, professional activity that you have learned about so far? What didn't you expect about being, or becoming, a professional psychologist?" When we have asked these questions in ethics courses and workshops, many trainees noted that they were unprepared for how quickly and how much their personal relationships changed. They noted that friends and family treated them as experts even before they had completed a single class. Others said they now felt constrained when they gave advice to friends because that advice could be misconstrued as therapy. Other facets of the profession that are surprising to students are the enormous responsibilities involved in helping people, the varying needs of different populations, and the challenge of reconciling the American Psychological Association's (2002) Ethics Code and the traditions of other cultural groups. Other students were not prepared for the obliga-

tion to help clients whom they would not choose to help as friends (e.g., perpetrators and the indigent).

Ethics Courses

Ethics courses present an excellent opportunity for students to explore their acculturation and to begin developing an ethical identity. It may be useful in such courses to have students engage in some reflection about their backgrounds, value traditions, and ethical cultures of origin, before or as they learn the relevant codes and discuss cases. Also, instructors may be more effective when they understand how their instruction fits within the values and skills of their students. One way to accomplish this may be to have trainees write an *ethics autobiography* in which they outline how they came to their present notion of what it means to be an ethical professional. In addition to being a good early assignment in an ethics class, such a paper could be assigned at the beginning of supervision, or even as part of an application to graduate school. Indeed, the assignment can be done several times during the course of training, and beyond.

A variation on the ethics autobiography could be *ethics ethnograms* or *genograms* (de las Fuentes et al., 2003), in which students explore the moral or professional orientation of their family members and other important people in their lives. Having a good sense of where they come from may help students understand and make good use of other class activities, such as studying case vignettes, narrative approaches, first-person accounts of clients, families, and professionals, and exploring the contextual and emotional factors that influence ethical behaviors (Knapp & Sturm, 2002).

Ethics autobiographies or genograms may also make it easier for students to understand that one's ordinary moral sense is not a sufficient basis for ethical behavior in many professional situations (Kitchener, 2000). When discussing therapeutic development, Grater (1985) wrote that "To a significant extent the trainee learns to replace social patterns of interacting with therapeutic responses" (p. 606). Similarly, trainees must see relationship boundaries, privacy, conflicts of interest, respect, and other issues not only from the vantage point of friendship but also from that of a well-defined set of professional principles. Understanding one's own implicit moral principles may make it easier to appreciate the philosophical principles behind ethics codes. Having students critique or debate the APA Ethics Code (see, e.g., Keith-Spiegel, 1994) may be an effective way to juxtapose principles from both cultures and thus move students toward integration.

An emphasis on self-reflection may be especially helpful for students who are involved in culture shedding (Berry, 1992), that is, "the *un*learning of aspects of one's previous repertoire that are no longer appropriate" (Berry & Sam, 1997, p. 298). Trainees need to give up some of their previous behaviors and replace them with behaviors that are more consistent with professional principles. Culture shedding may be especially stressful for those who have been in other professions and are retraining. For example, one trainee had previously worked as a counselor in a domestic abuse shelter, where it was common for counselors to engage in substantial self-disclosure, especially about their own abuse backgrounds. She initially resented the admonition that her self-disclosures as a psychologist had to be more selective and carefully timed.

Instructors who take a positive and developmental approach to ethical acculturation can also appreciate the importance of understanding where they themselves have come from. Trainers might consider writing their own ethics autobiographies and genograms and to ask themselves questions such as: "Where and how did I learn to be a professional? What are my strengths and weaknesses? Whom do (did) I wish to emulate, both professionally and ethically?" Selective sharing of these autobiographies and genograms with students may be helpful.

Practicum Supervision

As trainees progress from the classroom to their practicum placements, the acculturation tasks include putting their new ethical identities to the test in real situations. It may be important to prepare students for the types of dissonance that may occur and to encourage openness not only in the classroom but also in their ongoing supervision. Ethics instructors may have a difficult balancing act to perform. On the one hand, it might be useful to try to "immunize" students by warning them that people in complex real life situations do not always live up to their highest professional aspirations. On the other hand, this message may communicate to students that at least some level of ethically questionable activity is tolerated by professionals in positions of authority. Instructors and supervisors may want to reflect on how they first encountered this conflict and how they think about it now.

Caring about clients, students, or research participants, and knowing that their interests come first, are good starting points for ethical decision making. However, such first principles may not be sufficient in all situations. Stoltenberg and Delworth (1987) noted that it is only the more advanced trainees who "expect—rather than are confused by—the reality that different principles of their professional code seem to contradict each other" (p. 99). This appreciation of complexity and inherent ambiguity is a goal that trainers strive to facilitate, but for some students it remains elusive.

The clinical practicum milieu may include factors that inhibit the ability of new trainees to learn how to think through complex ethical issues. These factors may include the reliance on supervisors that occurs early in clinical training, a lack of time for reflection, and the necessity to act. Stoltenberg and Delworth (1987) stated that "when details of a specific case or situation give rise to an ethical dilemma . . . , the supervisor is expected to take charge and decide what should be done" (p. 59). The problem is that little time is devoted to skill development. Trainees may learn that ethical problems are crises, that there is only one right (and obvious) solution to an ethical problem based on this individual case, and that there is no need to consider thoughtfully the ethical dimensions of their work and how ethical dilemmas may be prevented. Likewise, in the press to get data collection moving, trainees may get the impression that all their ethical obligations are dispatched when institutional review board approval has been obtained.

Supervisors who take some time to think through ethical problems aloud may help students appreciate how personal and professional principles influence the decision-making process (Knapp & Sturm, 2002). Trainees who practice such integration should become better at making ethical decisions themselves.

Practicum supervisors might want to create an environment in which ethical issues and choices can be discussed openly. Again, it may be useful to approach such discussions as acculturation tasks rather than indications of ethical weakness or an ineffective ethics course. Supervisors may want to have trainees update (or

write) their ethics autobiographies, to ask about the acculturation tasks their new trainees have already faced, and to anticipate some of the adaptations that they will face. Consider this example: A trainee has a spouse who insists that good dinner conversation include details of sessions with therapy clients. Although this may seem like a small issue, the resolution of the trainee's dilemma reflects an initial acculturation strategy. The trainee may accede to the spouse's request to maintain marital harmony (isn't that what good people do?) but does so at the expense of violating patient confidentiality. Such a decision may be indicative of a nascent separation strategy. Alternatively, the trainee may choose assimilation and berate the spouse for being insensitive to transcendent professional obligations. The best, and most difficult, resolution comes from integration of the professional value of confidentiality with personal values of mutual respect and caring. In this case, the trainee might explain why such requests cannot be honored but find other ways to talk about his or her work.

Training Programs

Psychologists can strive to create an ethical culture for colleagues and trainees in academic departments and agencies. The development of an ethical orientation in psychology departments, like the development of a sense of community, is neither random nor accidental (Appleby, 2000). Faculty members who have reflected on their own acculturation appear most likely to be able to create an environment that facilitates an integrated acculturation strategy among their students.

An environment that includes the ethical value of caring for and supporting each other becomes an uplifting community that encourages self-reflection and facilitates ethical discussions. A sense of an ethical community can be fostered by individual faculty members. It can also be fostered by the development of institutional policies that involve students as coparticipants in the department culture as much as feasible. Students should not experience themselves as passive recipients of the program culture; instead, they should feel able to contribute actively to the community.

In addition, departments can foster an ethical environment through rituals (ethics conferences, ethics awards), and the identification of ethical role models (e.g., those who have been especially generous in sharing their skills with less fortunate members of society) and ethical narratives (stories of the virtues that inspired or sustained excellent ethical achievements). Gardner et al. (2001) provided a good model for such an enterprise by looking at the "good work" done in genetics and journalism.

Trainees may experience acculturation stress that is due to a mismatch between the espoused and practiced values in the culture of some training programs. A strong sense of ethical principles and values may be eroded by events in the training program or by the personal behaviors of faculty that do not reflect the highest traditions of the profession. The literature documents unethical conduct in some training programs, ranging from asking teaching assistants to lecture without any preparation to professors and students engaging in sexual relationships with each other (Branstetter & Handelsman, 2000; Glaser & Thorpe, 1986; Hammel, Olkin, & Taube, 1996).

Continuing Acculturation

Development does not and should not end when a degree and a license are earned. As cultures change, the process of shifting values and virtues, and how to implement them, continues throughout one's professional life. For example, managed care can be considered a significant cultural shift within the practice of the helping professions that has challenged the ethics and beliefs of many psychologists (Cooper & Gottlieb, 2000). A person's primary acculturation strategy can also change, in reaction to such factors as personal growth, professional experience, or marital and other relationships. Thus, even when the professional culture remains relatively stable, professionals continue to make adaptations for personal reasons. For example, motivations naturally shift as financial pressures fluctuate, relationships form and dissolve, children leave home, and the challenges of professional work wax and wane.

Continuing education efforts can facilitate ongoing ethical acculturation. Ethics autobiographies can be revisited, and discussions can focus on the internal and external factors that call for reassessing the ethical identities of psychologists. The profession can do its part as well. In this regard, the annual awards issue of the *American Psychologist* identifies psychologists who have earned well-deserved recognition for their accomplishments in teaching, research, or promoting professional practice. We lack similar national awards for psychologists who have accomplished much in teaching, researching, exhibiting, or promoting professional ethics.

How Culturally Pluralistic Is Psychology?

Berry and Kim (1988) noted two factors that characterize pluralism. The first is "the availability of a network of social and cultural groups that may provide support for those entering into the experience of acculturation"; the second is "a greater tolerance for or acceptance of cultural diversity" (p. 215). Acculturation influences both the culture of origin and the adopted culture, and members of a culture choose strategies for how they will deal with their new members (Segall, Dasen, Berry, & Poortinga, 1999). How open is psychology to the influence of diverse personal, national, ethnic, and religious traditions? For example, how are therapeutic methods adapted for different ethnic groups (Sue & Sue, 1999)?

We are not advocating that psychology be pluralistic in the absolute. "Even in plural societies . . . , there are still relative degrees of social acceptability of the various acculturating groups" (Berry & Kim, 1988, p. 217). Psychology has certain bedrock assumptions about how psychologists treat people (e.g., prohibitions against sex with clients), but other standards may be more open to influence. It is important for psychologists to explicitly address inclusiveness and diversity and continue to present a welcoming attitude toward the field's newest members.

Conclusion

An acculturation model may help improve the socialization of students, especially in the acquisition of their ethical identity. Indeed, we would like to see a shift from having students feel like involuntary refugees (e.g., "You're in this country now, and this is the way we do things") to having students feel like voluntary immigrants (e.g., "Welcome to our society!") who come because the new culture offers them something to enrich them. We see the goal of ethics training as the enrichment rather than replacement of ethical identities and the integration rather than alienation of new members into our culture.

The effectiveness of an acculturation model in facilitating ethical behavior is an empirical question. This approach could lead to fewer ethical infractions if the rules and principles are more firmly inculcated and embedded both within students' individual value systems and their professional networks. If so, students may feel less alienated and more likely to act appropriately on their knowledge of ethical principles and rules (cf. Bernard & Jara, 1986). Another prediction stemming from this approach is that students will be able to function better as independent ethical thinkers who are able to handle dilemmas that do not correspond so neatly to adherence to rules.

An acculturation model of ethics training may have more far-reaching results than lowering infractions. First, it could lead to excellent ethical behavior rather than simple rule adherence. Second, it could produce psychologists who are less alienated, better integrated, more professionally active (e.g., in terms of serving on ethics committees), more flexible in their responses to changing societal and professional conditions, and more capable of making greater contributions to society.

References

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57,* 1060–1073.

Appleby, D. (2000, November). Academic community building. *APA Monitor, 31,* 38–41.

Atkinson, D. R., Morten, G., & Sue, D. W. (1998). A minority identity development model. In D. R. Atkinson, G. Morten, & D. W. Sue (Eds.). *Counseling American minorities* (5th ed., pp. 35–52). Boston: McGraw-Hill.

Bernard, J. L., & Jara, C. S. (1986). The failure of clinical psychology graduate students to apply understood ethical principles. *Professional Psychology: Research and Practice, 17,* 313–315.

Berry, J. W. (1980). Acculturation as varieties of adaptation. In A. M. Padilla (Ed.). *Acculturation: Theory, models, and some new findings* (pp. 9–25). Boulder, CO: Westview Press.

Berry, J. W. (1992). Acculturation and adaptation in a new society. *International Migration, 30,* 69–85.

Berry, J. W. (2003). Conceptual approaches to acculturation. In K. M. Chun, P. B. Organista, & G. Marin (Eds.). *Acculturation: Advances in theory, measurement, and applied research* (pp. 17–37). Washington, DC: American Psychological Association.

Berry, J. W., & Kim, U. (1988). Acculturation and mental health. In P. R. Dasen, J. W. Berry, & N. Sartorius (Eds.), *Health and cross-cultural psychology* (pp. 207–236). Newbury Park, CA: Sage.

Berry, J. W., & Sam, D. L. (1997). Acculturation and adaptation. In J. W. Berry, M. H. Segall, & C. Kagitçibasi (Eds.), *Handbook of cross-cultural psychology* (pp. 291–326). Needham Heights, MA: Allyn & Bacon.

Branstetter, S. A., & Handelsman, M. M. (2000). Graduate teaching assistants: Ethical training, beliefs, and practices. *Ethics & Behavior, 10,* 27–50.

Bucher, R., & Stelling, J. G. (1977). *Becoming professional.* Beverly Hills, CA: Sage.

Competencies Conference 2002. (2002). *Future directions in education and credentialing in professional psychology.* Retrieved April 20, 2004, from http://www.appic.org/news/3_1_news_Competencies.htm

Cooper, C. C., & Gottlieb, M. C. (2000). Ethical issues with managed care: Challenges facing counseling psychology. *The Counseling Psychologist, 28,* 179–236.

de las Fuentes, C., Willmuth, M. E., & Yarrow, C. (2003, August). Knowledge is not enough: Training for ethical competence. In N. J. Kaslow (Chair), *2002 Competencies Conference: Update and future directions*. Symposium conducted at the 111th Annual Convention of the American Psychological Association, Toronto, Ontario, Canada.

Forsyth, D. R. (1980). A taxonomy of ethical ideologies. *Journal of Personality and Social Psychology, 39,* 175–184.

Gardner, H., Csikszentmihalyi, M., & Damon, W. (2001). *Good work: When excellence and ethics meet.* New York: Basic Books.

Glaser, R. D., & Thorpe, J. S. (1986). Unethical intimacy: A survey of sexual contact and advances between psychology educators and female graduate students. *American Psychologist, 41,* 43–51.

Grater, H. A. (1985). Stages in psychotherapy supervision: From therapy skills to skilled therapist. *Professional Psychology: Research and Practice, 16,* 605–610.

Hammel, G. A., Olkin, R., & Taube, D. O. (1996). Student–educator sex in clinical and counseling psychology doctoral training. *Professional Psychology: Research and Practice, 27,* 93–97.

Handelsman, M. M. (1986). Problems with ethics training by "osmosis." *Professional Psychology: Research and Practice, 17,* 371–372.

Handelsman, M. M., Knapp, S., & Gottlieb, M. C. (2002). Positive ethics. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 731–744). New York: Oxford University Press.

Helms, J. E. (1995). An update of Helms's White and people of color racial identity models. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 181–191). Thousand Oaks, CA: Sage.

Keith-Spiegel, P. (Ed.). (1994). The 1992 ethics code: Boon or bane? [Special section]. *Professional Psychology: Research and Practice, 25*(4).

Kitchener, K. S. (2000). *Foundations of ethical practice, research, and teaching in psychology.* Mahwah, NJ: Erlbaum.

Knapp, S., & Sturm, C. (2002). Ethics education after licensing: Ideas for increasing diversity in content and process. *Ethics and Behavior, 12,* 157–166.

Marincovich, M., Prostko, J., & Stout, F. (Eds.). (1998). *The professional development of graduate teaching assistants.* Bolton, MA: Anker.

Robertson, I., & Downs, S. (1979). Learning and the prediction of performance: Development of trainability testing in the United Kingdom. *Journal of Applied Psychology, 64,* 42–50.

Segall, M. H., Dasen, P. R., Berry, J. W., & Poortinga, Y. H. (1999). *Human behavior in global perspective.* Boston: Allyn & Bacon.

Skovholt, T. M., & Rønnestad, M. H. (1992). *The evolving professional self.* New York: Wiley.

Stoltenberg, C. D., & Delworth, U. (1987). *Supervising counselors and therapists: A developmental approach*. San Francisco: Jossey-Bass.

Sue, D. W., & Sue, D. (1999). *Counseling the culturally different: Theory and practice* (3rd ed.). New York: Wiley.

Worthington, E. L., Jr. (1987). Changes in supervision as counselors and supervisors gain experience: A review. *Professional Psychology, 18,* 189–209.

Received July 23, 2003
Revision received December 2, 2003
Accepted April 14, 2004 ■

Professional Psychology: Research and Practice
2004, Vol. 35, No. 2, 201–205

0735-7028/04/$12.00 DOI: 10.1037/0735-7028.35.2.201

Informed Consent Revisited: An Updated Written Question Format

Andrew M. Pomerantz
Southern Illinois University Edwardsville

Mitchell M. Handelsman
University of Colorado at Denver

This article presents an updated version of M. Handelsman and M. Galvin's (1988) suggested written format for facilitating informed consent to psychotherapy. Significant changes in the psychotherapy profession during the past 15 years, and the revisions regarding informed consent in the American Psychological Association's (2002a) ethics code, form the rationale for this revision. Like the original, this form is a thorough list of questions that clients have a right to discuss with their psychologists. This revised version, which is intended to be illustrative rather than prescriptive, includes new questions addressing insurance/managed care issues, manualized and evidence-based psychotherapy, and psychopharmacology.

Like its predecessor (American Psychological Association [APA], 1992), the new APA ethics code (APA, 2002a) includes standards for obtaining informed consent to psychotherapy. The new code, however, offers somewhat more detailed guidelines, including the directive for psychologists to "provide sufficient opportunity for the client/patient to ask questions and receive answers" (p. 1072). Handelsman and Galvin (1988) published a suggested list of such questions for psychologists to give to clients in writing, with the intention of facilitating the discussion and understanding of important therapy issues. Their set of questions seemed thorough at the time, with questions on the nature of the therapy, alternatives, appointments, confidentiality, money, and other issues. However, the psychotherapy field has witnessed significant changes in the 15 years since the publication of this list. Thus, we offer the current article as an update of Handelsman and Galvin's list for contemporary outpatient psychotherapy.

Of course, in recent years, numerous authors (e.g., Appelbaum, 1993; Haas & Cummings, 1991) have offered advice regarding informed consent to psychotherapy that has addressed contemporary issues. For example, Pope and Vasquez (1998) discussed the importance of making sure that clients understand how their managed care or insurance company may influence psychotherapy by limiting coverage or requiring disclosure of information. Shapiro (2001) also made specific suggestions for informed consent procedures regarding the release of client data to third-party payers, and Beahrs and Gutheil (2001) discussed the challenges of communicating information about third-party payers to clients. Acuff et al. (1999) considered a wide variety of ethical issues, including informed consent, in the context of managed care. All of these authors made clear recommendations about how to obtain informed consent to contemporary psychotherapy, but none offered the question-and-answer format proposed by Handelsman and Galvin (1988) and encouraged by the recently revised APA ethics code (APA, 2002a).

Prominent Issues in Contemporary Psychotherapy

As we look back on the past 15 years of developments in the field of psychotherapy, which issues have increased sufficiently in prominence or importance to merit inclusion in a revision of Handelsman and Galvin's (1988) list of questions? Or, to put this question in the context of the ethical concept of universalizability (Handelsman, 2001; Nagy, 2000): If we (or our loved ones) were clients, what topics would we want to be included in the process of informed consent to modern psychotherapy? Certainly, as discussed above, managed care qualifies as such an issue. In fact, the revised APA ethics code now specifically mentions "involvement of third parties" (APA, 2002a, p. 1072) as a topic about which clients should be informed by psychologists. Numerous articles have described the increasing prevalence of managed care in the field of psychotherapy or the widespread influences that managed care has had on psychotherapy (e.g., Murphy, DeBernardo, & Shoemaker, 1998; Phelps, Eisman, & Kohout, 1998; Pingitore, Scheffler, Haley, Sentell, & Schwalm, 2001; Rothbaum, Bernstein, Haller, Phelps, & Kohout, 1998). Additional studies (e.g., Pomerantz, 2000) have suggested that providing information to prospective clients about the effect of managed care on therapy evokes significant changes in attitudes toward therapy.

In addition (and in relation) to managed care, the rise of evidence-based and manualized psychotherapy practice appears to be another issue that merits inclusion in this update of Handelsman and Galvin (1988). Although described by a wide variety of terms (*treatment guidelines, manuals, best practices, textbook practice,*

ANDREW M. POMERANTZ earned his PhD in clinical psychology from Saint Louis University in 1996. He is currently associate professor of psychology at Southern Illinois University Edwardsville. His research has focused on ethics and psychotherapy.

MITCHELL M. HANDELSMAN earned his PhD in clinical psychology from the University of Kansas in 1981. He is currently professor of psychology and a President's Teaching Scholar at the University of Colorado at Denver. His research has focused on teaching and ethics.

WE WISH TO EXPRESS OUR APPRECIATION to Michael D. Galvin for his assistance with this article.

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Andrew M. Pomerantz, Department of Psychology, Southern Illinois University Edwardsville, Campus Box 1121, Edwardsville, IL 62026. E-mail: apomera@siue.edu

empirically supported/validated treatments), the fundamental notion that a course of psychotherapy should consist of a structured set of interventions supported to some degree by data on its effectiveness has certainly risen to prominence in the past 15 years. In fact, multiple task forces have been formed by APA to consider various aspects of this issue, including one to develop a template for evaluating treatment guidelines (Stricker et al., 1999) and another to establish criteria for empirically supported treatments (Chambless et al., 1996, 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995). Scaturo (2001) discussed this movement within the context of the history and evolution of psychotherapy. The movement has been championed by some (e.g., Chambless, 1996) and criticized by others (e.g., Garfield, 1996), but it has certainly risen in significance as a professional issue since 1988. In fact, in his discussion of informed consent, Plante (1999) argued that the movement toward empirically supported treatments has become so important to contemporary psychotherapy that "patients seeking treatment should be informed that empirically supported treatments exist, and the psychologist must let them know if they intend to use them (or not use them) in the treatment of the patient" (p. 400).

Prompting clients to ask about manualized therapies is important for several reasons. First, such questions provide an opportunity to discuss the strengths and weaknesses of evidence-based and manualized therapy practices, including their fallibility and the need to update them as warranted by continuing research. Second, empirical data suggest that clients prefer to know about inappropriate therapeutic techniques (Braaten & Handelsman, 1997), and this type of information may help address that desire. Third, clients may have questions about the techniques being discussed, based on discussions with friends or articles in newspapers or self-help books they've been reading. Fourth, clients may be confused about why the therapy being described for them is different from the therapy their friend (who may have referred them) received from the same therapist.

In addition to the increase in the number of therapies, the number of types of therapists has increased. A majority of states now license professional counselors (American Counseling Association, 2002; Bradley, 1995) and marriage and family therapists (American Association for Marriage and Family Therapy, n.d.). Alternative therapies, treatments, and practitioners seem to be growing at an exponential rate (e.g., Arnold, 1995; Mamtani & Cimino, 2002; Sachs, 1997). For this reason, we have added several questions designed to help therapists inform clients more fully about their credentials and approaches.

Another important development is that most therapists are required to provide information about their privacy policies and perhaps other information. The federal government's Health Insurance Portability and Accountability Act of 1996 (HIPAA; U.S. Department of Health and Human Services, 1996) is one important source of such requirements (Holloway, 2003a, 2003b). New clients may enter psychotherapy with a range of awareness of HIPAA regulations: They may have learned something about them through the media, other health providers may have provided some information, or they may be entirely ignorant of them. In any case, we have added a question specifically addressing HIPAA issues to provide clients with an opportunity to discuss the implications of this act regarding the confidentiality of different types of health information (e.g., psychotherapy notes as distinct from other types of patient information, electronically transmitted information; Holloway, 2003b). This type of discussion is especially relevant considering the empirical evidence that clients are quite desirous of information about confidentiality (Braaten & Handelsman, 1997).

Some states require therapists to provide written information to clients about therapist qualifications, credentials, and policies and about client rights. Our form is certainly not a substitute for any written information therapists provide. Rather, it is a complement that might increase the benefit of such written information.

Finally, we believe that the issue of psychopharmacology merits mention in our revised form. Of course, we recognize that most psychologists do not currently have prescription privileges, although psychologists have recently been making significant inroads toward obtaining prescription privileges (APA, 2002b). However, we see three reasons why some mention of psychopharmacology is warranted in our revised set of informed consent discussion questions. First, clients are far more aware of psychotropic drugs than they were in 1988. This is attributable to numerous factors, including the sheer proliferation of such drugs (it is now far more likely that a contemporary client personally knows someone who is taking drugs such as Paxil, Zoloft, or Prozac) and the millions of dollars spent in recent years on direct-to-consumer advertising of these drugs (Rosenthal, Berndt, Donohue, Frank, & Epstein, 2002). Second, this increased public awareness of available drugs is combined with what may be an unclear distinction between psychiatrists and psychologists in the public eye (Bremer et al., 2001; Warner & Bradley, 1991); thus, the likelihood of a client arriving in a psychologist's office with the expectation that the psychologist has the capacity to prescribe medicine is considerable. Third, there is a greater likelihood that clients will be taking medications and will want to know if their therapist is knowledgeable about the drugs they are taking.

Specific Additions to Handelsman and Galvin's (1988) Form

The updated question form appears in the Appendix. It consists of Handelsman and Galvin's (1988) original form, with additions printed in bold. We have made a few minor wording changes to the 1988 original but have omitted none of the original questions.

The section of questions on insurance and managed care (Section VI) is entirely new and is the most significant addition to the original. It consists of five questions designed to facilitate open discussion of the effect of third-party involvement on the therapy process. The questions address numerous issues: information to be shared between the psychologist and the third party (in more detail than the parenthetical reference in Question A of Section IV); the power of the third party to control the length or goals of therapy; the possibility of appealing a decision made by the third party; and policies regarding changes in insurance status. They also give rise to discussions of payment options that do not involve third parties (i.e., self-pay).

The first section of questions (the "Therapy" section) features several entirely new questions and several repetitions of the follow-up question. The last question in this section ("Will this therapy follow a preplanned format or structure?") is intended to facilitate discussion about the use of therapy manuals or guidelines, but not necessarily in such professional terms. The purpose

of this question is to give clients the opportunity to be informed about the extent to which their therapy will be directed by predetermined procedures and activities or determined in a more improvised or extemporaneous manner. The follow-up question ("How do you know?") appears three times in this section and once more in Section II. Each time, it follows a question that involves the issue of therapy efficacy or effectiveness. The purpose of this question is to give clients the opportunity to be informed about the evidence on which the psychologist is basing answers to questions about the extent to which therapy works. Of course, for most clients it would be inappropriate to answer such questions with detailed reports on outcome data, but some intelligible description of findings could be provided. Such findings could take a variety of forms, such as previous clinical trials demonstrating empirical support for a particular treatment of a particular presenting problem (as listed in Chambless et al., 1998), more global outcome data supporting the therapeutic power of common factors (as described in Norcross, 2002), or accountability data that are specific to an individual practitioner or clinic (Callaghan, 2001). New questions also appear that more specifically address psychopharmacology, other approaches to therapy, HIPAA requirements, and credentials.

Discussion

Discussions based on these questions should complement, not replace, written informed consent documents to be signed by the client and conversations about therapy information documented in other ways. Discussions based on these questions should also be documented by the psychologist (APA, 2002a; Moline, Williams, & Austin, 1998).

As stated in the original, it is not intended as a cookbook approach to obtaining informed consent (Handelsman & Galvin, 1988). Clearly, this form can be adapted to meet the needs of specific clients. Although it is beyond the scope of this article, a similar question-and-answer approach can be taken with assessment, consultation, teaching, or any other professional activities.

It might be argued that this kind of form might actually get in the way of establishing a therapeutic alliance. The available empirical data suggest just the opposite; in several studies assessing the impact of the original form (Handelsman & Galvin, 1988) and other written materials, the presence of readable documents did not reduce and often increased potential clients' ratings of therapists (Handelsman, 1990; Handelsman & Martin, 1992; Sullivan, Martin, & Handelsman, 1993), especially if the documents were presented in a personalized way (Wagner, Davis, & Handelsman, 1998).

This updated question form offers many strengths. It facilitates open and honest discussion about important issues in psychotherapy, including common contemporary issues like third-party payment, manualization, and psychopharmacology, which reasonable people seeking contemporary psychotherapy would find relevant (Braaten & Handelsman, 1997; *Canterbury v. Spence*, 1972). Discussions around this form may also improve the effectiveness of whatever written information therapists give their clients or ask them to read and sign. Such open discussion enables the growth of a strong therapeutic relationship between therapist and client (Appelbaum, Lidz, & Meisel, 1987; Handelsman, 2001), one based on autonomy and empowerment through information rather than withholding, distrust, or patronization. Moreover, such a practice not only matches the recommendations of the newly revised APA ethics code (APA, 2002a), but it is also self-protective in that it helps psychologists to avoid legal problems (Plante, 1999). As with the original form (Handelsman & Galvin, 1988), discussion of these questions alone does not constitute a completed informed consent process, but it is one important facet of a process that will enable clients to make genuinely informed decisions regarding contemporary psychotherapy.

References

Acuff, C., Bennett, B. E., Bricklin, P. M., Canter, M. B., Knapp, S. J., Moldawsky, S., & Phelps, R. (1999). Considerations for ethical practice in managed care. *Professional Psychology: Research and Practice, 30,* 563–575.

American Association for Marriage and Family Therapy. (n.d.). *Marriage and family therapy licensing and certification.* Retrieved February 11, 2003, from http://www.aamft.org/resources/Online_Directories/boardcontacts.htm

American Counseling Association. (2002). *Counselor licensure legislation: Protecting the public.* Retrieved February 11, 2003, from http://www.counseling.org/consumers/licensure.htm

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47,* 1597–1611.

American Psychological Association. (2002a). Ethical principles of psychologists and code of conduct. *American Psychologist, 57,* 1060–1073.

American Psychological Association. (2002b, March 6). *New Mexico governor signs landmark law on prescription privileges for psychologists.* Retrieved February 5, 2003, from http://www.apa.org/practice/nm_rxp.html

Appelbaum, P. S. (1993). Legal liability and managed care. *American Psychologist, 48,* 251–257.

Appelbaum, P. S., Lidz, C. W., & Meisel, A. (1987). *Informed consent: Legal theory and clinical practice.* New York: Oxford University Press.

Arnold, L. E. (1995). Some nontraditional (unconventional and/or innovative) psychosocial treatments for children and adolescents: Critique and proposed screening principles. *Journal of Abnormal Child Psychology, 23,* 125–140.

Beahrs, J. O., & Gutheil, T. G. (2001). Informed consent in psychotherapy. *American Journal of Psychiatry, 158,* 4–10.

Braaten, E. B., & Handelsman, M. M. (1997). Client preferences for informed consent information. *Ethics & Behavior, 7,* 311–328.

Bradley, L. J. (1995). Certification and licensure issues. *Journal of Counseling and Development, 74,* 185–186.

Bremer, B. A., Foxx, R. M., Lee, M., Lykins, D., Mintz, V. R., & Stine, E. (2001). Potential clients' beliefs about the relative competency and caring of psychologists: Implications for the profession. *Journal of Clinical Psychology, 57,* 1479–1488.

Callaghan, G. M. (2001). Demonstrating clinical effectiveness for individual practitioners and clinics. *Professional Psychology: Research and Practice, 32,* 289–297.

Canterbury v. Spence, 464 F.2nd 772 (D.C. Cir. 1972).

Chambless, D. (1996). In defense of dissemination of empirically supported psychological interventions. *Clinical Psychology: Science and Practice, 3,* 230–235.

Chambless, D. L., Baker, M. J., Baucom, D. H., Beutler, L. E., Calhoun, K. S., Crits-Christoph, P., et al. (1998). Update on empirically validated therapies, II. *Clinical Psychologist, 51,* 3–13.

Chambless, D. L., Sanderson, W. C., Shoham, V., Johnson, S. B., Pope, K. S., Crits-Christoph, P., et al. (1996). An update on empirically validated therapies. *Clinical Psychologist, 49,* 5–18.

Garfield, S. L. (1996). Some problems associated with "validated" forms of psychotherapy. *Clinical Psychology: Science and Practice, 3,* 218–229.

Haas, L. J., & Cummings, N. A. (1991). Managed outpatient mental health plans: Clinical, ethical, and practical guidelines for participation. *Professional Psychology: Research and Practice, 22,* 45–51.

Handelsman, M. M. (1990). Do written informed consent forms influence clients' first impressions of therapists? *Professional Psychology: Research and Practice, 21,* 451–454.

Handelsman, M. M. (2001). Accurate and effective informed consent. In E. R. Welfel & R. E. Ingersoll (Eds.), *The mental health desk reference* (pp. 453–458). New York: Wiley.

Handelsman, M. M., & Galvin, M. D. (1988). Facilitating informed consent for outpatient psychotherapy: A suggested written format. *Professional Psychology: Research and Practice, 19,* 223–225.

Handelsman, M. M., & Martin, W. L., Jr. (1992). Effects of readability on the impact and recall of written informed consent material. *Professional Psychology: Research and Practice, 23,* 500–503.

Holloway, J. D. (2003a, February). More protections for patients and psychologists under HIPAA. *Monitor on Psychology, 34,* 22–23.

Holloway, J. D. (2003b, January). What takes precedence: HIPAA or state law? *Monitor on Psychology, 34,* 28.

Mamtani, R., & Cimino, A. (2002). A primer of complementary and alternative medicine and its relevance in the treatment of mental health problems. *Psychiatric Quarterly, 73,* 367–381.

Moline, M. E., Williams, G. T., & Austin, K. M. (1998). *Documenting psychotherapy: Essentials for mental health practitioners.* Thousand Oaks, CA: Sage.

Murphy, M. J., DeBernardo, C. R., & Shoemaker, W. E. (1998). Impact of managed care on independent practice and professional ethics: A survey of independent practitioners. *Professional Psychology: Research and Practice, 29,* 43–51.

Nagy, T. F. (2000). *Ethics in plain English: An illustrative casebook for psychologists.* Washington, DC: American Psychological Association.

Norcross, J. C. (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients.* New York: Oxford University Press.

Phelps, R., Eisman, E. J., & Kohout, J. (1998). Psychological practice and managed care: Results of the CAPP Practitioner Survey. *Professional Psychology: Research and Practice, 29,* 31–36.

Pingitore, D., Scheffler, R., Haley, M., Sentell, T., & Schwalm, D. (2001). Professional psychology in a new era: Practice-based evidence from California. *Professional Psychology: Research and Practice, 32,* 585–596.

Plante, T. G. (1999). Ten strategies for psychology trainees and practicing psychologists interested in avoiding ethical and legal perils. *Psychotherapy, 36,* 398–403.

Pomerantz, A. M. (2000). What if prospective clients knew how managed care impacts psychologists' practice and ethics? An exploratory study. *Ethics & Behavior, 10,* 159–171.

Pope, K. S., & Vasquez, M. J. T. (1998). *Ethics in psychotherapy and counseling* (2nd ed.). San Francisco: Jossey-Bass.

Rosenthal, M. B., Berndt, E. R., Donohue, J. M., Frank, R. G., & Epstein, A. M. (2002). Promotion of prescription drugs to consumers. *New England Journal of Medicine, 346,* 498–505.

Rothbaum, P. A., Bernstein, D. M., Haller, O., Phelps, R., & Kohout, J. (1998). New Jersey psychologists' report on managed mental health care. *Professional Psychology: Research and Practice, 29,* 37–42.

Sachs, J. (1997). *Nature's Prozac: Natural therapies and techniques to rid yourself of anxiety, depression, panic attacks & stress.* Englewood Cliffs, NJ: Prentice Hall.

Scaturo, D. J. (2001). The evolution of psychotherapy and the concept of manualization: An integrative perspective. *Professional Psychology: Research and Practice, 32,* 522–530.

Shapiro, D. L. (2001). Informed consent to psychotherapy form. In VandeCreek, L., & Jackson, T. L. (Eds.), *Innovations in clinical practice: A source book* (Vol. 19, pp. 275–278). Sarasota, FL: Professional Resource Press.

Stricker, G., Abrahamson, D. J., Bologna, N. C., Hollon, S. D., Robinson, E. A., & Reed, G. M. (1999). Treatment guidelines: The good, the bad, and the ugly. *Psychotherapy, 36,* 69–79.

Sullivan, T., Martin, W. L., Jr., & Handelsman, M. M. (1993). Practical benefits of an informed consent procedure: An empirical investigation. *Journal of Clinical Psychology, 54,* 115–120.

Task Force on Promotion and Dissemination of Psychological Procedures. (1995). Training in and dissemination of empirically validated psychological treatments: Report and recommendations. *Clinical Psychologist, 48,* 3–23.

U.S. Department of Health and Human Services (1996, August 21). *Public law 104–191. Health Insurance Portability and Accountability Act of 1996.* Retrieved September 5, 2003, from http://aspe.hhs.gov/admnsimp/pl104191.htm

Wagner, L., Davis, S., & Handelsman, M. M. (1998). In search of the abominable consent form: The impact of readability and personalization. *Journal of Clinical Psychology, 54,* 115–120.

Warner, D. L., & Bradley, J. R. (1991). Undergraduate psychology students' views of counselors, psychiatrists, and psychologists: A challenge to academic psychologists. *Professional Psychology: Research and Practice, 22,* 138–140.

Appendix

Information You Have a Right to Know

When you come for therapy, you are buying a service. Therefore, you need information to make a good decision. Below are some questions you might want to ask. We've talked about some of them. You are entitled to ask me any of these questions, if you want to know. If you don't understand my answers, ask me again.

I. Therapy

A. What is the name of your kind of therapy?

B. How did you learn how to do this therapy? Where?

C. How does your kind of therapy compare with other kinds of therapy?

D. How does your kind of therapy work?

E. What are the possible risks involved? (like divorce, depression)

F. What percentage of clients improve? In what ways? **How do you know? (e.g., published research? your own practice experience? discussions with your colleagues?)**

G. What percentage of clients get worse? **How do you know?**

H. What percentage of clients improve or get worse without this therapy? **How do you know?**
I. About how long will it take?
J. What should I do if I feel therapy isn't working?
K. Will I have to take any kind of tests? What kind?
L. Do you follow a therapy manual with predetermined steps?
M. Do you do therapy over the phone? Over the Internet?

II. Alternatives
A. What other types of therapy or help are there? (like support groups)
B. How often do they work? **How do you know?**
C. What are the risks **and benefits** of these other approaches? **What are the risks and benefits of NO therapy?**
D. How is your type of therapy different from these others?
E. Do you prescribe medication? Do you work with others who do?
F. (If I am taking medications:) Will you be working together with the doctor who prescribed my medication? How much do you know about the medications I am taking?

III. Appointments
A. How are appointments scheduled?
B. How long are sessions? Do I have to pay more for longer ones?
C. How can I reach you in an emergency?
D. If you are not available, who is there I can talk to?
E. What happens if the weather is bad, or I'm sick?

IV. Confidentiality
A. What kind of records do you keep? Who has access to them? (insurance companies, supervisors, etc.)
B. Under what conditions are you allowed to tell others about the things we discuss? (suicidal or homicidal threats, child abuse, court cases, insurance companies, supervisors, etc.)
C. Do other members of my family, or the group, have access to information?
D. How do governmental regulations (such as federal Health Information Portability and Accountability Act regulations) influence how you handle the confidentiality of my records? Under these regulations, is confidentiality equal for all types of information?

V. Money
A. What is your fee?
B. How do I need to pay? At the session, monthly, etc.?
C. Do I need to pay for missed sessions?
D. Do I need to pay for telephone calls, letters, **or emails?**
E. What are your policies about raising fees? (for example, How many times have you raised them in the past two years?)
F. If I lose my source of income, can my fee be lowered?
G. If I do not pay my fee, will you pursue legal or debt collection activity? Under what circumstances?

VI. Insurance/Managed Care
A. How much and what kind of information will you be required to tell the insurance company about our sessions? (diagnosis, symptoms, etc.)
B. How much influence does the insurance company have on the therapy? (length, goals, etc.)
C. What if I switch insurance companies or lose my insurance? Or what if you stop accepting my insurance?
D. What if you disagree with the insurance company about the best treatment?
E. How would therapy be different if I chose to pay without using insurance?

VII. General
A. What is your training and experience? Are you licensed **by the state?** Supervised? Board certified?
B. Are you a psychologist? Psychiatrist? Family therapist? Counselor? What are the advantages and limitations of your credentials?
C. Who do I talk to if I have a complaint about therapy which we can't work out? (e.g., supervisor, state board of psychological examiners, American Psychological Association ethics committee)

I have already given you some written information. This included a contract, privacy statement, brochure, and/or consent form. We have also talked about some aspects of our work together. This information dealt with most of these questions. I will be happy to explain them, and to answer other questions you have. This will help make your decision a good one. You can keep this information. Please read it carefully at home. We will also look this over from time to time.

Note. From "Facilitating Informed Consent for Outpatient Psychotherapy: A Suggested Written Format." by M. M. Handelsman and M. D. Galvin, 1988, *Professional Psychology: Research and Practice, 19,* p. 225. Copyright 1988 by the American Psychological Association. Adapted with permission.

Received March 11, 2003
Revision received September 10, 2003
Accepted October 9, 2003 ■