CHAPTER ONE

Helping Without Hurting

Personal Responsibility, Constant Questioning, and Basic Assumptions

Psychotherapy holds out the promise of help for people who are hurting and in need. It can change lives.

Clients can find their strengths. They can change course toward a more meaningful life. They can confront loss, tragedy, hopelessness, and the end of life in ways that do not leave them numb or paralyzed. They can discover what brings them joy and what sustains them in hard times. They can begin to trust, or to trust more wisely. They can learn new behaviors in therapy and how to teach themselves new behaviors after therapy ends. They can question what they always believed was unquestionable. They can find out what matters most to them and stop wasting time. They can become happier, or at least less miserable. They can become better able, as Freud noted, to love and to work.

Our ethics acknowledge our profession's responsibilities. We can often help, but if our ethics slip, we can needlessly hurt.

ETHICS AND PERSONAL RESPONSIBILITY

What we do can make a difference in whether a client loses hope and commits suicide or chooses to live, whether a battered spouse finds

shelter or returns to someone who may kill, and whether an anorexic teenager gets help or starves to death. Even new therapists know that such dramatic examples tell only part of the story. So many people come to us facing what seem to be minor, hard-to-define problems, yet the hard, risky, unpredictable twists and turns of their therapy can lead to more meaningful, effective, fulfilling lives.

Few therapists take these responsibilities lightly. Few set aside their concern about a suicidal client between sessions. Few sit unmoved while a client talks, perhaps for the first time, about what it was like to survive an atrocity. Few turn away untroubled when a managed care company refuses to authorize treatment for someone in desperate need of help, someone who lacks enough money to put food on the table, let alone pay for therapy out of pocket.

The purpose of this book is to provide therapists with ideas, information, and resources that can help them think through these responsibilities and what they want to do about them.

Recognizing these responsibilities as they appear in our day-to-day work and deciding how to respond can be stressful and sometimes overwhelming. We may feel short of time, resources, or wisdom. The responsibilities can weigh us down, rattle us, make us want to run and hide. They can make us more vulnerable to other sources of stress.

Uncertainty causes stress for some of us. We cannot find that magical book that will tell us what to do, especially in a crisis. Research, guidelines, manuals, our own experience, and consultation help, but we cannot know the best course in all situations, or even how the "best" course will turn out. We are constantly thrown back on our own judgment. If we believe a client might kill someone but there is no explicit threat or other legal justification under the state's law to hospitalize the client or breach confidentiality, what do we do? Whether doubling the number of therapy sessions during a crisis would help or hurt (or even have no net effect) is a decision that must be made on the basis of professional judgment regarding the individual client. What diagnosis should we write down if we know that the insurance company will not cover treatment for the client's condition and believe that the client's need for treatment is urgent? Will using stress-reducing imagery techniques help a particular client (reducing stress and increasing the client's effectiveness) or cause harm (enabling the client to adapt to an abusive job or relationship) is a question without an instantly clear and infallible answer. Does informed consent make sense if all the process will accomplish is cause a patient to turn

away from life-saving treatment? The inescapable responsibility of making careful, informed professional judgments regarding issues of enormous complexity and potentially life-and-death implications can push even the most resourceful therapists to their limits.

Fearing that formal review agencies will hold us accountable after the fact stresses and distresses some of us. Some agencies, such as local, state, and national professional ethics committees, focus specifically on the ethical aspects of our work. Others, such as state licensing boards and the civil courts, enforce professional standards of care that may reflect ethical responsibilities. The prospect of review agencies second-guessing us with the benefit of hindsight can make difficult judgments a nightmare for some therapists. They may suffer a debilitating performance anxiety, dread going to work, and discover that the focus of their work has changed from helping people to avoiding a malpractice suit.

Managed care has stressed some therapists. For example, capitation contracts provide a limited sum of money to cover all services for a group of patients. The agency providing services, having estimated the average number of sessions needed for each patient, must limit the total number of sessions to make a profit. Strict guidelines may limit how many sessions a therapist can provide. Therapists may feel pressure to terminate before the limit. Even if clinicians follow the agency's formal procedures, they may face charges before an ethics committee, licensing board, or malpractice court for patient abandonment, improper denial of treatment, or similar issues. Therapists may fear not only that a formal review agency will sanction them but also that the limited sessions fall far short of what their clients need. One national study found that 86 percent of the participating therapists had experienced fear that a client may need clinical resources that are unavailable (Pope & Tabachnick, 1993).

Teaching or learning therapy can stress some of us. As supervisors, we may grow uncomfortable with how the supervisee responds to the client differently from how we would, with our responsibility to evaluate the supervisee's work, and with the demands of our role as teacher and mentor. As supervisees, we may doubt our ability to carry out clinical responsibilities (especially when they involve suicidal or homicidal risks), dread making mistakes, feel uneasy about differences in values or theoretical orientation between ourselves and our supervisor, and figure that if we are completely honest in describing to our supervisor what we actually thought, felt, and did with our clients, we

might be advised to look for another line of work (see Pope, Sonne, & Greene, 2006).

SEVEN SCENARIOS

We created the following seven fictional scenarios for ethics and malpractice workshops. None of the hypothetical vignettes, which follow, is based on an actual or specific case (and none of the individuals is based on an actual clinician or patient), but all the scenarios represent the kinds of challenges that therapists and counselors face. In these scenarios, the clinicians were attempting to do their best. Readers may disagree over whether each clinician met the highest or even minimal ethical standards, and such disagreements can form the focus of classroom, case conference, supervision, or related discussions. In at least one or two instances, you may conclude that what the clinician did was perfectly reasonable and perhaps even showed courage and sensitivity. In some cases, you may feel that significant relevant information is missing. But in each instance, the professional's actions (or failures to act) became the basis of one or more formal complaints.

Computer Coincidences

What happened to these therapists was so traumatic that even though they are fictional characters and never existed, they have fled into other lines of work, do not want to be recognized, and demand anonymity in this hypothetical scenario. The catastrophes seemed to start when one of them hit the Send button on his computer.

For many years these therapists had maintained a small and very successful group practice. Then they modernized, bringing in state-of-the-art computers, elegantly networked and equipped with wonderful software that made the therapists' work much easier—until one day the first therapist hit the Send button.

The therapist had carefully collected all the electronic records of one of his patients, who was involved in litigation, to e-mail to the patient's attorney. There were the billing records, results of psychological testing, records of therapy sessions, as well as the background records (employment, disability, and others) that the therapist had on file. The therapist gave one last look and then hit the Send button.

It was only after watching his computer send off the records that he realized he had used the wrong address on the e-mail. The patient records were on their way not to the patient's attorney, but to a large Internet discussion list that the therapist belonged to. This unfortunate series of events led to a formal complaint against the therapist.

By a farfetched coincidence typical of hypothetical scenarios, the second therapist walked into the first therapist's office just when the first therapist was hitting the Send button. Here is what the second therapist said: "Can you believe it!? I'm being sued, and it's all because of my computer! When my patient temporarily moved to the East Coast for a sabbatical, we thought it best to continue treatment, but because of the time difference and our heavy schedules, we couldn't find a time when we could both talk, so we decided to communicate by e-mail. But then she got mad at me about something and filed complaints against me *in the other state!* So now they're saying I was providing psychological services in that state without being licensed there and that I failed to follow that state's rules and regulations about . . . well, you'd have to read the complaints her attorney has filed with the licensing board, the courts, and the ethics committee. It's terrible!"

As if sensing that another wild coincidence was needed to keep the story moving, the third therapist rushed into the first therapist's office at that moment and cried , "You won't believe what just happened! I just got a formal notice that I'm being sued! I just found out what happened: somehow a virus or Trojan or Worm or one of those things got into my computer and took my files—you know, all my confidential case files—and sent them to everyone listed in my address book and to all the other addresses in my computer's memory. What do I do now?"

On cue, the fourth therapist ran into the room and wailed, "Help! I'm in such trouble! One of my patients is involved in a nasty lawsuit, and I received a court order to produce all my records. The patient had given me consent to turn them over because she and her attorney believe they will be the key to their winning the case. So I sat down to print them out and . . . they're gone! My hard drive crashed, and when I hired a company to rescue what they could, they retrieved some of the files. but all the files for that patient are gone. What do I do now?"

Although the room was getting crowded, the fifth therapist slouched in, collapsed in a chair, and announced, "I'm doomed. I kept all my records on my laptop. But while I was at lunch today, someone broke into my car and stole my laptop. Then I got worse news. I thought at least the files would be safe because I encrypted them, but I just found out from a colleague that since the program I used to encrypt and unencrypt them is on that computer and since many thieves have software that enables them to get past passwords and gain use of the encryption program, it would be pretty easy for a hacker to unencrypt my files."

When the final member of their group practice failed to show up with bad news, they grew concerned and went down the hall to her office. She was sitting at her desk with a big smile on her face. She chirped, "I can't tell you how good I feel! I've been so concerned about keeping records on my computer that I finally decided it just wasn't worth the worry. I printed out all my records, made extra copies that I put in my safe deposit box, and got rid of my computer. It was such a good move for me. I haven't felt this good in days."

It was only months later that she discovered, as she read the complaint filed against her, that she had done a poor job of trying to erase her hard drive before selling her computer. The person who had bought it had little trouble retrieving the supposedly erased files and reading all the details about her patients.

Life in Chaos

Mr. Alvarez, a thirty-five-year-old professor of physics, has never before sought psychotherapy. He shows up for his first appointment with Dr. Brinks. Mr. Alvarez says that his life is in chaos. He was granted full professor status about a year ago, and about a month after that, his wife suddenly left him to live with another man. He became very depressed. About four months ago, he began to feel anxious and have trouble concentrating. He feels he needs someone to talk to so that he can figure out what happened. Mr. Alvarez and Dr. Brinks agree to meet twice a week for outpatient psychotherapy.

During the first few sessions, Mr. Alvarez says that he feels relieved that he can talk about his problems, but he remains anxious. During the next few months, he begins talking about some traumatic experiences in his early childhood. He reports that he is having even more trouble concentrating. Dr. Brinks assures him that this is not surprising; problems concentrating often become temporarily worse when a patient starts becoming aware of painful memories that had been repressed. She suggests that they begin meeting three times a week, and Mr. Alvarez agrees.

One month later, Mr. Alvarez collapses and is rushed to the hospital, where he is pronounced dead on arrival. An autopsy reveals that a small but growing tumor had been pressing against a blood vessel in his brain. When the vessel burst, he died.

Months after Mr. Alvarez's death, Dr. Brinks is served notice that the state ethics committee is opening a formal case against her based on a complaint filed by Mr. Alvarez's relatives. Furthermore, she is being sued for malpractice. The ethics complaint and the malpractice suit allege that she was negligent in diagnosing Mr. Alvarez in that she had failed to take any step to rule out organic causes for Mr. Alvarez's concentration difficulties, had not applied any of the principles and procedures of the profession of psychology to identify organic impairment, and had not referred Mr. Alvarez for evaluation by a neuropsychologist or to a physician for a medical examination.

Psychotherapists and counselors in ethics and malpractice workshops (who would probably not constitute a random sample of practicing psychologists) who have reviewed this scenario have tended to conclude that Dr. Brinks may have been functioning beyond the range of her competence and violated some of the fundamental standards of assessment (see Chapter Twelve).

Evaluating Children

Ms. Cain brings her two children, ages four and six, to Dr. Durrenberger for a psychological evaluation. She reports that they have become somewhat upset during the past few months. They are having nightmares and frequently wet their beds. She suspects that the problem may have something to do with their last visit with their father, who lives in another state.

Dr. Durrenberger schedules three sessions in which he sees Ms. Cain and her two children together and three individual sessions with each of the children. As he is preparing his report, he receives a subpoena to testify in a civil suit that Ms. Cain is filing against her ex-husband. She is suing for custody of her children. During the trial, Dr. Durrenberger testifies that the children seem, on the basis of interviews and psychological tests, to have a stronger, more positive relationship with their mother. He gives his professional opinion that the children would be better off with their mother and that she should be given custody.

Mr. Cain files an ethics complaint, a civil suit, and a licensing complaint against Dr. Durrenberger. One basis of his complaint is that Dr. Durrenberger had not obtained informed consent to conduct the assessments. When Mr. and Ms. Cain had divorced two years previously, the court had granted Mr. Cain legal custody of the children but had granted Ms. Cain visitation rights. (Ms. Cain had arranged for the assessments of the children during a long summer visit.) Another basis of the complaint was that Dr. Durrenberger had made a formal recommendation regarding custody placement without making any attempt to interview or evaluate Mr. Cain. Mr. Cain's attorney and expert witnesses maintained that no custody recommendation could be made without interviewing both parents.

Although laws regarding rights of custodial and noncustodial parents differ from state to state and province to province, participants in ethics and malpractice workshops tend to conclude that Dr. Durrenberger had not fulfilled his ethical (and, in many states, legal) responsibility to obtain adequate informed consent from the relevant parent (see Chapter Eleven) and that he had failed to conduct an adequate assessment to justify his conclusion (see Chapter Twelve).

The Fatal Disease

When George, a nineteen-year-old college student, began psychotherapy with Dr. Hightower, he told the doctor that he was suffering from a fatal disease. Two months into therapy, George felt that he trusted his therapist enough to tell her that the disease was AIDS.

During the next eighteen months, much of the therapy focused on George's losing battle with his illness and his preparations to die. After two stays in the hospital for pneumonia, George informed Dr. Hightower that he knew he would not survive his next hospitalization. He had done independent research and talked with his physicians, and he was certain that if pneumonia developed again, it would be fatal due to numerous complications and that it would likely be a long and painful death. George said that when that time came, he wanted to die in the off-campus apartment he had lived in since he came to college—not in the hospital. He would, when he felt himself getting sicker, take some illicitly obtained drugs that would ease him into death. Dr. Hightower tried to dissuade him from this plan, but George refused to discuss it and said that if Dr. Hightower continued to bring up the subject, he would quit therapy. Convinced that George would quit therapy rather than discuss his plan, Dr. Hightower decided that the best course of action was to offer caring and support—rather than confrontation and argument—to a patient who seemed to have only a few months to live.

Four months later, Dr. Hightower was notified that George had taken his life. Within the next month, Dr. Hightower became the defendant in two civil suits. One suit, filed by George's family, alleged that Dr. Hightower, aware that George was intending to take his own life, did not take reasonable and adequate steps to prevent the suicide, she had not notified any third parties of the suicide plan, had not required George to get rid of the illicit drugs, and had not used hospitalization to prevent the suicide. The other suit was filed by a college student who had been George's lover. The student alleged that Dr. Hightower, knowing that George had a lover and that he had a fatal sexually transmitted disease, had a duty to protect the lover. The lover alleged ignorance that George had been suffering from AIDS.

This scenario has been one of the most agonizing and controversial for the psychotherapists and counselors who consider it at ethics and malpractice workshops. Some believe that Dr. Hightower acted in the most humane, sensitive, and ethical manner; others believe that she was wrong to accept, without more vigorous challenge, George's decision to take his own life. In this sense, it illustrates the dilemmas we face when confronted with a suicidal individual (see Chapter Seventeen). It also illustrates how such issues as confidentiality (see Chapter Sixteen) have been challenged when a specific third party or the public more generally is perceived to be put at risk by a client.

Many would argue that the main goal of therapy when suicide is an issue is to defuse the potentially lethal situation. According to this stance, we have a professional duty to take appropriate affirmative measures to prevent patients from harming themselves, a duty that

may include in extreme cases seeking a civil commitment of the patient. However, there has been increasing attention to an alternate view in which the clinician may respect and accept the client's autonomy to such a degree that the client's decision to commit suicide is respected and accepted. Some would accord this "right to die" to any client; others would recognize it only in certain extreme situations (for example, if the client is suffering from a painful and terminal disease). Some would draw the line at accepting a client's decision to commit suicide and taking no steps to interfere with the client's self-destructive acts; others would consider actively assisting the person to die. These agonizing, controversial issues have become especially difficult for some who provide mental health services to those with AIDS (see Pope & Morin, 1990), as in this vignette. As is so often the case, the ethical and clinical issues are interwoven with legal standards. Some states have considered and continue to consider legislation related to the issue of assisted suicide, and the topic continues to be complex and controversial (Carter, VandeKieft, & Barren, 2005; Downie, 2004; Ganzini, 2006; Gostin, 2006; Hamilton & Hamilton, 2005; Herlihy & Watson, 2004; Kleespies, 2004; Okie, 2005; Radtke, 2005; Rosenfeld, 2004; Werth & Blevins, 2006).

The Mechanic

Ms. Huang, whose family had moved from mainland China to the United States fifteen years ago, is a forty-five-year-old automobile mechanic. She agreed, at the strong urging of her employer, to seek psychotherapy for difficulties that seem to affect her work. She has been showing up late at her job, has often phoned in sick, and frequently appears distracted. She complains to her new therapist, Dr. Jackson, of the difficulties of coping with both psychomotor epilepsy, which has been controlled through medication, and her progressive diabetes, for which she is also receiving medical care.

Although she has no real experience treating those from the Chinese culture or those with chronic medical conditions such as epilepsy, Dr. Jackson begins to work with Ms. Huang. She meets with her on a regular basis for three months but never feels that a solid working alliance is developing. After three months, Ms. Huang abruptly quits therapy. At the time, she has not paid for the past six sessions.

Two weeks later, Dr. Jackson receives a request to send Ms. Huang's treatment records to her new therapist. Dr. Jackson notifies Ms. Huang that she will not forward the records until the bill has been paid in full.

Some time later, Dr. Jackson is notified that she is the complainee in an ethics case opened by the Ethics Committee of the American Psychological Association (APA) and

that she has been sued for malpractice. The complaints allege that Dr. Jackson had been practicing outside her areas of competence because she had received no formal education or training and had no supervised experience in treating people from the Chinese culture or those with multiple serious and chronic medical diseases. The complaints also alleged that Ms. Huang had never adequately understood the nature of treatment, as evidenced by the lack of any written informed consent. Finally, the complaints alleged that "holding records hostage" for payment violated Ms. Huang's welfare and deprived her subsequent therapist of having prompt and comprehensive information necessary to Ms. Huang's treatment.

Participants in ethics and malpractice workshops, asked to assume the role of an ethics committee to review this scenario, tend to conclude that Dr. Jackson was acting without adequate competence to treat someone from a different culture (see Chapter Fifteen) or with a chronic medical condition, had not obtained adequate consent (see Chapter Eleven), and had misused the power of her role as therapist in refusing to disclose records because of an unpaid bill.

The Internship

Dr. Larson is executive director and clinical chief of staff at the Golden Internship Health Maintenance Organization. For one year, he closely supervises an excellent postdoctoral intern, Dr. Marshall. The supervisee shows great potential, working with a range of patients who respond positively to her interventions. After completing her internship and becoming licensed, Dr. Marshall goes into business for herself, opening an office several blocks from Golden Internship Health Maintenance Organization. Before terminating her work at the HMO, Dr. Larson tells Dr. Marshall that she must transfer all patients to other center therapists. All of the patients who can afford her fee schedule, however, decide to continue in therapy with her at her new office. The patients who cannot afford Dr. Marshall's fee schedule are assigned to new therapists at the center. Dr. Larson hires an attorney to take legal action against Dr. Marshall, asserting that she unethically exploited the HMO by stealing patients and engaging in deceptive practices. He files formal complaints against her with both the state licensing board and the APA Ethics Committee, charging that she had refused to follow his supervision in regard to the patients and pointed out that he, as the clinical supervisor of this trainee, had been both clinically and legally responsible for the patients. He refuses to turn over the patients' charts to Dr. Marshall or to certify to various associations to which she has applied for membership that she has successfully completed her internship.

Dr. Marshall countersues, claiming that Dr. Larson is engaging in illegal restraint of trade and not acting in the patients' best interests. The patients, she asserts, have

formed an intense transference and an effective working alliance with her; to lose their therapist would be clinically damaging and not in their best interests. She files formal complaints against Dr. Larson with the licensing board and the APA Ethics Committee, charging that his refusal to deliver copies of the patients' charts and to certify that she completed the internship violates ethical and professional standards.

Some of the patients sue the HMO, Dr. Larson, and Dr. Marshall, charging that the conflict and the legal actions (in which their cases are put at issue without their consent) have been damaging to their therapy.

Workshop participants have tended to conclude that both Dr. Larson and Dr. Marshall have behaved unethically in terms of misusing their power (see Chapter Three), failing to clarify in advance the conclusion of Dr. Marshall's work with the patients (see Chapter Ten), and neglecting to address these issues adequately in the supervisory contract (see Chapter Eighteen).

Staying Sober

In therapy for one year with Dr. Franks, Mr. Edwards is an alcoholic and drank heavily for four years prior to the therapy. Dr. Franks uses a psychodynamic approach and incorporates behavioral techniques specifically designed to address the drinking problem.

Two months into therapy, when it became apparent that outpatient psychotherapy alone was not effective, Mr. Edwards agreed to attend Alcoholics Anonymous (AA) meetings as an adjunct to his therapy. During the past nine months of therapy, Mr. Edwards had generally been sober, suffering only two relapses, each time falling off the wagon for a long weekend.

Now, a year into therapy, Mr. Edwards suffers a third relapse. He comes to the session having just had several drinks. During the session, Dr. Franks and Mr. Edwards conclude that some of the troubling material that has been emerging in the therapy had led Mr. Edwards to begin drinking again. At the end of the session, Mr. Edwards feels that he has gained some additional insight into why he drank. He decides to go straight from the session to an AA meeting.

One month later, Dr. Franks is notified that he is being sued. On his way from the therapy session to the AA meeting, Mr. Edwards had run a red light and had killed a mother and her child who were crossing the street. The suit alleged that the therapist knew or should have known his patient to be dangerous and should have taken steps to prevent him from driving until his alcoholism no longer constituted a danger to the public.

Although workshop participants tend to fault Dr. Franks for not adequately assessing his client's condition and the danger that the

client's driving in that condition would constitute for the public, there was a common empathic response, as with many of the other scenarios. Clinicians tended to identify with the fictional Dr. Franks and thought, "There, but for the grace of God, go I." Struck by the enormous complexity and responsibilities the clinicians face in these scenarios, we wonder if we would do any better were we in their places and if we are doing any better in our own practices (our failures of responsibility perhaps being in different areas though just as serious).

The Realities of Our Practice

Each scenario tends to bring home the reality that formal mechanisms of accountability act to protect clients from unethical and potentially harmful practices, but may also increase the stress that we feel at the possibility that one day we may be the subject of a formal complaint.

Yet another source of stress for some of us is the sense that in some areas at least, the responsibilities to which we are held accountable do not seem matched by our abilities and resources. For example, society (through the courts) may hold us accountable for predicting and preventing homicide. But accurately predicting whether someone will or will not kill seems to be beyond the capacity of mental health professionals or anyone else, for that matter (see Chapter Twelve).

In the midst of all this responsibility, complexity, uncertainty, and stress, remaining alert to the ethical aspects of our work in a consistent and meaningful manner can seem overwhelming.

ETHICS AND DENIAL

If the stress overwhelms us, all of us are vulnerable to denial and other ways of dismissing, distorting, or discounting ethical questions. We all have our favored ways of making uncomfortable ethical challenges disappear, perhaps by transforming them almost magically into something else, perhaps by attacking the client or colleague who raises the ethical question, perhaps by viewing ourselves as helpless, as compelled by necessity to act in a way that we suspect may be unethical. Take a few minutes to conduct a private self-assessment of the degree to which these forms of ethical denial may have infiltrated your own practice as a therapist, counselor, supervisor, or trainee.

For the therapist, counselor, supervisor, or trainee, professional ethics represent three basic tasks (discussed more fully in Chapter

Three). First, professional ethics involve acknowledging the reality and importance of the individuals whose lives we affect. Second, they involve understanding the nature of the professional relationship and professional interventions. Third, they involve affirming accountability for our behavior. A moment of active and honest self-assessment can give us at least a general sense of how well we are accomplishing these tasks.

Are the people whom we serve real to us? To what extent do we misuse valid diagnostic and classification systems in a way that diminishes clients? Do we think of three clients we are working with not so much as people but as the two schizophrenics and the one borderline? To what extent do we view them as somehow inferior because they are clients? If we are in independent practice, have we begun thinking of our clients less as individuals to be helped than as sources of payment for office overhead? Do we treat our clients any differently than we would like to be treated if we were in their place?

To what extent do we maintain an adequate awareness of the nature and implications of the professional relationship and of our professional interventions? Have we become insensitive to the trust with which so many of our clients invest their relationship to us, of the degree to which they count on us for hope and help? Have we begun to tangle professional boundaries so that certain clients are confused about whether they are our clients, business partners, friends, creditors (from whom we get low-interest loans), dates, or lovers?

To what extent do we hold ourselves accountable not only for what we do but also for what we fail to do as professionals? Do we tend to push responsibility onto our employer, the community, the legal system? Do we blame others for keeping us from doing what we believe is right? Do we find ourselves saying nothing when we see something that is wrong because we are afraid to speak up?

BASIC ASSUMPTIONS

Our shared vulnerability to stress, denial, and human imperfection can make recognizing and meeting our ethical responsibilities hard, and yet we cannot spare ourselves from constant ethical challenges, from responsibility for how our choices help or hurt.

This book does not try to provide an encyclopedic approach to ethical aspects of every topic related to psychotherapy and counseling and does not provide "right answers" to use when approaching ethical

questions in various areas. Rather, it presents an approach to ethics in the early chapters and focuses in the later chapters on a few of the major areas of practice such as assessment, working with suicidal clients, and supervision.

Seven basic assumptions inform the approach presented in this book:

1. Ethical awareness is a continuous, active process that involves constant questioning. Fatigue, habits, stress, dogma, and routine can erode our personal responsiveness and our sense of personal responsibility. They can lull us into ethical sleep, putting us on automatic when we need to wake up to what we are missing. It is crucial to practice continued alertness to the ethical implications of what we do.
2. Awareness of the ethical standards and codes is crucial to competence in the area of ethics, but standards and codes cannot take the place of an active, deliberative, and creative approach to fulfilling our ethical responsibilities. They prompt, guide, and inform rather than preclude our ethical considerations. We cannot apply standards and codes in a rote, unthinking manner. Each new client, whatever his or her similarities to previous clients, is unique. Each situation is unique and changes over time. Standards and codes may identify some approaches as clearly unethical. They may identify significant ethical values and concerns, but they cannot tell us what form these values and concerns will take. They may set forth essential tasks, but they cannot tell us the best way to accomplish those tasks with a unique client facing unique problems.
3. Awareness of the scientific and professional literature, the evolving research, and theory is crucial to competence in the area of ethics, but the claims and conclusions emerging in the literature can never be passively accepted and reflexively applied. A necessary response to published claims and conclusions is active, careful, informed, persistent, and comprehensive questioning.
4. We believe that the overwhelming majority of therapists and counselors are conscientious, dedicated, caring individuals who are committed to ethical behavior. But none of us is infallible. Whatever our experience, accomplishments, or wisdom, all of us can—and do—make mistakes, overlook something important, and reach conclusions that are wrong. An important part of our work is questioning ourselves, asking, "What if I'm wrong about this? Is there something I'm overlooking? Could there be another way of understanding this situ-

ation? Could there be a more creative, more effective, better way of responding?"

5. Many of us find it easier to question the ethics of others than to question what we ourselves do. It may be a red flag worth paying attention to if we find ourselves preoccupied, to the exclusion of questioning our own beliefs and behaviors, with how wrong others are in some area of ethics and certain that we are the one to set them right, or at least to point out repeatedly how wrong they are. It is important to question ourselves—our own ethical values, beliefs, and behavior—as much as we question others.

6. Many of us find it easier to question ourselves in areas where we are uncertain. It tends to be much harder, but often much more productive, to question ourselves about what we are most sure of, what seems beyond doubt or question. Nothing can be placed off-limits for this questioning. We must follow this questioning wherever it leads us, even if we venture into territories that some might view as politically incorrect or—much more difficult for most of us—"psychologically incorrect" (Pope et al., 2006).

7. Clinicians repeatedly encounter ethical dilemmas for which a clear ethical response is elusive. The therapist confronts needs that do not match resources; values and responsibilities that clash; situations whose meaning varies according to perspective and context; limits to our scientific understanding of conditions or interventions; our own feelings; or other reactions that seem to block or sidetrack an effective response. There is no legitimate way to avoid these struggles. Clinicians must be prepared to actively examine these dilemmas as a normal and expected part of our work. Chapters Ten through Eighteen end with a set of scenarios, each with a series of questions for readers to consider, to encourage an active approach to such dilemmas.

Because this book's approach emphasizes personal responsibility and the need to think clearly about the responsibilities emerging from each new situation, Chapter Two focuses on critical thinking.