Twenty-First Century Ethical Challenges for Psychology

Gerald P Koocher

Available at: https://works.bepress.com/gerald_koocher/8/
Foreseeable social and technological changes will force us to reevaluate our thinking about ethically appropriate ways to fulfill our mission of using psychology to advance human health and welfare in the twenty-first century. Three categories of challenge related to societal and technological changes have become particularly evident. First, increasing patterns of delivering services over substantial distances by electronic means (i.e., telepsychology) demand consideration. Second, we must parse our ethical obligations to individuals, to groups, and to society at large as our influence working behind the scenes as “invisible” psychologists grows. Finally, as we witness the accelerating demise of psychiatry, we must make sure not to follow a similar path. As we face new ethical challenges, we must continuously ask ourselves where our responsibilities lie as individuals and as a profession. We must learn not to repeat the mistakes of the past and focus instead on optimizing the future for a science and practice of psychology focused on human health and welfare.

Keywords: confidentiality, ethics, psychiatry, telehealth, telepsychology

And I believe
These are the days of lasers in the jungle
Lasers in the jungle somewhere
Staccato signals of constant information . . .

—Paul Simon, “The Boy in the Bubble”

Although written more than two decades ago, Paul Simon’s (1986) lyrics for “The Boy in the Bubble” highlight many of the issues we face as twenty-first century psychologists. His words call our attention to the horrors of terrorism in the daily lives of ordinary people, dramatic advances in science and medicine, the omnipresence and power of electronic media, the resulting pressures on daily family life, and the ultimate paradox of lasers in the jungle: modern technologies interacting with basic human realities. We can anticipate many new ethical challenges unfolding as psychologists continue to advance our science and profession to promote human health and well-being.

This article addresses three obvious categories of challenge. The first involves increasing demands to deliver our services by electronic means (i.e., telepsychology). The second addresses the increasingly complex problem of parsing our ethical obligations to individuals, to groups, and to society at large as many of our colleagues practice outside the view of those affected by their work. Finally, as we watch the decline of psychiatry as a profession, we must learn from its errors.

Telepsychology

Rapid advances in microelectronics have made portable communication devices, data, image, and sound storage devices, and a wide range of transmission devices affordable and readily available in much of the world. A broad array of personal communications and business transactions now occur in the realm of cyberspace. We must expect that psychologists will increasingly face expectations by our clients to provide services in the context of their preferred modes of communication. As we move away from the traditional context of sitting face to face with our clients across a room, the Greek prefix tele, meaning from a distance, comes to mind and leads naturally to a consideration of the ethics of telepsychology.

What we traditionally agreed to as we formed alliances and contracts with clients in the past will certainly require rethinking, as will our traditional professional standards. From the perspective of professional ethics, we need to consider four Cs: contracting, competence, confidentiality, and control. What contracts or agreements for providing services will we make with our clients? What competencies will we need in order to offer services remotely? What new factors will constrain confidentiality protections? Who will control the practice of telepsychology (i.e., the regulation of practice and data access)?

Contracting

Psychotherapists now offer clinical services around the world by telephone and via the Internet through e-mail, chat rooms, Web sites, and interactive audio and video...
technology (Aronson, 2000; Barak, 1999; Barnett & Scheetz, 2003; Marks, 2005; Stanberry, 2006). When we agree to work with clients via telemetry, the nature and terms of how we relate change significantly from those in traditional vis-à-vis relationships. Practitioners will need to reach accords on new contracts or agreements regarding the nature of psychological services and the manner of providing them. For example, we will have to obtain and document clients’ informed consent to communicate with them electronically (Derrig-Palumbo & Zeine, 2005; Hyler & Gangure, 2004). Such consent will doubtless require many changes such as the necessity for us to establish reasonable security and encryption precautions (Fisher & Fried, 2003; Hyler & Gangure, 2004; Sokol & Car, 2006; Woody, 1999). We will have to keep relevant consumer information posted on professional Web sites up to date and will need to provide precise instructions regarding the nature of the services, access, and emergency coverage (Barak, 1999; Jerome & Zaylor, 2000).

Providers will have to consider a myriad of new contractual issues with related liability components. Will we contract to correspond or provide services electronically only with existing psychotherapy clients, or will we accept new referrals of people we have never met in close proximity for any or all of our services? Will we agree to conduct all assessment, consultation, or therapy relationships entirely via telemetry or will we offer only a limited range of electronically mediated services? Will we compromise traditional boundaries and promise real-time electronic access 24/7/365 (Gutheil & Simon, 2005)? If so, how will we offer emergency coverage or provide backup for clients who live hundreds or thousands of miles away or perhaps in other countries (Aronson, 2000; Barak, 1999; Marks, 2005; Pettifor & Sawchuk, 2006)? How will record keeping change, given the ease with which we can record, store, and alter such communications? Will our fees and reimbursement policies differ from those for office-based services?

**Competence**

New standards of care and professional competencies will apply when we offer direct services remotely. The Ethics Committee of the American Psychological Association (1997) noted that the Ethics Code does not specifically address electronically mediated services and by this intentional omission has created no rules prohibiting such services. The Committee has consistently stated a willingness to address any complaints regarding such matters on a case-by-case basis while directing psychologists to apply the same standards used in “emerging areas in which generally recognized standards for preparatory training do not yet exist,” by taking “reasonable steps to ensure the competence of their work and to protect patients, clients, students, research participants, and others from harm.” Aside from another general caution about reviewing “the characteristics of the services, the service delivery method, the provisions for confidentiality, and licensure board rules,” no clear professional consensus or detailed ethical guidelines for telepsychology currently exist (American Psychological Association, 2002).

Psychologists have long used electronic means to keep in touch with traditionally established clients during vacations, relocations, and emergencies. A growing body of research has also demonstrated the potential benefits of delivering psychological interventions by telephone (e.g., Aronson, 2000; Bastien, Morin, Ouellet, Blais, & Bouchar, 2004; Heckman et al., 2004; McKay et al., 2004; Mermelstein, Hedeker, & Wong, 2003; Sandgren & McCaul, 2003). The practical value of electronically mediated health and mental health care delivery (Jerome & Zaylor, 2000) as well as clinical supervision (e.g., Wood, Miller, & Hargrove, 2005) has been well documented in many studies. We must view the success reported to date with caution, however, because many of these studies have compared electronic interventions with wait list controls as opposed to in vivo treatment. In addition, peer-reviewed journals generally have little interest in publishing studies with nonsignificant or negative findings. Not surprisingly, some research has shown ratings of therapeutic alliances formed via videoconferencing to fall significantly below similar ratings of interactions under face-to-face conditions (Rees & Stone, 2005), and as with most things, psychoanalysts have considerable ambivalence about teletherapy (Leffert, 2003). We actually know very little about what specific competencies of individual psychologists translate into what types of alliances (effectively or ineffectively) for particular clients. Some types of therapeutic intervention will not easily translate into electronic activities (e.g., play therapy with young children or interventions involving therapeutic touch). This challenging domain remains one of the most rapidly evolving areas of professional practice and one of the ripest areas for clinical research.

Gerald P. Koocher
We must also not overlook the obvious potential for mischief. Both those offering to provide services and those seeking to obtain them may more easily engage in misrepresentation. How can one be certain that the person on the other end of the phone line or computer terminal is the person he or she claims to be? How accurate are the claims of telespsychology practitioners regarding their credentials, skills, and success rates with remote interventions? How will you feel when someone intent on a modern-day replay of Rosenhan’s (1973) famous study or an angry former client posts edited excerpts of his or her “sessions” with you on www.youtube.com or www.stupidvideos.com? Will telespsychology lead to greater caution and reduced liability (e.g., by reducing the risk of client–therapist sexual intimacy) or greater risk (e.g., reduced ability to respond across distances with suicidal clients)? Only time will bring answers to such intriguing questions.

In addition to consultation or psychotherapy, some practitioners offer electronically mediated psychological assessment procedures, but not without significant ethical challenges. For example, published empirical evaluations of Web-based personality tests indicate that they can prove reliable and valid (Buchanan, 2002, 2003). However, we cannot assume that Web-based versions of the tests will always equivalently measure the same constructs as their traditionally administered antecedents. Aside from the general integrity problem (i.e., how does one know who sits at the other end of the connection and/or who may provide real-time coaching to that person?), remote assessment will prove challenging in terms of assessing special needs, disabling conditions, cultural issues, and linguistic competence. The psychologist choosing to make use of such assessments retains ethical responsibility for all applicable psychometric standards and must exercise great caution (Barak, Buchanan, Kraus, Zack, & Stricker, 2004; Buchanan, 2002; Lievens, 2006; Naglieri et al., 2004).

Searching for “psychological testing” on Google yielded well over 4 million results as this manuscript went to press. Many Web sites invite visitors to sample a range of do-it-yourself (DIY) “tests” of uncertain validity or reliability without clearly identified responsible individuals (see, e.g., http://www.psychtests.com/ or http://www.colorquiz.com/). Other sites trade on the names and reputations of well-known individuals while touting newly invented hypothetical constructs seemingly crafted to the public Zeitgeist and the profit motive (see, e.g., http://www.authenticity.sas.upenn.edu/questionnaires.aspx). Still others offer strong appeal based on face validity and societal concerns despite serious questions about their validity, faking potential, or arbitrary metrics. One example comes from social psychology, where some researchers have long touted the Implicit Association Test as a means to provide members of the lay public with feedback about their supposed “hidden biases” via Internet testing (see https://implicit.harvard.edu/implicit/). Despite substantial criticism (see, e.g., Arkes & Tetlock, 2004; Blanton & Jaccard, 2006; Blanton, Jaccard, Gonzales, & Christie, 2006; Fiedler & Bluemke, 2005), promoters of such techniques and sites attempt to sidestep ethical problems by eschewing clinical meaning and describing their work as exploratory, informational, or even fun. One has no way of knowing what private pain (or pleasures) members of the public receive by learning that they are allegedly racially biased or authentically happy, respectively.

Recently, the ethical ante has increased with the advent of several DIY screening tests having significant clinical implications. Some tests for dementia have become available for purchase by the general public via drugstore chains, telephone, and the Internet. Various Internet sites also offer screening tests for various mental health problems ranging from anxiety and depression to attention-deficit/hyperactivity disorder. These screening tests generally fall outside the purview of government regulators and have yet to result in ethical complaints against psychologists (Kapp, 2003; Kier & Molinari, 2003, 2004). At the same time, these DIY tests create potential for misuse and errors in interpretation, particularly for those without access to skilled in vivo support or counseling.

Confidentiality

Constraints on confidentiality when electronically mediated telespsychology services take place lie well beyond the control of most psychologists. We must take reasonable steps to protect client privacy, but what can individual professionals actually control in the context of modern national security threats? Who else will overhear our conversations with our clients? Consider the programs known as Carnivore, ECHELON, and TEMPEST.

TEMPEST is a categorical code word for electromagnetic snooping (Hesseldahl, 2000). Most ordinary citizens lack “TEMPEST-hardened” electronic equipment typically available only to the military for shielding against high-tech spying, disruptive interference, and electromagnetic pulse destruction. Carnivore and ECHELON, two particular programs of the U.S. government, have become public in some respects (Ewing, 2003; Reams & Anglim, 2002; Richelson, 2001). Carnivore, an e-mail screening system developed and used by the Federal Bureau of Investigation (FBI), captures and reads e-mail messages circulated among suspected criminals, terrorists, and everybody else. ECHELON, a global spy system begun by the National Security Agency (NSA) in the 1970s, can reportedly automatically search through millions of intercepted messages for preprogrammed keywords, analyzing virtually every telephone call, fax, e-mail, and telex message sent anywhere in the world. One can reasonably assume that the capabilities of the FBI and the NSA have only improved with enhanced technology since early reports of their existence became known (for additional details visit http://www.epic.org/).

Following the attack on New York’s World Trade Center, the Foreign Intelligence Surveillance Act (FISA) of 1978 and Section 215 of the USA Patriot Act (i.e., officially known as the Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act of 2001) have made it clear that FBI agents may seek secret warrants to conduct stealth searches of suspects’ homes and to demand secret access to
the files of those who have any dealings with such individuals. Although no instance in which a mental health professional has faced secret searches of client records based on national security has come to light, the well-documented case of Theresa Squillacote illustrates the potential intrusion of security agencies into the realm of psychotherapy.

Theresa Marie Squillacote, also known as Tina, Mary Teresa Miller, The Swan, Margaret, Margit, and Lisa Martin, and her husband, Kurt Stand, were convicted of espionage. Squillacote had earned a law degree and worked for the Department of Defense in a position requiring a security clearance. In 1996 the FBI obtained a warrant to conduct clandestine electronic surveillance, including the monitoring of all conversations in Squillacote’s home, calls made to and from the home, and Squillacote’s office. On the basis of the monitored conversations, including Squillacote’s conversations with her psychotherapists, a Behavioral Analysis Program (BAP) team at the FBI prepared a report of her personality for use in furthering the investigation. The BAP report noted that she suffered from depression, took antidepressant medications, and had “a cluster of personality characteristics often loosely referred to as ‘emotional and dramatic’” (United States of America v. Theresa Marie Squillacote, 2000). The BAP team recommended taking advantage of Squillacote’s “emotional vulnerability” by describing the type of person with whom she might develop a relationship and pass on classified materials. Ultimately, she did transmit national defense secrets to a government official posing as a foreign agent and using strategies suggested by the BAP team (United States of America v. Theresa Marie Squillacote, 2000).

Some implications of electronic surveillance technologies, as in the Squillacote case, are discussed in the second section of this article, which identifies psychologists’ obligations to layers of clients. In the spirit of full disclosure of the limits of confidentiality, these factors warrant specific discussions with clients when psychologists use electronic communications of any sort. Psychologists should remind clients that the use of unencrypted Internet communications, computers in the workplace, wireless devices, and even telephones with wired extensions may all be subject to monitoring by others (Sokol & Car, 2006).

Control

Questions about the control or regulation of telepsychology practice remain highly fluid. One survey (Koocher & Morray, 2000) documented considerable variability across licensing jurisdictions in the United States with respect to electronic practice across state lines. With state, provincial, and territorial governments regulating professional practice within U.S. and Canadian jurisdictions, the Association of State and Provincial Psychology Boards (ASPPB) has taken the lead in attempting to foster interstate practice and mobility credentials for psychologists in North America. However, little agreement exists regarding interstate or international telepractice, and the fundamental concepts involved challenge attempts at resolution.

When a client in Boston enters teletherapy with a psychotherapist in Los Angeles, Toronto, or Hyderabad, who regulates the practice (see, e.g., Barnett & Scheetz, 2003; Fisher & Fried, 2003; Marks, 2005; Nickelson, 1998; Pettifor & Sawchuk, 2006; Stanberry, 2006)? Does the treatment take place where the client sits, where the therapist sits, or in cyberspace? If something goes wrong, to whom can one complain? In the United States, licensing boards function as state government entities with only intrastate authority. Will a domestic licensing board even open a complaint against one of its own licensees who has treated a client residing outside its geographic jurisdiction? If it does, will the state government’s enforcement branch authorize prosecution, and will the courts recognize any jurisdiction? We simply do not know the answers.

Recommendations for Telepsychology

Those psychologists considering establishing telerelationships with clients should give careful consideration to three particular steps. First, they should specifically discuss their planned services with the client and confirm mutual agreement to the terms in written form. The agreement should cover all of the usual issues discussed in a therapeutic contract (e.g., access to the practitioner, billing, and what to do in emergencies) and should state by mutual consent what jurisdiction’s laws will apply. The practitioner should hold a valid license in that jurisdiction. Second, the practitioner should have some reasonable basis for confidence that the services rendered will prove effective and should take steps to monitor the client’s progress as a way of ensuring a successful outcome. Finally, the practitioner should review the standard HIPAA (Health Insurance Portability and Accountability Act) confidentiality provisions and also caution the client about vulnerabilities associated with using electronic communications.

Identifying Our Clients and the Role of the Invisible Psychologist

As a behavioral science and health profession, psychology has benefited significantly from generations of undergraduate psychology majors and increased coverage of our field in the media. Applications of psychological principles and research have found wide acceptance in commerce and the justice system, as well as in both medical and mental health care. With such successes come new ethical challenges, not the least of which involve identification of our ethical responsibilities both to individuals and to society at large. We must begin to conceptualize our professional obligations much like the leaves of an artichoke, all of them connected at the base (by our ethical responsibilities) and closely packed, but still distinct and separable.

Beneficence and nonmaleficence form the foundation of the American Psychological Association’s (APA’s) Ethics Code (APA, 2002), followed closely by fidelity and responsibility. We strive to benefit those with whom we work while taking care to do no harm. We attempt to safeguard the welfare and rights of those with whom we interact professionally and those of other affected persons.
When we confront conflicts among our obligations or concerns, we seek to resolve them responsibly while seeking to avoid causing harm. At times, avoiding all harm becomes impossible, and we must attempt instead to minimize harm resulting from our work. At the same time that we strive to establish relationships of trust with our clients, we must remain mindful of our professional and scientific responsibilities to society and our communities (APA, 2002).

These concepts date back to the Hippocratic oath, which originated as a pledge by a healer undertaking treatment of a patient. It is interesting that the Hippocratic oath has a rather paternalistic tone, making no mention of consent by the patient.

At times, the medical tradition has recognized the necessity to favor the needs of one person over the needs of others (e.g., making a triage decision to provide immediate care for a patient who has suffered a respiratory arrest even though another person who arrived earlier must wait in acute pain with a compound fracture) or to coercively limit the freedom of clients (e.g., quarantining highly infectious patients or using restraints with violent mentally ill patients). In the past half century, many mental health professionals have taken on the mantle of applying behavioral science for societal benefit apart from direct, individual-focused contracts. Such applications include providing services to multiple individuals delivered as a unit, providing services at the behest of a known third party, and undertaking professional activities on behalf of a third party unknown by or invisible to the individuals under treatment or study.

The Individual Client

The individual client offers the simplest case for observing principles of beneficence, nonmaleficence, fidelity, and responsibility. After all, with one client, the psychologist’s professional obligations seem well-focused. However, history and law have long recognized the role of healers to assist in acting on behalf of the greater good of society. The doctrine of parens patriae illustrates the origin of such intervention. Parens patriae, Latin for “father of the people,” refers in law to the public policy duties of the state to use its powers to act as a kind of ultimate parent for vulnerable citizens. Under this doctrine, government may mandate some types of medical or mental health intervention, or usurp the rights of natural parents or legal guardians to act as the parent of a child or individual deemed in need of protection (e.g., a child whose parents are unable or unwilling to provide care, or an incapacitated and dependent individual of any age).

Under such doctrine, legislative bodies have routinely enacted statutes mandating breaches of confidentiality and reporting by designated professionals to government authorities when a vulnerable person or society becomes threatened in defined ways (Brann & Mattson, 2004; Koocher, 1995; Monahan, 1980; Sarkar, 2006). The most common examples affecting psychologists in the United States include laws that command us to report suspicions that a child, an elderly person, or a dependent person has been abused. We may also face obligations to seek the hospitalization of people dangerous to themselves or others, including an obligation to warn potential intended victims. Similarly, physicians and nurses may face requirements to report those suffering from gunshot wounds or certain highly infectious diseases to police or public health authorities. Obviously, some of the patients who come to us and disclose such behaviors or hazards would prefer that we keep silent and may experience reporting to and subsequent intervention by the state as nonbeneficent and maleficient.

Because most legislative bodies tend to behave reactively, often in response to horrific events, we frequently see a patchwork of laws that betray social biases and inconsistencies both within and across jurisdictions. Suppose, for example, that a new client in Massachusetts informs a psychologist at the first session that he murdered his spouse last week and would like help dealing with residual guilt feelings about that act. Under state law, the psychologist has an obligation to treat that communication as confidential and privileged, unless it turns out that the late spouse was under age 18 (hence a child), over age 60 (hence elderly), or disabled. If required to make a mandatory report, the clinician would have to choose among three different state agencies and a county prosecutor. The same laws also require reporting any disclosure by a client regarding financial abuse of a person over age 60 but prevent reporting knowledge that a child or disabled person had been financially abused. If practicing in Pennsylvania, the psychologist would also face a requirement to report unsafe drivers (Pennsylvania Vehicle Code, 2001).

In some situations, government has deemed the vulnerabilities of certain categories of people significant enough to warrant trampling the privacy rights of individual clients, potentially forcing such clients to face public embarrassment, fines, or incarceration triggered by disclosures to their psychologist. Some legislators and attorneys who represent plaintiffs want to require that therapists must report to state agencies when clients tell them of sexual intimacies with prior therapists, even over the clients’ objections. The post-Tarasoff era (see Tarasoff v. Regents of University of California, 1976) has also spawned a spate of so-called progeny cases and legislation related to the duty of the psychotherapist to protect third parties from harm (see, e.g., Eisner, 2006; Quattrocchi & Schopp, 2005; VandeCreek & Knapp, 2001; Yufik, 2005). We can probably anticipate other future arguments that the parens patriae doctrine should apply to other types of breaches of duties to individual clients. We deal with this ethically by advising clients of confidentiality limits at the outset of a professional relationship, but the fact remains that some of our professional duties may force us choose to take actions potentially harmful to an individual client but deemed beneficial to society as a whole.

Couples, Families, and Groups of Clients

Couples, families, or groups of clients seen together pose more complex situations of conflicting interests. Suppose a couple seeks the services of a psychologist to help improve their relationship. Now suppose that over time it becomes
clear to the clinician that the best outcome for one member of the dyad would involve exiting the relationship, while the best outcome for the other member would require maintaining the relationship. In such situations, one party may well suffer harm while the other benefits. Does the fault lie with the psychologist whose intervention triggered a decision-making insight by one partner, or does the decision rest on the free will of one client (Bass & Quimby, 2006; Blow & Hartnett, 2005; Snyder & Doss, 2005)? Similarly, whenever groups of people enter treatment together, the best outcomes for all parties will seldom prove congruent. We constantly strive to do good, retain clients’ trust, and minimize harm, even in contexts where we recognize that some parties may ultimately feel unhappy or harmed as a result of their participation. Our ethical obligation involves foreseeing potential difficulties, affording thoughtful informed consent or permission, and retaining our professional integrity as we strive to advance common interests. Nonetheless, sometimes we must recognize that some parties may well experience feelings of harm resulting from participation in multiple-client psychological interventions.

**Known Third Parties**

Conflicting interests also occur frequently when the authority or request for a psychologist’s services originates with a known third party. In the most benign context, a third party such as an insurer or managed care company provides its customers with a panel of selected providers who have agreed to provide selected services for specified fees. Subtle conflicts may sometimes occur in such situations if a psychologist feels dependent on or subject to pressure from the third party in a way that precludes acting in the client’s best interest. In most circumstances, however, little reason exists to question the practitioner’s goal of helping and not harming the client. In a number of other situations, however, a psychologist may ethically undertake intervention or evaluation at the behest of a third party that may lead a client to feel harmed. Examples include child custody, competency, or criminal responsibility evaluations and independent examinations to determine disability, fitness for duty, or suitability for employment. In such contexts, a third party (e.g., the courts, an employer, an insurance company, or a government agency) has requested or ordered the evaluations.

Both the entity requesting the service and the person undergoing evaluation hold a kind of client status in such cases. The process involves an appearance of mutual consent but conflicting interests and, hence, a degree of coercion. The individual facing evaluation may decline to participate or to share the results of such an evaluation with the requesting party. However, such refusals will have predictable adverse consequences such as loss of custody, loss of employment, or loss of disability coverage. One hopes that in such situations a competent psychologist with a high degree of integrity will perform a skilled, valid evaluation and provide accurate, useful data that benefit both the institutional client and the individual client. Society as a whole clearly gains by having significant decisions of this sort aided by valid behavioral science data. Still, one party may experience a degree of harm or may fail to benefit from the ethical work of the psychologist.

**Invisible Third Parties**

A more complex set of ethical issues arises when the authority or request for a psychologist’s services originates with a concealed or invisible third party. In such situations, psychologists become invisible to the object of their professional attention. For example, attorneys with cases that involve psychological issues or testimony by psychological experts will often hire psychologists to review and critique the work of the other experts, who will soon face cross-examination. Still other psychologists might help advise a lawyer on jury selection, run a jury simulation, use crime details to devise profiles of perpetrators to assist police investigators, help the Secret Service assess the seriousness of threats made against the president, help an employer strategize about interviewing applicants for a specific job, or develop a training program to assist investigators (pick the venue of your choice) in interviewing or interrogation. In such instances, the client owed the ethical duty may well not be the person on whom the psychologist focuses attention but rather a third party seeking behavioral science advice. The person under study may never know that he or she has been studied, profiled, critiqued, or subjected to behavioral analysis, as the psychologist’s activities effectively take place behind the scenes. In addition, the person may experience harm as the result of the psychologist’s work. Careless or incompetent expert witnesses may find themselves embarrassed on the witness stand. Serial killers may find themselves identified and convicted based on psychological analysis of crime scene evidence. Candidates for executive positions may lose a job opportunity because of emotional or personality factors uncovered during a probing interview.

Consumers also become frequent objects of study by anonymous psychologists in the employ of advertising agencies. One notorious example became public in the late 1980s when the R. J. Reynolds Tobacco Company planned to test market two new brands of cigarette. One, called *Uptown*, contained menthol, and its marketing was aimed heavily toward African American smokers. Marketing for the other brand, called *Dakota*, was aimed at young, poorly educated, White females, termed “virile females” (Cotton, 1990). The APA urged its members not to participate in helping to market “lethal and addictive” products, although some members objected to this prohibition, noting that the profession should not bar colleagues from working for purveyors of legal commercial entities. Still other psychologists argued that psychological ethics should preclude psychologists from assisting in the marketing of alcohol and firearms as well.

Hostage situations afford another example. Suppose that an angry, troubled teenager has brought a gun to school and taken a class hostage. A SWAT team arrives and prepares to storm the classroom, as snipers focus their laser sights on the armed teen. Now suppose that a psychologist working with the police interviews the parent of the hos-
tage taker, who has arrived on the scene. On the basis of
information gleaned from the parent, the psychologist con-
tacts the hostage taker via cell phone, attempts to establish
rapport, asks questions, and engages him emotionally. Be-
cause of the intentional work of the psychologist, the teen
ultimately becomes tearful or distracted and momentarily
lowers his weapon, allowing the SWAT team the seconds
needed to rush in and disarm him. By using psychological
skills and personal data in such situations, psychologists
have saved lives, while never incurring a therapeutic obliga-
tion or even disclosing their professional identities to the
people whose behavior they attempted to influence.

Yet another example involves concerns about psy-
chologists consulting to those involved with interrogations
associated with national security. Shameful behaviors by
military personnel dealing with detainees at the Abu Ghaib
prison in Iraq or the Guantanamo detention site (e.g.,
intimidation with dogs, sleep deprivation, infliction of
physical discomforts, forced nudity, and other types of
humiliation) have rightly attracted condemnation. APA has
clearly stated that psychologists who commit role viola-
tions (i.e., mixing health services delivery and interrogation
support) or who participate in any way in torture or inhu-
mane or degrading practices have violated the ethics code
(Behnke, 2006; American Psychological Association, Pres-
idential Task Force on Psychological Ethics and National
Security, 2005). Reports of involvement by Behavioral
Science Consultation Teams (i.e., so-called BSCTs) at such
facilities have led many to call on APA to demand that
psychologists refuse to work in such capacities. Often such
demands come from people who assume that the BSCT
personnel engage in torture or similar behavior. Still others
recognize potential legitimate, lawful, and nonabusive roles
for such personnel (e.g., advising on establishing rapport,
managing frustration, and observing from behind one-way
mirrors to watch for behavioral drift on the part of inter-
rogators) but argue that no participation by psychologists at
such facilities is ever acceptable in any capacity. Some
opposition to psychologists’ participation in such activities
flows from principled political objections rather than
broader ethical principles. Should we expect that military
psychologists would have to disobey lawful orders or that
psychologists should decline any military service? Or
should we provide ethical guidance to assist our colleagues
in challenging situations to actively discriminate among
choices on the basis of professionally accepted standards?
Given that reasonable, ethical psychologists can come to
different conclusions, the latter path supportive of contin-
uous peer interaction and consultation seems most appro-
priate (Gonzalez & Packer, 2004; Williamson, 2006; Wil-
son, 2006).

Some psychologists occasionally argue against any
concealed roles involving the application of behavioral
science to serve the needs of some third parties, usually by
asserting a personally important moral values position. Our
ethics code has generally not attempted to prohibit such
activities, so long as the psychologists in such roles per-
form their duties lawfully. As psychological science ad-
vances, we must expect that private parties, governments,
and corporations will continue to seek psychological con-
sultation out of public view. The ethics code should compel
attention to human welfare, integrity, appropriate role clar-
ity, and obedience to law but should not become a tool for
advancing political or narrow social agendas.

Protection of the public and of vulnerable members of
society should remain a prime directive for psychologists.
In many situations, psychologists will face requests for
services that involve multiple layers of clients, each with
different positions in a hierarchy of control and vulnera-
bility. We must remain mindful of these nuances and focus
on retaining our professional integrity while providing
high-quality service in the context of appreciating the rel-
ative strengths and weaknesses of the parties involved.

Recommendations for Ethical Role
Management

As our science continues to improve and gains public
recognition for value added to decision making, we will
find ourselves increasingly drawn into situations where a
multitude of social and political interests apply across
hierarchies of individuals to whom we owe various degrees
of professional duties. Three considerations can help guide
our responses in such situations. First, by clarifying our
professional obligations to ourselves and the other parties
involved at the outset of our professional relationships we
reduce the risk of subsequent confusion and misunder-
standing. Second, at times, legal standards or emergent
need may legitimately dictate the precedence of one per-
son’s needs over another’s in considering professional ob-
ligations. Such standards should emerge from legitimate
public policy decision-making processes and not become
clouded by political ideologies of the right or the left.
Third, by focusing on the welfare and best interests of the
most vulnerable party in the chain of individuals to whom
one owes a legitimate professional duty, psychologists op-
timize the likelihood of a good outcome. At times, the most
vulnerable party may be the public at large.

Witnessing the Demise of Psychiatry

The specialty of psychiatry has long stood at the lowest
rung of the medical hierarchy ladder in terms of both
scientific prestige, professional recognition, and institu-
tional authority within medical institutions. Recent de-
velopments in psychiatric practice have accelerated a decline
in the profession, and psychologists should take note of the
key contributory factors and learn. As he ended his term as
president of the American Psychiatric Association in May
2006, Steven Sharfstein addressed the issue of prescribing
privileges for psychologists and told his colleagues,

But let’s be quite clear about the terrain of prescriptions. Most of
the prescribing of psychotropic medications has been dominated
by general physicians who do the bulk of prescribing, estimated at
more than 75 percent of all prescriptions for psychiatric medica-
tions in the U.S. . . . Of greater concern for psychiatry is the
domination of treatment of mental illness by psychopharmacology
means and the attrition of psychotherapeutic and psychoso-
cial approaches in our practice. Psychopharmacology ascen-
dance in practice has been driven by managed care protocols,
which deemphasize the psychotherapeutic skills of psychiatrists and puts [sic] a premium on very short-term hospital care, medication management, and reevaluation of diagnosis and treatment. (p. 3)

Sharfstein’s (2006) remarks highlight the predictable demise of psychiatry as a profession over the next several decades. As psychologists, we already knew that the training model in psychiatry (i.e., newly minted physicians with a minimal background in psychiatry get hospital-based on-the-job training in psychopathology, psychotherapy, and psychopharmacology after leaving the academy) could not compete effectively with the focused study of these topics and many others in a context of behavioral science research, as delivered in psychology doctoral programs. As the above quote by Sharfstein indicates, most physicians in the United States do not rely on psychiatrists for prescribing advice and have not done so for many years. At the same time, psychopharmacology has become the focus of most psychiatry residency training, to the exclusion of psychotherapy and psychosocial interventions. Advances in psychopharmacology and the demonstrated effectiveness of prescribing psychologists with appropriate postdoctoral training signal the end to any claims of uniqueness or incremental quality on the part of medical providers trained in the traditional psychiatric model.

A highly respected academic psychiatrist (Gabbard, 2005) has noted that he frequently encounters psychiatric residents who claim that they have no interest in psychotherapy and therefore see no point in attending seminars on the subject or meeting with a psychotherapy supervisor for one-to-one instruction. He hardly stands alone in noting the increasing disinterest of psychiatrists in the practice of psychotherapy (Detre, 1987; Reist & VandeCreek, 2004; Stedman, 2006; Winston, Been, & Serby, 2005). Gabbard (2005) went on to implore his colleagues to improve their teaching, citing as one key point the need to avoid teaching theory with clinical examples. Rather, he suggested teaching the practice of psychotherapy as a series of hypotheses that are repeatedly tested and that are altered again and again. He acknowledged that practitioners will make occasional errors and that they should avoid “worship at the altar of evidence-based therapies” (p. 336). While Gabbard’s recommendations reflect a certain wisdom, they also highlight the very different background and inherent inadequacies physicians bring to the practice of psychotherapy, when contrasted with graduate psychology curricula and clinical training.

Recent medical school graduates already recognize the issues. Moran (2006) reported that according to the National Resident Matching Program, a total of 983 medical school graduates entered PGY-1 (i.e., Post Graduate Year 1, or the first year out of medical school) general psychiatry residency programs in July 2006. Of those, only 643 (65%) had graduated from U.S. medical schools, a 2% decline from the class entering psychiatry residencies in 2005. These numbers represent a leveling off of U.S. medical student interest in psychiatry after very slow growth between 2000 and 2005. Psychiatric residencies no longer hold much attraction for the best and brightest young physicians interested in brain functions and their relationship to mental health. The best young physicians with such interests increasingly seek additional doctoral degrees and specialization in clinical neuroscience.

As psychologists with postdoctoral credentials in psychopharmacology grow in numbers, and the aging population of baby-boomer psychiatrists retires, psychiatry will disappear as a medical specialty. The hazard facing psychologists will involve avoiding the pitfalls that twentieth century psychiatry ignored. We must guard against potential loss of competence in the skills that have traditionally offered our clients incremental value: our scientific foundations in assessment, psychotherapy, and other nonmedicinal interventions. Reaching for a prescription pad is easier than conducting a well-founded assessment and expert psychotherapy. The demands of the marketplace may make it more lucrative to prescribe than to talk.

Prescribing psychologists will also begin to face other ethical hazards, including those related to commercial pharmaceutical sponsorship. I hope that we will learn by having observed our physician colleagues struggle with such issues. We will also have to remain aware of self-medication hazards. Studies suggest that physicians, while less likely than their age and gender counterparts to have used cigarettes and illicit substances (e.g., such as marijuana, cocaine, and heroin) in the past year, were more likely to have used alcohol and two types of prescription medications—minor opiates and benzodiazepine tranquilizers (Hughes et al., 1992). Richard F. Corlin, the 2002 president of the American Medical Association, has stated, “The drug physicians are most likely to get addicted to is not cocaine or heroin—but hydrocodone. A common prescription pain killer” (http://www.ama-assn.org/ama/pub/article/2542-6121.html). As we gain new skills, we must not allow other skills to atrophy or allow ourselves to fall prey to the hazards of those who have gone before us.

**Recommendations in Preparation for the Demise of Psychiatry**

We can learn several lessons by watching the recent evolution of psychiatry as a profession and use these lessons to advance the public welfare. First, we should actively differentiate ourselves from psychiatry, giving particular emphasis to the research and science that underpin our interventions and to the depth and breadth of our preparation for practice. For example, when psychiatrists point to medical school as preparation, we should highlight the inadequacy of medical school and residency training for scientific psychodiagnostic and psychotherapeutic practice. Second, we should continue to promote excellence in behavioral neuroscience as a psychological specialty. Third, we should move forward with well-grounded education and training for expanded practice, such as prescription privileges. However, we should do so with full caution learned by observing psychiatry’s failings in these areas. For example, we should not forget the practice of psychotherapy by too often reaching first for the prescription pad; we should avoid the slippery slope of pharmaceutical industry seduc-
tions; and we must remain mindful that the authority to prescribe also includes the authority to unprescribe inappropriately or unscientifically ordered medications. Fourth, we must update our licensing standards to move key competence assessment and examinations to the predoctoral level, so that our graduates stand ready to enter practice upon graduation with a terminal degree, as is the case with our sister professions (e.g., medicine, nursing, and social work). Finally, we must encourage our colleagues who specialize to achieve board certification from rigorous organizations recognized by the APA.

In Conclusion

Our successes in translating behavioral science into valuable applications to advance human health and welfare will continue to draw us into new arenas. The evolution of our field will empower us to reach more people and provide more effective help. We will also have increasing opportunities to carry our scientific and professional skills into previously unimagined domains. With such progress we will face new ethical challenges, and we must continually ask ourselves where our responsibilities lie as individuals and as a profession. We must learn not to repeat mistakes of the past and focus instead on optimizing the future for a science and practice of psychology focused on human health and welfare.

REFERENCES


July–August 2007 ● American Psychologist 383


