Ethics for Addiction Psychologists

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Workshop objectives

Upon completing this workshop, participants will be able to:

- List at least three major ethical principles and standards for psychologists, and apply them to the practice of addiction psychology
- Explain at least two basic behavioral ethics constructs (e.g., bounded ethicality, *system 1* vs. *system 2* thinking, *want* vs. *should* thinking, etc.).
- Describe at least two strategies for increasing the likelihood of ethical decision-making

Two ways to think about ethics

- **Content**: Principles, standards, codes
- **Process**: Decision-making, cognitive and behavioral dynamics
- Both are important
- Both should be considered when studying ethics
- In this workshop we will focus on both

The ***content*** of ethical decision making

Principles, standards, codes

There are many disciplines involved in mental healthcare…

- Psychologists
- Psychiatrists
- Social workers
- Certified counselors
- Marriage and family therapists
- Drug and alcohol counselors

…and each has their own set of ethical standards with common themes

Common themes in Ethics Codes

- The importance of client/patient welfare
- Practicing within scope of one's competence
- Avoiding harm and exploitation
- Protecting confidentiality and privacy
- Acting responsibly
- Not discriminating in providing services
- Striving for aspirational practice

Koocher & Keith-Spiegel (2008). *Ethics in psychology and the mental health professions: S*tandards and cases (3rd ed.). New York: Oxford University Press.

Unique features of addiction treatment

- Addictions are complex
- No two people with addictions are exactly alike, with the same needs and manifestations
- Addictions are chronic, often requiring ongoing tx
- Potential for risk to self
- Potential for risk to others
- Stigma (including self)
- May involve illicit behaviors
- Co-existing conditions
- Involvement in other therapeutic activities (e.g., group, twelve-step)
- Involvement with other mental health disciplines
- Outsider inquiries (e.g., legal, family, other providers)
- A changing legal environment

What Addiction Psychologists need to know about ethics

- *Ethical Standards of Psychologists* − APA's current ethical code and updates related to working with people with SUDs and addictions
- Local, federal laws regarding substance use
- Federal Regulations regarding confidentiality of records of SUD clients. (e.g., CFR 42)
- State and local regulations regarding medical record confidentiality with addicted clients

What Addiction Psychologists need to know about ethics

- Ethics issues relevant to people with SUDs and addictions (e.g., participation in groups, self-harm potential, family and interprofessional involvement, interpersonal ruptures)
- Importance of interprofessional collaboration
- Limits of scope of practice
- HIPAA guidelines (practice, confidentiality, record keeping)

APA Ethical Principles of Psychologists and Code of Conduct

- **Introduction** − Intent, organization, procedural considerations, scope of applications
- **Preamble** − Aspirational statement
- **General principles** − Aspirational goals to guide psychologists toward highest ideals
- **Specific ethical standards** − enforceable rules of conduct for psychologists

APA General Principles

- Principle A: Beneficence and Nonmaleficence
- Principle B: Fidelity and Responsibility
- Principle C: Integrity
- Principle D: Justice
- Principle E: Respect for People's Rights and Dignity

Beneficence and Nonmaleficence

Psychologists strive to:

- Benefit those with whom they work and take care to do no harm
- Safeguard the welfare and rights of those with whom they interact
- Resolve conflicts between obligations or concerns in a fashion that avoids or minimizes harm
- Be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work

Fidelity and Responsibility

Psychologists:

- Establish relationships of trust
- Are aware of their professional and scientific responsibilities to society and their community
- Uphold professional standards of conduct
- Make clear their professional roles
- Are concerned about the conduct of other psychologists
- Strive to contribute a portion of their time

Integrity

Psychologists:

- Seek to promote accuracy, honest, truth in science, teaching, and psychology practice
- Do not steal, cheat, or engage in fraud, subterfuge, or intentional misrepresentation of fact
- Keep promises, avoid unwise or unclear commitments

Justice

Psychologists:

- Recognize that fairness and justice entitle all persons access to equal quality of psychological care
- Exercise reasonable judgment and take precautions to ensure that their potential biases, boundaries of competence and limitations do not lead to or condone injustice

Respect for People's Rights and Dignity

Psychologists:

- Respect the dignity and worth of all people and the rights of individuals to privacy, confidentiality, and self-determination
- Are aware that special safeguards may be necessary where vulnerable individuals are concerned
- Are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language and SES when working with members of such groups

Ethical Standards Categories

1. Resolving ethical issues
2. Competence
3. Human relations
4. Privacy and confidentiality
5. Advertising and other public statements

Ethical Standards Categories

6. Record keeping and fees
7. Education and training
8. Research and publication
9. Assessment
10. Therapy

The ***process*** of ethical decision-making

- Various ethicists, ethics teachers, and scholars have devised their own algorithms.
- Among the most seminal is J. R. Rest (1986)
- According to Rest's model, individuals making ethical decisions go through these steps:
  - Moral awareness
  - Moral judgment
  - Moral intention
  - Moral action

Behavioral ethics and *Blind Spots*

- Despite all we know about ethical behavior, we tend to cross ethical lines on a regular basis
- Examples include spending just a little less time with patients than we claim, assigning a diagnosis that is likely to be reimbursed and avoiding an addiction diagnosis, checking the "Denies Harm to Self and Others" box when the question was never actually asked

Bazerman & Tenbrunsel (2011). *Blind Spots: Why we fail to do what's right and what to do about it*. Princeton, NJ: Princeton University Press.

Behavioral Ethics and *Blind Spots*

- **Judgment-action gap** – Most psychologists would claim to be extremely ethical, but there's often a gap
- **Bounded ethicality** – When environmental circumstances (i.e., situations) dominate our ethical decisions
- **Unconscious bias** – Conformity, overconfidence, greed, convenience, organizational demands, competition
- **Want vs. should self** – Conflict between emotional versus rational processes
- **System 1 vs. System 2 thinking** – Automatic vs. deliberate thinking

…These all contribute to *blind spots*

Bazerman & Tenbrunsel (2011). Blind Spots: Why we fail to do what's right and what to do about it. Princeton, NJ: Princeton University Press.

System 1 and System 2 thinking

System 1 thinking
- Intuitive system of processing information
- Fast
- Automatic
- Effortless
- Implicit
- Emotional
- Efficient
- Appropriate for most decisions

System 2 thinking
- Slower
- Conscious
- Effortful
- Explicit
- More logical

Kahneman, D. *Thinking, Fast and Slow*

Unique features of addiction treatment

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Case examples

Questions:

- Is this an ethical issue?
- Which ethical principles and/or codes of conduct are relevant?
- Which blind spots are most relevant?
- What do you do to prepare for this problem?
- What do you do in the heat of the moment?
- What do you do after the fact?

Case #1: The psychologist who should have gone to medical school

- Suboxone clinic, multidisciplinary team
- Psychologists working closely with physicians, nurses, social workers, case managers
- Psychologists are well respected, largely as a result of their knowledge of addictions and treatment modalities (including MAT)
- Physicians often ask for their opinions
- One psychologist in particular likes to give advice regarding medications

Case #2: The angry ex-husband

- 29 year-old man referred by a physician, unemployed, minimal education, has never held a full-time job, multiple legal problems, severe methamphetamine use disorder, ex-wife recently filed a no-contact order
- They have a 3-year-old child, ex-wife has sole custody, will not permit any contact
- He is very angry, has been violent in the past
- All he wants to talk about is how angry he is

Case #3: The angry psychologist

- You work in a treatment clinic with other psychologists
- One of them tends to be moody and volatile
- The clinic manager, a psychologist, has made it clear that conflict between psychologists is unacceptable
- He views conflict as everyone's responsibility
- You see a patient for opioid use disorder
- In a session one day she gives you cause to be concerned about child neglect when she is using
- When you raise questions she transfers to the another staff psychologist. When you approach that psychologist she becomes angry, insisting, "I can handle this."

Case #4: Group therapy and alcohol breath

- This patient has been in group drug treatment for 9 months
- He actively participates, is well-liked by other group members, has severe alcohol use disorder
- Goes for long periods of time without using and then has severe binges lasting a few days
- In a particular session, group member asks if he's been drinking, he says yes, and then continues to participate actively, constructively

Case #5: Between a rock and a hard place

- You have been seeing a family that has benefited greatly from your care
- Now that they are doing well and have a great deal of respect for you they are ready to encourage another family member ("Joey") to see you
- You explain that Joey needs to initiate therapy
- Joey calls and says he wants to come in for help
- Several days later you hear from a family member who says Joey has overdosed and died
- They are overwhelmed with anger at Joey for not calling you for an appointment
- Can you tell them that he called for an appointment?

Case #6: The group member who cared and talked too much

- During a recent drug and alcohol treatment group session, a well-liked member shares a recent conversation he had with his wife
- He says he's told his wife how much he worries about a particular woman in the group, "Mary"
- He tells his wife that Mary is in her 40s, single, with no extended family, lives alone, and has been abstinent from alcohol for 3 months
- During this session he turns to Mary and says, "I care so much about your well-being. That's why I talked to my wife about you."

Case #7: Good Buddies

- You're at your favorite sports bar with a group of neighborhood friends on a Friday night
- You've been looking forward to this night
- You and your friends are just starting your first round of beverages and have chosen sides for a game of darts
- All of a sudden one of your favorite patients approaches you, intoxicated, and is very friendly; lingers as the game of darts begins

Ethics in research

Self-report of questionable behaviors

1. In a paper, failing to report all of a study's dependent measures
2. Deciding whether to collect more data after looking to see whether the results were significant
3. In a paper, failing to report all of a study's conditions
4. Stopping collecting data earlier than planned because one found the result that was sought
5. In a paper, "rounding off" a *p* value for advantage

John, L.K, Loewenstein, G., & Prelec, D. (2012). Measuring the prevalence of questionable research practices. *Psychological Science, 23*(5), 524-532.

Ethics in research

Self-report of questionable behaviors

6. In a paper, selectively reporting studies that worked
7. Deciding whether to exclude data after looking at the impact of doing so on results
8. In a paper, reporting an unexpected finding as having been predicted from the start
9. In a paper, claiming that results are unaffected by demographic variables (e.g., gender) when the results have been effected by demographics
10. Falsifying data

John, L.K, Loewenstein, G., & Prelec, D. (2012). Measuring the prevalence of questionable research practices. *Psychological Science, 23*(5), 524-532.

Table 1. Results of the Main Study: Mean Self-Admission Rates, Comparison of Self-Admission Rates Across Groups, and Mean Defensibility Ratings

Item	Self-admission rate (%)		Odds ratio (BTS/control)	Two-tailed *p* (likelihood ratio test)	Defensibility rating (across groups)
	Control group	BTS group			
1. In a paper, failing to report all of a study's dependent measures	63.4	66.5	1.14	.23	1.84 (0.39)
2. Deciding whether to collect more data after looking to see whether the results were significant	55.9	58.0	1.08	.46	1.79 (0.44)
3. In a paper, failing to report all of a study's conditions	27.7	27.4	0.98	.90	1.77 (0.49)
4. Stopping collecting data earlier than planned because one found the result that one had been looking for	15.6	22.5	1.57	.00	1.76 (0.48)
5. In a paper, "rounding off" a *p* value (e.g., reporting that a *p* value of .054 is less than .05)	22.0	23.3	1.07	.58	1.68 (0.57)
6. In a paper, selectively reporting studies that "worked"	45.8	50.0	1.18	.13	1.66 (0.53)
7. Deciding whether to exclude data after looking at the impact of doing so on the results	38.2	43.4	1.23	.06	1.61 (0.59)
8. In a paper, reporting an unexpected finding as having been predicted from the start	27.0	35.0	1.45	.00	1.50 (0.60)
9. In a paper, claiming that results are unaffected by demographic variables (e.g., gender) when one is actually unsure (or knows that they do)	3.0	4.5	1.52	.16	1.32 (0.60)
10. Falsifying data	0.6	1.7	2.75	.07	0.16 (0.38)

Note: Items are listed in decreasing order of rated defensibility. Respondents who admitted to having engaged in a given behavior were asked to rate whether they thought it was defensible to have done so (0 = no, 1 = possibly, and 2 = yes). Standard deviations are given in parentheses. BTS = Bayesian truth serum. Applying the Bonferroni correction for multiple comparisons, we adjusted the critical alpha level downward to .005 (i.e., .05/10 comparisons).

John, Lowenstein, & Prelec (2012). Measuring the prevalence of questionable research practices. *Psychological Science*.

Some recommendations

- Informed consent
- Documentation
- "Recognize your vulnerability to your own unconscious biases" (i.e., Blind Spots)
- Anticipate the "Want" self and plan
- Give voice to your "Should" self (rehearse)
- Move from concrete to abstract thinking

Bazerman & Tenbrunsel (2011). Blind Spots: Why we fail to do what's right and what to do about it. Princeton, NJ: Princeton University Press.