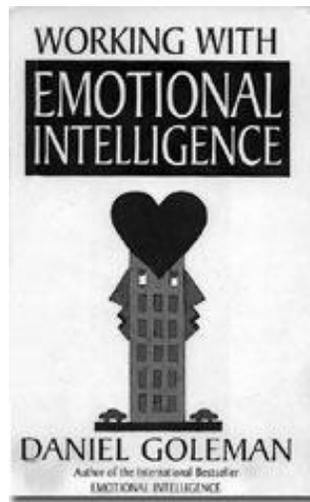


# The Psychology Major's Roadmap

to  a  
**SUCCESSFUL** **PLACEMENT**

**PSYCHOLOGY 455, 456**  
**INTERNSHIP**



**PSYCHOLOGY 450, 451**  
**FIELD STUDY**

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## Psychology 455 or 456: Internship (130 hours min.)

The purpose of the internship is to provide a “real-world” learning experience and opportunities to integrate use psychology coursework knowledge in a workplace.

In order to provide you with the richest experience possible, you will be give a copy of the *Roadmap to a Successful Internship or Field Placement*. Read this thoroughly as it describes not only on how to benefit from the placement but, also, has a copy of the form you will be evaluated by your supervisor(s) and the form you will evaluate the placement. Included, also, is helpful guidance on benefiting from supervision, confidentiality, and client or patient relationships with you as a staff person. And you will be meeting with your supervisor(s) at the facility on a regular basis to discuss and enhance your experience.

You are required to keep a reflective log of each day’s experiences being sure to use psuedonames. Your journal will form the basis for the reaction paper due at the end of the term.

As the internship faculty supervisor, I shall make an in-person visit to your internships site to meet with you and your supervisor(s).

Toward the end of the internship, your supervisor(s) will evaluate you and you will evaluate the placement as well(as noted above, copies of the forms are in the *Roadmap*).

As the internship draws to a close you will prepare and submit a rigorous reaction paper describing your experience positive, negative and neutral. What you enjoyed and what you didn’t. It is critical that demonstrate how your psychology major assisted you in understanding and/or questioning about what you saw, heard and did. Your paper should include a job description, problems encountered and resolutions, expectations met and not met, and a self-evaluation,

Your grade will be based on supervisor feedback and the grade on your reaction paper.

Thank You Letter: Submit a copy of a letter of thanks to your supervisor. This is not a check of the content, but a gentle nudge to get it done. The and copy to me can be done as an email.

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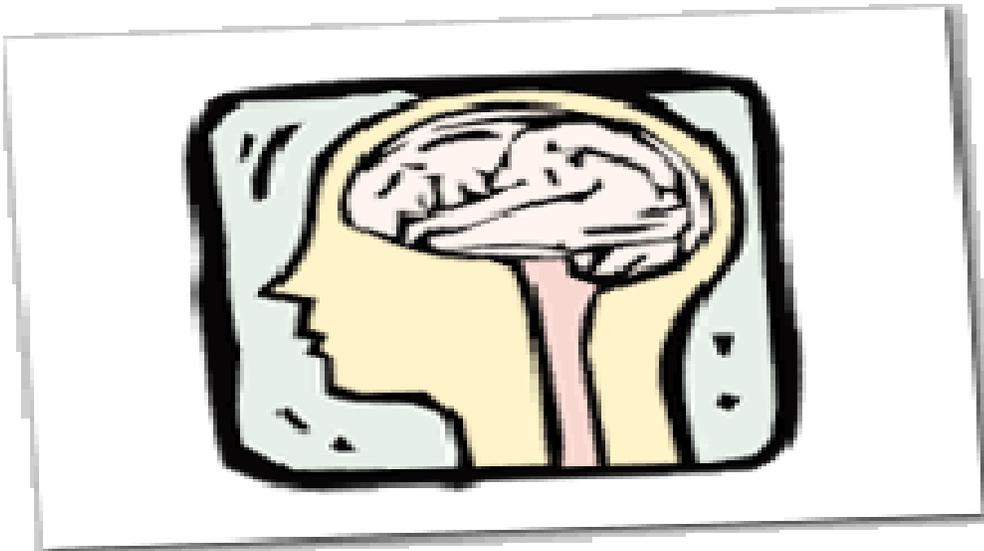
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## INTRODUCTION

This guide is given to you as a Randolph-Macon College student undertaking a semester field placement (8 hours per week) or a J-term “full time” intern. Either experience will provide valuable real-life exposure by immersion in professional settings. Always remember you are a “student-professional” representing yourself and Randolph-Macon College. You will want the placement to reflect positively on both. Further, such experience may help clarify career goals and vocational interests and, hopefully, serve to guide you in future academic and career objectives. I urge you to read this guide thoroughly and thoughtfully. Note there is a glossary of abbreviations that may be used at your training site and is provided as an aid to decipher the “code”. Your comments about how to improve this guide are most welcome. My friend and colleague, Dr. John Norcross was most helpful in developing this guide. Both of us believe “re-inventing wheels” is a very inefficient.

Keeping a journal is a “must”. Your faculty supervisors will want to review and discuss them with you.

Be aware of the “Four D’s” that could lead to malpractice claim against a student at a clinical placement. And, be sure to read and understand the American Psychological Code of Ethics as it applies to your business or clinical setting. Discuss them with me or your faculty supervisor if you have questions or need clarification. Breaches of confidentiality or releasing/discussing privileged information out of the placement site can have potentially very serious and dire consequences. Be sure to alter identities whenever a patient/client are mentioned in your journal. On the “Professional Bill of Rights” insert “student” for “clinician” to help you integrate your role as a “student-professional”.

“Getting The Most Out Of Your Practicum” and “Profiting From Your Supervision” are important sections of the guide and are self-explanatory to maximize benefits from the placement. Do read the section on “How We Shut People Up”, it will help you during your placement and does generalizes to everyday social interactions.

As the placement evaluates you; you will evaluate the placement and its viability for future Randolph-Macon students. Please turn it in at the end of your placement. It is NOT shared with the placement. You will also find a copy of the form that is completed about you at the end of the internship and at mid-semester and end of semester for a field placement.

Again let me encourage you to use your faculty supervisor and/or me as resources as you complete your placement. We are available and sounding boards, cheer leaders, problems solvers and knowledgeable allies during your “real-life” professional experience.

Enjoy your experience!!

## JOURNAL GUIDELINES

Obtain a bound notebook (or a secure computer file/disk) to use as your journal and immediately record your name. A field journal is a collection of notes on your observations, thoughts, questions and feelings about your off-campus learning experience. Like an anthropologist in the field, you will keep notes on the activities around you, and the people you work with.

Your journal will serve three major purposes: (1) as a method of organizing, reporting, and assimilating your clinical experience; (2) as a means of relating the assigned readings to your field experience; and (3) as an aid to self-exploration and self-growth. It is also a place where you can reflect on the meaning of the experience and examine differences of power culture in the workplace.

Each day you are at your field work placement make a dated entry. Record the number of hours you spent at your placement that day, and maintain a running tally of the total number of hours. You don't need an hour by hour account, but don't be too cryptic, i.e.; one paragraph.

The types of topics you can address include:

- (a) concrete details – “what I did today,” “what so-and-so did today,” “ what happened on the ward.” Concrete incidents that are revealing, amusing, disturbing or otherwise of interest. You might even want to include details that are not so interesting but represent a change, e.g., new admission, high staff absenteeism, which may be significant over the long run.
- (b) your personal reactions – “how I feel today,” “my opinions about an incident,” “ my guesses about what will happen.” By recording each day your feelings and thoughts you will be able to look back at how relationships developed. Retrospectively, it is more difficult to obtain an accurate and comprehensive picture of early reactions.
- (c) analysis or insights – “how I conceptualize what happened,” “it just occurred to me that,” “changes occurring here or in me.” Typically, these are based on pertinent information from readings, class, and your placement. You may have a question about something you have experienced, or something discussed in a class happened to you. Are they ethical issues or dilemmas?

Above all, adhere to the principle of confidentiality. Do not write anything that would identify individual persons or institutions. This means no last names (use first names, initials or nicknames) and no agency identifications. It should be shared only for purposes of learning and teaching, and then in a professional manner.

One final word: Your journal, like any sort of writing, can be a useless piece of junk and an unpleasant chore to produce; or it can be an exciting record of your work and a dynamic exploration of yourself. The difference rests with your attitude toward writing it and the commitment you make to share yourself. Only in this way will it become a useful tool for reflection and conceptualization.

During the last week of the practicum, I would like you to summarize your experiences at the placement. This **self-study** should include the following topics, numbered as such in your journal. However, you are by no means limited to these, and you are encouraged to reflect on the entire experience.

1. Discuss the development of your interpersonal relationships at the agency with clients, patients, co-workers, and supervisors. What did you learn from these relationships? What do you still have to learn?
2. How did your field experience relate to and strengthen your previous course work in psychology, if at all? Please give specific examples.
3. What have you learned about yourself personally and professionally from the entire experience?
4. What do you consider your biggest successes? Your worst frustrations?
5. Look back through your journal and attempt an overview of your placement. Can you identify changes in your thinking and feeling over the semester? How do you account for these changes?
6. Where does this field experience leave you? Lead you? Having evaluated the experience, what do you want to do next? Has it altered or reinforced your career choice?

*Adapted from materials provided by Dr. Jim Dalton, Bloomsburg University, Dr. Laurie Heatherington, Williams College, and Dr. John Norcross, University of Scranton.*

## FOUR ELEMENTS OF MALPRACTICE

To succeed in a malpractice claim, the plaintiff must prove a case that stands on four distinct legs, called elements of malpractice. These are also known by the mnemonic of the **4 D's**.

1. **Duty:** A professional relationship was formed between the psychologists, client or patient. Only thus does a practitioner incur a legal duty of care.
2. **Dereliction of duty:** There is a demonstrable standard of care, and the practitioner breached that standard. He or she is said to have practiced "below the standard of care."
3. **Damages:** The client or patient suffered harm or injury, which must be demonstrated and established.
4. **Direct causation:** The practitioner's breach of duty to practice was the proximate cause of the client or patient's injury; that is, the injury was a reasonably foreseeable consequence of the breach.

**Source:** Bennett et al. (1990)

## **A PROFESSIONAL BILL OF RIGHTS**

Many clinicians (students) experience difficulty with assertion in professional settings, particularly with their clients and patients. Following are eight professional rights and parallel stances of the assertive therapist.

- I. Clinicians (students) have the right to say “no” to their clients or patients.
- II. Clinicians (students) have the right not to become emotionally involved with their clients or patients.
- III. Clinicians (students) have the right not to like their clients or patients.
- IV. Clinicians (students) have the right to actively avoid their client or patient’s feelings.
- V. Clinicians (students) have the right to prevent clients or patients from interfering in their personal lives.
- VI. Clinicians (students) have the right to disagree with their clients or patients.
- VII. Clinicians (students) have the right to be less than technically perfect with their clients or patients.
- VIII. Clinicians (students) have the right to have limits in their areas of professional expertise.

**Source:** Janzen, W.B., & Myers, D.V. (1981). Assertion for therapists: A professional bill of rights. Psychotherapy, 18, 291-298.

## GETTING THE MOST OUT OF YOUR PRACTICUM

Practica are delicate balances between putting out through work and taking in through learning. If the work element seriously outweighs learning in a practicum, the experience may become boring and repetitive and lose its educational value. If learning seriously outweighs working, the practicum may lose its unique participatory element and resemble a “field trip.” The goal is to maintain a fluid balance between the two.

What underlies the success of your practicum is a complex and sometimes difficult transition. As a student for 14 or more years, you have pursued your learning by reading and following directions given to you by your teachers. They have been more responsible than you have been for what you have learned. You have been able to see quickly how you were doing through grades on papers and exams. As wonderful or awful as it may have been, it was a generally passive mode of learning. You were only responsible for following directions and assimilating organized material.

As you enter your practicum, you will quickly notice a huge change in your relationship to your learning. Very few people and possibly no one will tell you what to learn or how to learn it. The material, knowledge, and skills to be acquired will not be well organized. Often you will not know what to do, how to do it, or how you are doing. In other words, many of the signs of successful learning, so omnipresent on campus, will be absent. As a result, you are likely at times to feel unsure of yourself, rudderless, and reticent about which way to turn.

In short, you will be largely on our own and completely responsible for what you learn or fail to learn. You will have to become an active, self-directed learner. The following materials may help you achieve this transition from one who is passively led through a set of curriculum to one who actively defines what is to be learned.

### Starting Out

1. Dress. Look for clues from your supervisor and other staff members on dress codes. On the first day, dress neatly and appropriately for your job. If you have any questions about your dress, consult with your supervisor.
2. Promptness. Oversleeping is a poor excuse for being late on the first day or any day. Time a test ride to work and plan enough time for meals, dressing, etc.
3. Attitude. Your attitude is one of your greatest assets. After your appearance, it is the next factor noticed. A positive attitude will benefit you as well as your co-workers. Show teamwork!
4. Agency Rules. Discover, follow, and respect the regulations of the organization.
5. Dependability. Whether you work alone or as part of a team, other responsibilities will come your way if your supervisor can depend on you. Show initiative and be willing to take on difficult assignments.

### Problems with Co-Workers

A number of practicum students are initially shocked and dismayed by the less-than-cordial attitude of some of their co-workers. Welcome to the real world! Here are several problems some students have experienced and ways to cope with them.

1. Resentment. Some practicum students discover that co-workers resent them because of the special nature of field experiences and their advanced education. After all, your co-workers are not allowed to

interview their supervisors or attend board meetings, as you might be able to do. It is your supervisor's responsibility to explain your role to fellow employees, but you can help by being sensitive to this issue. Also, be curious. Co-workers may enjoy having students around as new folks to talk to and as people with new perspectives on the workplace.

2. Overtime. The working world doesn't stop every day at 5:00 pm and you may be asked or simply feel pressured to work late. Many interesting learning situations occur before and after regular business hours. Working extra hours may help you learn more from your practicum and experiencing situations not otherwise available. However, you are an independent person and have to make a judgment about when enough is enough. So, if you find yourself confused about work hours, talk to your supervisor and negotiate a solution that takes into account your needs and those of the organization. This is a crucial work skill and you might as well start learning it now.
3. Communication. You are a member of an agency and you may begin to feel as though your ideas don't count, aren't good enough or are ignored. This may be true and thus require action. On the other hand, you may not be letting people know what you have to offer. Before you get upset, examine your participation and be sure that you have really communicated your thoughts.

Most of you will not run into these particular problems but a few of you may and you should not be surprised if you do. They are typical "real world" problems, and learning to deal with them is one aspect of the practicum.

A positive frame of mind is your best support. You are not an expert but you are a capable individual. Setbacks and disappointments will come but, by remembering who you are, you will be in a better position to handle them when they arise. Keep them in perspective and don't consider them to be a personal condemnation of your abilities.

### **Learning from Experience**

Maintaining a journal are important elements in insuring the learning part of the practicum equation. However, since this method is so focused on you and your interests, your learning will be incomplete unless you find ways to become aware of the people, events, and environments which surround you and your practicum but which do not necessarily impact on you in a direct way.

You may also need to learn more about and from these people and events, not only to insure the learning aspect of your experience but to assist you in your working responsibilities. Solving problems, completing projects, and working with people may be difficult unless you learn to navigate the often-murky waters of your agency and investigate it from several perspectives.

There is no set or easy formula for learning these things. You may be surprised by the difficulty of the aspect of your practicum. You may have assumed that, if you keep your ears and eyes open, information will come to you. Our experiences tell us differently.

**Source:** Stanton, T., & Ali, K. (1982). The experienced hand: A student manual for making the most of an internship. Cranston, RI: Carroll Press.

## PROFITING FROM YOUR SUPERVISION

**Be open to learning.** Be open to input not only from supervisors but also from teachers, peers, colleagues, clients, or patients. Be willing to make mistakes and talk openly with your supervisor about these mistakes. If you are too afraid of making errors, you won't be willing to try anything new. You will be overly conscious about what you are doing and whether you are doing it "right." Take advantage of your student rule. You are not expected to know everything. Give yourself permission to be a learner.

**Be able to say, "I don't know."** Being willing to admit your ignorance is important in interactions with both your supervisor and your clients or patients. You can acknowledge to your client or patient your limitations, but you keep the door open to providing her with information she can use in resolving her own problems.

**Express your reactions.** In working with both students and professionals, we often find that they have many good reactions that they keep to themselves. We typically encourage our trainees to talk out loud more often, rather than engaging in a silent monologue.

**Focus on both elements of supervision.** One approach to supervision emphasized the client or patient's dynamics and teaches you intervention strategies for dealing with specific problems. Another approach is to focus on your dynamics as a therapist, as a person, and on your behavior in relationship to your client or patient. Certainly, adequate supervision must take both of these elements into consideration. You need to understand models of helping clients or patients, and you need to understand yourself if you hope to form truly therapeutic alliances.

**Learn, but don't copy.** Some trainees limit their own development by trying too hard to copy the style of a supervisor or teacher. With supervisors whom you respect, you are likely to watch them carefully and may tend to adopt their methods. It is important, however, to be aware of how easy it is to become a carbon copy of another person. To get the most from your supervision, try different styles but continually evaluate what works for you and what doesn't.

**Learn to be assertive.** Define how you want to spend your time in an agency, and get the supervision you need. Don't passively wait to be told what to do. At least think about what you would like to learn and what skills you would like to acquire. Let your supervisor know. Clearly spell out what you would like to experience and learn before you leave. You may not always get what you want. But if you are not clear what you want in the first place and are not willing to ask for it, you surely will not obtain it.

**Respect the supervisor's workload.** It helps to realize that supervisors are people too. They get bogged down with their own demands. As their client or patient load grows and pressures increase, they may not initiate the regular supervision sessions that they have promised. At times their training for being a supervisor is minimal, and they are expected to "learn by doing." If you are able to understand the predicament of supervisors, you are more likely to establish a basis of communication with them. Within a climate of open communication, you can sensitively and assertively let them know that you need help.

**Accept different styles of supervision.** It can benefit you to learn how to function under a range of supervisory styles, both now as a student and later as a helping professional. One supervisor may believe that harsh confrontation is a way to cut through a client or patient's stubborn defenses. Another treats clients or patients as victims who are not responsible for their problems. Another provides unlimited resources of advice

for clients or patients and promotes a problem-solving orientation for every client or patient problem. There are supervisors who foster a supportive and positive orientation and who give out “warm fuzzies” exclusively.

Be open to supervisors with various orientations and learn to incorporate their viewpoints into your style of helping. Do not be too quick to criticize a style different from yours. If you do have trouble with a supervisor, the answer is not always finding a new one. In such situations you may need to discuss your expectations and goals regarding supervision with your supervisor. Later, when you accept a position in an agency, you typically do not have the option of changing supervisors. What is more, you often don't have choices in who your co-workers will be. Thus, it is important to learn the interpersonal skills necessary in working out differences while the stakes are not too high.

**Solve problems in your supervision.** You may encounter a number of problems in working with a supervisor. Communication may not be open or encouraged. Some supervisors may poorly define what they expect of you. Some may fail to show up for appointments. There are also supervisors who do not carry out their responsibility to give feedback. They keep the student in the dark and offer very little direction.

The resistance that often characterized the therapeutic relationship can also operate in the process of supervision. Supervisors are responsible for and will evaluate the supervisee, so that supervisees are understandably anxious about being observed and evaluated. Students can challenge themselves by converting this resistance into productive energy. You can spend time thinking about what you want and being to find ways to ask directly for it. You need not submit to the anxiety of being evaluated or allow yourself to be frozen by these fears.

**Source:** Corey, M.S. & Corey, G. (1989). Becoming a helper. Pacific Grove: Books/Cole.

## INTERVIEWING SKILLS AND CAUTIONS

Good interviewing is more about attitude than skill. The most important factor in interviewing is the perception of the interviewee about the person doing the interview.

Things to avoid:

Evaluative Statements: bad, good, excellent, terrible, disgraceful, stupid, etc. should rarely be used in an interview.

Probing Statements: Don't demand information, using, "Why." It tends to make people defensive

Why did you yell at him? BETTER: Tell me more about what happened. How did you happen to yell at him. What led up to the situation.

Why did you say that? BETTER: Can you tell me what you mean? I'm not sure I understand. How did you happen to say that?

Why can't you sleep? BETTER: Tell me more about your sleeping problems. Can you identify what prevents you from sleeping? How is it that you are unable to sleep?

Hostile Statements: These direct anger to the interviewee. Unless you are interested in the person's response to anger, these are statements to avoid.

Reassurance Statements: These can be helpful, but should not be based on false hope or incorrect information/data.

Things to do:

Closed-end Statements: Question that seeks specific information or used with interviewees who "over-answer" questions. Example: How many sisters do you have. How old is your mother? Are you married?

Open-ended statements: Questions that invite more information.

Example: Tell me about your family. Tell me about yourself. What kinds of things do you like to do for fun?

Keep the Interaction Flowing:

Transitional Phrase: "Yes"; "I see," "Go on", "uhuh."

Verbatim Playback: repeat interviewees exact words as a question. "You have held five jobs?"

Paraphrase: repeat the interviewee's response in different words, again as a question. If interviewee had used the above, you could respond: "You have held several jobs recently?"

Summarizing: Puts together the meaning of several responses. "You seem to have had some difficulty in school."

Empathy/Understanding: Reflect back to interviewee your understanding of what they are feeling or experiencing. “Teacher yelled at me in front of the whole class.” Response: That’s embarrassing.

And finally:

Increase your cultural awareness: be sensitive to cultural, social class and ethnic differences.

Be Flexible: suspend your preconceived notions. Consider perspectives that are not your own.

Look Beyond Yourself: Try to appreciate things from the interviewee’s perspective. Put yourself in their shoes.

Know Yourself. Be aware of your own stereotypes and prejudices. Don’t let them get in the way of your collecting important information.

*(Kaplan, R.M., Saccuzzo, D.P. (2001) Psychological Testing, Principles, Applications, and Issues, 5<sup>th</sup> edition, Wadsworth/Thompson Learning: Belmont, California.)*

## HOW WE SHUT PEOPLE UP

Communication is a two-way affair. Besides expressing our feelings to others, we must permit others to express their feelings to us. Here are some ways I see people in the workshops shutting others up, stopping communication:

1. Explaining too soon: justifying oneself before responding to the other's feelings. (the hidden message: You have no right to feel that way.)
2. Reassuring before responding to feelings: "You don't have to be hurt." (You're stupid to feel that way.)
3. Condescending: "Tell me all about it. I want to help you." (I don't care how you feel about me; you cannot move me. I'm so strong and you're so weak.)
4. Blackmailing: "You're giving me a headache, heart attack, depression." (I'm so sensitive and you are a brute.)
5. Responding too soon: "I'm sorry I didn't mean it. I know how you feel" before the other has had a chance to express his feelings fully. (I don't want to hear. Please stop feeling.)
6. Interpreting: "You are hostile to me because I remind you of your mother." (I don't care how you feel about me; you cannot move me. I'm so clever and you are so sick.)
7. Punishing: "Oh yeah? Well let me tell you what you did." (I'll get you, you dirty rat. You'll be sorry you picked on me.)
8. Pretending to be stupid: "Sorry, I don't understand what you're talking about." (And I don't want to, so why don't you give up?)
9. Passing the buck: "That's your problem." (I don't care how you feel about me, and you cannot move me. I'm so healthy, and you are so sick.)
10. Changing the subject by replacing the content instead of the emotion: "That's very interesting. I've often noticed that women tend to have that attitude toward men. Why do you suppose that is?" (As an individual person, you are unimportant. Don't take yourself so seriously.)
11. Playing lawyer: "When did I say that? I never said those words." (You made a mistake in this detail and that proves you have no right to your feelings.)
12. Joking: turning the whole thing into a joke with a witty remark. (You are not worth taking seriously.)
13. Scolding: "That's very rude." (You are a vulgar child, beneath my notice. I cannot take your feelings seriously. You are worthless.)
14. Being bored or absent-minded: "Sorry, I didn't hear you. My mind wandered." (Your feelings are unimportant.)
15. Deadpan, no response: (You are beneath my notice.)

**Source:** Muriel Schiffman, exact reference unknown.

# LAW & MENTAL HEALTH PROFESSIONALS

## Confidential Relations and Communications

Generally, a confidential communication is written or verbal information conveyed by the client to an MHP in the course of a professional relationship. Confidentiality originated in professional ethics codes arising from a belief that effective psychotherapy required a guarantee from the therapist that no information obtained in the course of evaluation or treatment would be given to others. MHP's may be liable in civil suits initiated by clients who have been harmed by breaches of confidentiality. (See (D) Liability for Breach of Confidentiality.)

This chapter will discuss the source, scope, and limitations on confidentiality separately for psychologists, social workers, psychiatrists, and nurses and conclude with a discussion of the general liability of mental health professionals for violations of confidentiality.

### (A) Psychologists

#### (A) (1) Psychologists Covered Under These Statutes

The law covers both psychologists and clinical psychologists.<sup>1</sup>

#### (A) (2) Scope of the Duty

Unless specifically permitted by law (see chapter 3.3(A)(3)), psychologists cannot disclose the record of a client. Under the law, the term "record" includes written, printed, or electronically recorded information, any oral or written communication made by the client to the professional in confidence, and any information acquired in confidence from outside sources by the psychologist about the patient.<sup>2</sup>

#### (A) (3) Limitations on the Duty

The duty of confidentiality is limited in certain circumstances. Included among these are:

1. The client or patient has given written consent (or oral consent in emergency situations) specifying a third party with whom the record will be shared,<sup>3</sup>
2. A subpoena is issued<sup>4</sup> (see chapter 3.5);
3. The psychologist is defending him or herself against a claim of wrongdoing, trying to collect a fee, or subject to investigation, review, or audit;<sup>5</sup>
4. The client has requested the psychologist to submit bills to an insurance carrier;<sup>6</sup>
5. The psychologist suspects child abuse or neglect (see chapter 4.8); or
6. The client has communicated a specific threat to harm a specific person.

1. VA. CODE ANN. § 32.1-127.1:03(B) (Michie, LEXIS through 1998 Reg. & Spec. Sess.).

2. *Id.*

3. VA. CODE ANN. § 32.1-127.1:03(H), 8.01-413© (Michie, LEXIS through 1998 Reg. & Spec. Sess.).

4. VA. CODE ANN. §§ 32.1-127.1:03(H), 8.01-413© (Michie, LEXIS through 1998 Reg. & Spec. Sess.).

5. VA. CODE ANN. §§ 32.1-127.1:03(D)(3), 801.399(F) (Michie, LEXIS through 1998 Reg. & Spec. Sess.).

6. VA. CODE ANN. § 32.1-127.1:03(D)(16) (Michie, LEXIS through 1998 Reg. & Spec. Sess.).

7. VA. CODE ANN. §§ 32.1-127.1:03(D)(6), (19), 54.1-2400.1(B) (Supp., Michie 1997).

8. VA. CODE ANN. § 32.1-127.1:03 (Michie, LEXIS through 1998 Reg. & Spec. Sess.).

**Source:** (Lynne T. Porfiri, JD, Robert J. Resnick, Ph.D., (2000) *Law & Mental Health Professionals, Virginia, 1<sup>st</sup> edition, American Psychological Association, Washington, D.C.*)

## **PRIVILEGED COMMUNICATIONS**

Two primary areas of law exist that attempt to protect the client's communications from disclosure. The most well known is confidentiality law, whose principles originated in professional ethics codes and have now been incorporated in legislation and court rulings. (See chapter 3.3) Confidentiality laws are designed to encourage frank discussion and the exchange of reliable information and protects the client from improper disclosure of information by the MHP in most situations. The law does not, however, protect the client from court orders requiring the MHP to disclose information.

For protection in the courtroom, the communications must be of the type that are covered by a privileged communication statute. Psychologists, psychiatrists, nurses, and certified social workers must be knowledgeable of this law so that they can advise their clients of the limits of confidential information. There are no privileged communication laws for MHPs other than those mentioned, and their client's disclosures can be revealed in a court hearing if the MHP is required to testify.

This chapter will discuss the privileges issues separately for clinical psychologists and psychiatrists, social workers, and psychologists and conclude with a discussion of the general liability of mental health professionals for violation of privileged communication statutes.

### **(A) Clinical Psychologists and Psychiatrists**

Virginia's privileged communications law distinguishes between psychologists and clinical psychologists. Along with psychiatrists, clinical psychologists are covered under the physician-patient privilege, and psychologists are included in the privilege covering counselors, social workers, and psychologists. Privileged communications are those statements made by those persons within a protected relationship such as physician-patient, husband-wife, and the like which the law protects from forced disclosure at the option of the patient or spouse.<sup>1</sup>

#### **(A)(1) Privilege for Clinical Psychologists and Psychiatrists**

Both clinical psychologists and psychiatrists are covered by the physician-patient privilege. The extent of this privilege is governed by Commonwealth statute. Since privileged communications prevent the disclosure in court of relevant information that may be necessary to establish the truth and to decide a dispute fairly, they are disfavored and strictly construed. Generally, clinical psychologists and psychiatrists are not required to testify in a civil action about any information they gained in treating their client unless the client requests or consents to such disclosure.<sup>2</sup>

#### **(A)(2) Assertion and Waiver of the Privilege**

A patient can consent to or request the testimony of his or her physician thereby waiving the privilege and allowing the physician to testify.<sup>3</sup> This is the only way the patient can employ the privilege; otherwise the physician cannot be required to testify except under narrow statutory exceptions. (See next section.)

### **(A)(3) Limitations on the Scope of the Privilege**

If the physical or mental condition of the client is an issue in the civil case, the clinical psychologist or psychiatrist will have to testify at trial or in pretrial and discovery as to what the MHP has learned in the treatment and care of the client.<sup>4</sup> The clinical psychologist or psychiatrist will not have to disclose such information if, on request of the patient, the court determines that such facts are not relevant to the subject matter of the case.<sup>5</sup> Finally, the clinical psychologist or psychiatrist is not prevented from disclosing information if such disclosure is necessary for:

1. The treatment or care of the patient;
2. The protection of the practitioner's legal rights (including those rights with respect to malpractice claims);
3. The operation of a health care facility; or
4. Compliance with state (for example, testifying in a criminal trial) or federal laws.<sup>6</sup>

There is no physician-patient privilege in a criminal prosecution and therefore, a physician can be compelled to testify about confidential patient matters.<sup>7</sup>

The physician-patient privilege is inapplicable in legal proceedings in cases of child abuse,<sup>8</sup> in worker's compensation cases,<sup>9</sup> when a physician reports to the Department of Motor Vehicles a mental or physical disability that affects the patient's ability to operate a motor vehicle safely,<sup>10</sup> and in health regulatory board investigations or proceedings.<sup>11</sup>

### **(B) Social Workers, Counselors, and Psychologists**

Licenses clinical social workers, professional counselors, and psychologists are all governed by the same privileged communication law in Virginia.<sup>12</sup> This privilege applies only in civil cases.

#### **(B)(1) Privilege for Licensed Clinical Social Workers, Professional Counselors, and Psychologists**

Unless requested or consented to by the client, none of these professionals are required to testify in a civil case about any information told them by the client in a confidential manner, so long as the client shared the information while seeking professional treatment or advice.<sup>13</sup> The law carved out some exceptions to this privilege that are discussed in chapter 3.4 (B)(3).

#### **(B) (2) Assertion and Waiver of the Privilege**

The client can consent to or request the testimony of his or her social worker, counselor, or psychologist hereby waiving the privilege and allowing the MHP to testify.<sup>14</sup> This is the only way the patient can employ the privilege; otherwise the MHP cannot be required to testify except under narrow statutory exceptions. (See next section.)

### **(B) (3) Limitations on the Scope of the Privilege**

Disclosure may be required if the client's physical or mental condition is an issue in the civil case, or if the court determines disclosure is necessary for the administration of justice. Also, the privilege does not exist in matters of child abuse or neglect.<sup>15</sup>

1. Black's Law Dictionary 1198 (6<sup>th</sup> ed. 1990).
2. VA. CODE ANN. § 8.01-399 (Supp., Michie 1997).
3. *Id.*
4. VA. CODE ANN. § 8.01-399(B) (Supp., Michie 1997).
5. *Id.*
6. VA. CODE ANN. § 8.01-399(F) (Supp., Michie 1997).
7. *Gibson v. Commonwealth*, 219 S.E. 2d 845 (1975), *cert. denied*, 425 U.S. 994 (1976).
8. VA. CODE ANN. § 63.1-248.11 (Michie, LEXIS through 1998 Reg. & Spec. Sess.).
9. VA. CODE ANN. § 65.2-607 (Michie, LEXIS through 1998 Reg. & Spec. Sess.).
10. VA. CODE ANN. § 54.1-2966.1 (Michie, LEXIS through 1998 Reg. & Spec. Sess.).
11. VA. CODE ANN. § 54.1-2400.2© (Michie, LEXIS through 1998 Reg. & Spec. Sess.).
12. VA. CODE ANN. § 8.01-400.2 (Michie, LEXIS through 1998 Reg. & Spec. Sess.).
13. *Id.*
14. *Id.*
15. VA. CODE ANN. § 8.01-400.2 (Michie, LEXIS through 1998 Reg. & Spec. Sess.).

**Source:** (Lynne T. Porfiri, JD, Robert J. Resnick, Ph.D., (2000) Law & Mental Health Professionals, Virginia, 1<sup>st</sup> edition, American Psychological Association, Washington, D.C.)

## **GRADES**

Toward the end of this semester your academic supervisor will contact your site supervisor who will be asked to comment on your performance in the following areas: General work skills, Interpersonal style, and attitude.

Supervisors will also be asked to rate your performance and contributions on a scale of 1 to 10 (unsatisfactory to distinguished) and to indicate if, on the basis of their experiences with you, they would accept another R-MC student intern in the future.

All supervisors will be given an opportunity to make additional comments regarding their perception of your strengths and/or need for growth or development.

Site supervisors will be asked to suggest a grade. However, given their limited experience in grading at a college level, such grades are advisory; the final grade will be given by the R-MC faculty. Please note that there is no “expected grade”, that is, your grade is based on many factors including your supervisor’s comments and your reaction paper which should, among other things, demonstrate how your psychological knowledge was applied to your placement. Your grade will be affected by such things as failing to meet expectations of the placement, e.g., not being on time, not dressed properly, etc. Should you have any question about this, contact me or your faculty supervisor.

Any problems, concerns or questions about the placement, your performance or the experience itself should be raised as early as possible with me or your faculty supervisor. Do not hesitate to do this as we want to make your experience the best it can possibly be.

## STUDENT EVALUATION

Student: \_\_\_\_\_ Date: \_\_\_\_\_

Placement: \_\_\_\_\_ Supervisor \_\_\_\_\_

Please circle all that apply.

1. Work ethic: punctual, late, dependable, interested, disinterested, reliable, collaborative, shows initiative, responsible, accepts, constructive criticism, seeks out supervision, "volunteers"

Comment: \_\_\_\_\_

2. Social Skills: poor, good, excellent, outstanding (Staff)  
poor, good, excellent, outstanding (patient/client)

Comment: \_\_\_\_\_

2. Benefits from Supervision: poor, good, excellent, outstanding

Comment: \_\_\_\_\_

3. Understand the Culture of the Placement: no sometimes yes

Comment: \_\_\_\_\_

4. Strengths of Student:

5. Areas of needed growth/development:

6. Compared to other students, how would you rate this student:

1 unsatisfactory to 10 Outstanding student \_\_\_\_\_

7. What grade would you suggest (A through F) \_\_\_\_\_.

9. Other comments about student:

Return To:

**Robert J. Resnick, Ph.D., ABPP**  
**Professor of Psychology**  
**Randolph-Macon College**  
**P.O. Box 5005**  
**Ashland, VA 23005-5005**

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**Residence: 270-9595**  
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**PRACTICUM EVALUATION**

Please use this form to evaluate your agency supervisor, and practicum setting. The information that you provide is for my personal use; it will not be communicated to agency personnel unless you indicate otherwise.

Supervisor(s):

Placement setting:

### I. Agency Supervisor

1. On the average, how many minutes per week did you spend in face-to-face supervision? \_\_\_\_ minutes a week.
2. In general, what was the quality of this supervision?  
Very poor    poor    fair    Good    very good
3. Were there any significant deviations from the contract you and your supervisor signed?  
Yes    No  
If yes, please explain.
4. My supervisor helped me to define and achieve specific goals for myself during the practicum  
Not at all    a little    some    a lot    a great deal
5. My supervisor gave me useful feedback when I did something wrong.  
Not at all    a little    some    a lot    a great deal
6. My supervisor accepted and respected me as a person.  
Not at all    a little    some    a lot    a great deal
7. My supervisor recognized and encouraged further development of my capabilities.  
Not at all    a little    some    a lot    a great deal
8. My supervisor gave me useful feedback when I did something well.  
Not at all    a little    some    a lot    a great deal

9. My supervisor offered resource information when I requested or needed it.
- Not at all      a little      some      a lot      a great deal
10. My supervisor allowed me to discuss problems I encountered in my practicum setting.
- Not at all      a little      some      a lot      a great deal
11. Any additional comments about your supervision or supervisor:

## II. Practicum Setting

1. In general, what was the quality of your relationships with other agency employees?
- Very poor      poor      fair      good      very good
2. Did you engage in any activities at your placement which you considered to be a waste of time?  
Yes    No  
If yes, specify:
3. Were there any activities which you would have liked to engage in but did not?  
Yes    No  
If yes, specify:
4. Did you feel needed at your agency?
- Not at all      a little      some      a lot      a great deal
5. Did you feel wanted at your agency?
- Not at all      a little      some      a lot      a great deal
6. Please rate the overall quality of your practicum setting.
- Very poor      poor      fair      good      very good
7. Please reflect on your practicum placement and list one or two concrete ways in which the experience could be improved for the next student placed at your agency.

# Ethical Principles of Psychologists and Code Of Conduct

## [History and Effective Date Footnote](#)

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## **INTRODUCTION AND APPLICABILITY**

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

*This Ethics Code applies only to psychologists' activities that are part of their scientific, educational, or professional roles as psychologists. Areas covered include but are not limited to the clinical, counseling, and school practice of psychology; research; teaching; supervision of trainees; public service; policy development; social intervention; development of assessment instruments; conducting assessments; educational counseling; organizational consulting; forensic activities; program design and evaluation; and administration. This Ethics Code applies to these activities across a variety of contexts, such as in person, postal, telephone, internet, and other electronic transmissions. These activities shall be distinguished from the purely private conduct of psychologists, which is not within the purview of the Ethics Code.*

*Membership in the APA commits members and student affiliates to comply with the standards of the APA Ethics Code and to the rules and procedures used to enforce them. Lack of awareness or misunderstanding of an Ethical Standard is not itself a defense to a charge of unethical conduct.*

*The procedures for filing, investigating, and resolving complaints of unethical conduct are described in the current Rules and Procedures of the APA Ethics Committee. APA may impose sanctions on its members for violations of the standards of the Ethics Code, including termination of APA membership, and may notify other bodies and individuals of its actions. Actions that violate the standards of the Ethics Code may also lead to the imposition of sanctions on psychologists or students whether or not they are APA members by bodies other than APA, including state psychological associations, other professional groups, psychology boards, other state or federal agencies, and payors for health services. In addition, APA may take action against a member after his or her conviction of a felony, expulsion or suspension from an affiliated state psychological association, or suspension or loss of licensure. When the sanction to be imposed by APA is less than expulsion, the 2001 Rules and Procedures do not guarantee an opportunity for an in-person hearing, but generally provide that complaints will be resolved only on the basis of a submitted record.*

*The Ethics Code is intended to provide guidance for psychologists and standards of professional conduct that can be applied by the APA and by other bodies that choose to*



*adopt them. The Ethics Code is not intended to be a basis of civil liability. Whether a psychologist has violated the Ethics Code standards does not by itself determine whether the psychologist is legally liable in a court action, whether a contract is enforceable, or whether other legal consequences occur.*

*The modifiers used in some of the standards of this Ethics Code (e.g., reasonably, appropriate, potentially) are included in the standards when they would (1) allow professional judgment on the part of psychologists, (2) eliminate injustice or inequality that would occur without the modifier, (3) ensure applicability across the broad range of activities conducted by psychologists, or (4) guard against a set of rigid rules that might be quickly outdated. As used in this Ethics Code, the term reasonable means the prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge the psychologist had or should have had at the time. In the process of making decisions regarding their professional behavior, psychologists must consider this Ethics Code in addition to applicable laws and psychology board regulations. In applying the Ethics Code to their professional work, psychologists may consider other materials and guidelines that have been adopted or endorsed by scientific and professional psychological organizations and the dictates of their own conscience, as well as consult with others within the field. If this Ethics Code establishes a higher standard of conduct than is required by law, psychologists must meet the higher ethical standard. If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to this Ethics Code and take steps to resolve the conflict in a responsible manner. If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing authority in keeping with basic principles of human rights.*

## **PREAMBLE**

*Psychologists are committed to increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching, and publication. They strive to help the public in developing informed judgments and choices concerning human behavior. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness. This Ethics Code provides a common set of principles and standards upon which psychologists build their professional and scientific work.*

*This Ethics Code is intended to provide specific standards to cover most situations encountered by psychologists. It has as its goals the welfare and protection of the individuals and groups with whom psychologists work and the education of members, students, and the public regarding ethical standards of the discipline.*

*The development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically; to encourage ethical behavior by students, supervisees, employees, and colleagues; and to consult with others concerning ethical problems.*

## **GENERAL PRINCIPLES**

*This section consists of General Principles. General Principles, as opposed to Ethical Standards, are aspirational in nature. Their intent is to guide and inspire psychologists toward the very highest ethical ideals of the profession. General Principles, in contrast to Ethical Standards, do not represent obligations and should not form the basis for imposing sanctions. Relying upon General Principles for either of these reasons distorts both their meaning and purpose.*

### **III. PRINCIPLE A: BENEFICENCE AND NONMALEFICENCE**

*Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because psychologists' scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence. Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work.*

### **IV. PRINCIPLE B: FIDELITY AND RESPONSIBILITY**

*Psychologists establish relationships of trust with those with whom they work. They are aware of their professional and scientific responsibilities to society and to the specific communities in which they work. Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage conflicts of interest that could lead to exploitation or harm. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work. They are concerned about the ethical compliance of their colleagues' scientific and professional conduct. Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage.*

### **V. PRINCIPLE C: INTEGRITY**

*Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not steal, cheat, or engage in fraud, subterfuge, or intentional misrepresentation of fact. Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques.*

### **VI. PRINCIPLE D: JUSTICE**

*Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists. Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices.*

## VII. PRINCIPLE E: 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. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making. Psychologists 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 socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.*

## ETHICAL STANDARDS

### VIII. 1. RESOLVING ETHICAL ISSUES

#### **1.01 Misuse of Psychologists' Work**

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

#### **1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority**

*If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to the Ethics Code and take steps to resolve the conflict. If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing legal authority.*

#### **1.03 Conflicts Between Ethics and Organizational Demands**

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

#### **1.04 Informal Resolution of Ethical Violations**

*When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual, if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved. (See also Standards 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority, and 1.03, Conflicts Between Ethics and Organizational Demands.)*

#### **1.05 Reporting Ethical Violations**

*If an apparent ethical violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution under Standard 1.04, Informal Resolution of Ethical Violations, or is not resolved properly in that fashion, psychologists take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, to state licensing boards, or to the appropriate institutional authorities. This standard does not apply when an intervention would violate confidentiality rights or when psychologists have been retained to review the work of another psychologist whose professional conduct is in question. (See also Standard 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority.)*

### **1.06 Cooperating With Ethics Committees**

*Psychologists cooperate in ethics investigations, proceedings, and resulting requirements of the APA or any affiliated state psychological association to which they belong. In doing so, they address any confidentiality issues. Failure to cooperate is itself an ethics violation. However, making a request for deferment of adjudication of an ethics complaint pending the outcome of litigation does not alone constitute noncooperation.*

### **1.07 Improper Complaints**

*Psychologists do not file or encourage the filing of ethics complaints that are made with reckless disregard for or willful ignorance of facts that would disprove the allegation.*

### **1.08 Unfair Discrimination Against Complainants and Respondents**

*Psychologists do not deny persons employment, advancement, admissions to academic or other programs, tenure, or promotion, based solely upon their having made or their being the subject of an ethics complaint. This does not preclude taking action based upon the outcome of such proceedings or considering other appropriate information.*

## **IX. 2. COMPETENCE**

### **2.01 Boundaries of Competence**

*(a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.*

*(b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies.*

*(c) Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.*

*(d) When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study.*

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

*(f) When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles.*

### **2.02 Providing Services in Emergencies**

*In emergencies, when psychologists provide services to individuals for whom other mental health services are not available and for which psychologists have not obtained the necessary training, psychologists may provide such services in order to ensure that services are not denied. The services are discontinued as soon as the emergency has ended or appropriate services are available.*

### **2.03 Maintaining Competence**

*Psychologists undertake ongoing efforts to develop and maintain their competence.*

### **2.04 Bases for Scientific and Professional Judgments**

*Psychologists' work is based upon established scientific and professional knowledge of the discipline. (See also Standards 2.01e, Boundaries of Competence, and 10.01b, Informed Consent to Therapy.)*

### **2.05 Delegation of Work to Others**

*Psychologists who delegate work to employees, supervisees, or research or teaching assistants or who use the services of others, such as interpreters, take reasonable steps to (1) avoid delegating such work to persons who have a multiple relationship with those being served that would likely lead to exploitation or loss of objectivity; (2) authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided; and (3) see that such persons perform these services competently. (See also Standards 2.02, Providing Services in Emergencies; 3.05, Multiple Relationships; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.02, Use of Assessments; 9.03, Informed Consent in Assessments; and 9.07, Assessment by Unqualified Persons.)*

### **2.06 Personal Problems and Conflicts**

*(a) Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.*

*(b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties. (See also Standard 10.10, Terminating Therapy.)*

## **X. 3. HUMAN RELATIONS**

### **3.01 Unfair Discrimination**

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

### **3.02 Sexual Harassment**

*Psychologists do not engage in sexual harassment. Sexual harassment is sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with the psychologist's activities or roles as a psychologist, and that either (1) is unwelcome, is offensive, or creates a hostile workplace or educational environment, and the psychologist knows or is told this or (2) is sufficiently severe or intense to be abusive to a reasonable person in the context. Sexual harassment can consist of a single intense or severe act or of multiple persistent or pervasive acts. (See also Standard 1.08, Unfair Discrimination Against Complainants and Respondents.)*

### **3.03 Other Harassment**

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

### **3.04 Avoiding Harm**

*Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.*

### **3.05 Multiple Relationships**

*(a) A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.*

*A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.*

*Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.*

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

*(c) When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, at the outset they clarify role expectations and the extent of confidentiality and thereafter as changes occur. (See also Standards 3.04, Avoiding Harm, and 3.07, Third-Party Requests for Services.)*

### **3.06 Conflict of Interest**

*Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence, or effectiveness in performing their functions as psychologists or (2) expose the person or organization with whom the professional relationship exists to harm or exploitation.*

### **3.07 Third-Party Requests for Services**

*When psychologists agree to provide services to a person or entity at the request of a third party, psychologists attempt to clarify at the outset of the service the nature of the relationship with all individuals or organizations involved. This clarification includes the role of the psychologist (e.g., therapist, consultant, diagnostician, or expert witness), an identification of who is the client, the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality. (See also Standards 3.05, Multiple Relationships, and 4.02, Discussing the Limits of Confidentiality.)*

### **3.08 Exploitative Relationships**

*Psychologists do not exploit persons over whom they have supervisory, evaluative, or other authority such as clients/patients, students, supervisees, research participants, and employees. (See also Standards 3.05, Multiple Relationships; 6.04, Fees and Financial Arrangements; 6.05, Barter With Clients/Patients; 7.07, Sexual Relationships With Students and Supervisees; 10.05, Sexual Intimacies With Current Therapy Clients/Patients; 10.06, Sexual Intimacies With Relatives or Significant Others of Current*

*Therapy Clients/Patients; 10.07, Therapy With Former Sexual Partners; and 10.08, Sexual Intimacies With Former Therapy Clients/Patients.)*

### **3.09 Cooperation With Other Professionals**

*When indicated and professionally appropriate, psychologists cooperate with other professionals in order to serve their clients/patients effectively and appropriately. (See also Standard 4.05, Disclosures.)*

### **3.10 Informed Consent**

*(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)*

*(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.*

*(c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.*

*(d) Psychologists appropriately document written or oral consent, permission, and assent. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)*

### **3.11 Psychological Services Delivered To or Through Organizations**

*(a) Psychologists delivering services to or through organizations provide information beforehand to clients and when appropriate those directly affected by the services about (1) the nature and objectives of the services, (2) the intended recipients, (3) which of the individuals are clients, (4) the relationship the psychologist will have with each person and the organization, (5) the probable uses of services provided and information obtained, (6) who will have access to the information, and (7) limits of confidentiality. As soon as feasible, they provide information about the results and conclusions of such services to appropriate persons.*

*(b) If psychologists will be precluded by law or by organizational roles from providing such information to particular individuals or groups, they so inform those individuals or groups at the outset of the service.*

### **3.12 Interruption of Psychological Services**

*Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist's illness, death, unavailability, relocation, or retirement or by the client's/patient's relocation or financial limitations. (See also Standard 6.02c, Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work.)*

## XI. 4. PRIVACY AND CONFIDENTIALITY

### **4.01 Maintaining Confidentiality**

*Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship. (See also Standard 2.05, Delegation of Work to Others.)*

### **4.02 Discussing the Limits of Confidentiality**

*(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (See also Standard 3.10, Informed Consent.)*

*(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.*

*(c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.*

### **4.03 Recording**

*Before recording the voices or images of individuals to whom they provide services, psychologists obtain permission from all such persons or their legal representatives. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing With Informed Consent for Research; and 8.07, Deception in Research.)*

### **4.04 Minimizing Intrusions on Privacy**

*(a) Psychologists include in written and oral reports and consultations, only information germane to the purpose for which the communication is made.*

*(b) Psychologists discuss confidential information obtained in their work only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters.*

### **4.05 Disclosures**

*(a) Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law.*

*(b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. (See also Standard 6.04e, Fees and Financial Arrangements.)*

### **4.06 Consultations**

*When consulting with colleagues, (1) psychologists do not disclose confidential information that reasonably could lead to the identification of a client/patient, research participant, or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and (2) they disclose information only to the extent necessary to achieve the purposes of the consultation. (See also Standard 4.01, Maintaining Confidentiality.)*

#### **4.07 Use of Confidential Information for Didactic or Other Purposes**

*Psychologists do not disclose in their writings, lectures, or other public media, confidential, personally identifiable information concerning their clients/patients, students, research participants, organizational clients, or other recipients of their services that they obtained during the course of their work, unless (1) they take reasonable steps to disguise the person or organization, (2) the person or organization has consented in writing, or (3) there is legal authorization for doing so.*

## **XII. 5. ADVERTISING AND OTHER PUBLIC STATEMENTS**

### **5.01 Avoidance of False or Deceptive Statements**

*(a) Public statements include but are not limited to paid or unpaid advertising, product endorsements, grant applications, licensing applications, other credentialing applications, brochures, printed matter, directory listings, personal resumes or curricula vitae, or comments for use in media such as print or electronic transmission, statements in legal proceedings, lectures and public oral presentations, and published materials. Psychologists do not knowingly make public statements that are false, deceptive, or fraudulent concerning their research, practice, or other work activities or those of persons or organizations with which they are affiliated.*

*(b) Psychologists do not make false, deceptive, or fraudulent statements concerning (1) their training, experience, or competence; (2) their academic degrees; (3) their credentials; (4) their institutional or association affiliations; (5) their services; (6) the scientific or clinical basis for, or results or degree of success of, their services; (7) their fees; or (8) their publications or research findings.*

*(c) Psychologists claim degrees as credentials for their health services only if those degrees (1) were earned from a regionally accredited educational institution or (2) were the basis for psychology licensure by the state in which they practice.*

### **5.02 Statements by Others**

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

*(b) Psychologists do not compensate employees of press, radio, television, or other communication media in return for publicity in a news item. (See also Standard 1.01, Misuse of Psychologists' Work.)*

*(c) A paid advertisement relating to psychologists' activities must be identified or clearly recognizable as such.*

### **5.03 Descriptions of Workshops and Non-Degree-Granting Educational Programs**

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

### **5.04 Media Presentations**

*When psychologists provide public advice or comment via print, internet, or other electronic transmission, they take precautions to ensure that statements (1) are based on their professional knowledge, training, or experience in accord with appropriate psychological literature and practice; (2) are otherwise consistent with this Ethics Code; and (3) do not indicate that a professional relationship has been established with the recipient. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)*

### **5.05 Testimonials**

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

### **5.06 In-Person Solicitation**

*Psychologists do not engage, directly or through agents, in uninvited in-person solicitation of business from actual or potential therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence. However, this prohibition does not preclude (1) attempting to implement appropriate collateral contacts for the purpose of benefiting an already engaged therapy client/patient or (2) providing disaster or community outreach services.*

## **XIII. 6. RECORD KEEPING AND FEES**

### **6.01 Documentation of Professional and Scientific Work and Maintenance of Records**

*Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law. (See also Standard 4.01, Maintaining Confidentiality.)*

### **6.02 Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work**

*(a) Psychologists maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium. (See also Standards 4.01, Maintaining Confidentiality, and 6.01, Documentation of Professional and Scientific Work and Maintenance of Records.)*

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

*(c) Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists' withdrawal from positions or practice. (See also Standards 3.12, Interruption of Psychological Services, and 10.09, Interruption of Therapy.)*

### **6.03 Withholding Records for Nonpayment**

*Psychologists may not withhold records under their control that are requested and needed for a client's/patient's emergency treatment solely because payment has not been received.*

### **6.04 Fees and Financial Arrangements**

*(a) As early as is feasible in a professional or scientific relationship, psychologists and recipients of psychological services reach an agreement specifying compensation and billing arrangements.*

*(b) Psychologists' fee practices are consistent with law.*

*(c) Psychologists do not misrepresent their fees.*

*(d) If limitations to services can be anticipated because of limitations in financing, this is discussed with the recipient of services as early as is feasible. (See also Standards 10.09, Interruption of Therapy, and 10.10, Terminating Therapy.)*

*(e) If the recipient of services does not pay for services as agreed, and if psychologists intend to use collection agencies or legal measures to collect the fees, psychologists first inform the person that such measures will be taken and provide that person an opportunity to make prompt payment. (See also Standards 4.05, Disclosures; 6.03, Withholding Records for Nonpayment; and 10.01, Informed Consent to Therapy.)*

#### **6.05 Barter With Clients/Patients**

*Barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative. (See also Standards 3.05, Multiple Relationships, and 6.04, Fees and Financial Arrangements.)*

#### **6.06 Accuracy in Reports to Payors and Funding Sources**

*In their reports to payors for services or sources of research funding, psychologists take reasonable steps to ensure the accurate reporting of the nature of the service provided or research conducted, the fees, charges, or payments, and where applicable, the identity of the provider, the findings, and the diagnosis. (See also Standards 4.01, Maintaining Confidentiality; 4.04, Minimizing Intrusions on Privacy; and 4.05, Disclosures.)*

#### **6.07 Referrals and Fees**

*When psychologists pay, receive payment from, or divide fees with another professional, other than in an employer-employee relationship, the payment to each is based on the services provided (clinical, consultative, administrative, or other) and is not based on the referral itself. (See also Standard 3.09, Cooperation With Other Professionals.)*

### **XIV. 7. EDUCATION AND TRAINING**

#### **7.01 Design of Education and Training Programs**

*Psychologists responsible for education and training programs take reasonable steps to ensure that the programs are designed to provide the appropriate knowledge and proper experiences, and to meet the requirements for licensure, certification, or other goals for which claims are made by the program. (See also Standard 5.03, Descriptions of Workshops and Non-Degree-Granting Educational Programs.)*

#### **7.02 Descriptions of Education and Training Programs**

*Psychologists responsible for education and training programs take reasonable steps to ensure that there is a current and accurate description of the program content (including participation in required course- or program-related counseling, psychotherapy, experiential groups, consulting projects, or community service), training goals and objectives, stipends and benefits, and requirements that must be met for satisfactory completion of the program. This information must be made readily available to all interested parties.*

#### **7.03 Accuracy in Teaching**

*(a) Psychologists take reasonable steps to ensure that course syllabi are accurate regarding the subject matter to be covered, bases for evaluating progress, and the nature of course experiences. This standard does not preclude an instructor from modifying course content or requirements when the instructor considers it pedagogically necessary or desirable, so long as students are made aware of these modifications in a manner that enables them to fulfill course requirements. (See also Standard 5.01, Avoidance of False or Deceptive Statements.)*

*(b) When engaged in teaching or training, psychologists present psychological information accurately. (See also Standard 2.03, Maintaining Competence.)*

#### **7.04 Student Disclosure of Personal Information**

*Psychologists do not require students or supervisees to disclose personal information in course- or program-related activities, either orally or in writing, regarding sexual history, history of abuse and neglect, psychological treatment, and relationships with parents, peers, and spouses or significant others except if (1) the program or training facility has clearly identified this requirement in its admissions and program materials or (2) the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training- or professionally related activities in a competent manner or posing a threat to the students or others.*

#### **7.05 Mandatory Individual or Group Therapy**

*(a) When individual or group therapy is a program or course requirement, psychologists responsible for that program allow students in undergraduate and graduate programs the option of selecting such therapy from practitioners unaffiliated with the program. (See also Standard 7.02, Descriptions of Education and Training Programs.)*

*(b) Faculty who are or are likely to be responsible for evaluating students' academic performance do not themselves provide that therapy. (See also Standard 3.05, Multiple Relationships.)*

#### **7.06 Assessing Student and Supervisee Performance**

*(a) In academic and supervisory relationships, psychologists establish a timely and specific process for providing feedback to students and supervisees. Information regarding the process is provided to the student at the beginning of supervision.*

*(b) Psychologists evaluate students and supervisees on the basis of their actual performance on relevant and established program requirements.*

#### **7.07 Sexual Relationships With Students and Supervisees**

*Psychologists do not engage in sexual relationships with students or supervisees who are in their department, agency, or training center or over whom psychologists have or are likely to have evaluative authority. (See also Standard 3.05, Multiple Relationships.)*

## **XV. 8. RESEARCH AND PUBLICATION**

### **8.01 Institutional Approval**

*When institutional approval is required, psychologists provide accurate information about their research proposals and obtain approval prior to conducting the research. They conduct the research in accordance with the approved research protocol.*

### **8.02 Informed Consent to Research**

*(a) When obtaining informed consent as required in Standard 3.10, Informed Consent, psychologists inform participants about (1) the purpose of the research, expected duration, and procedures; (2) their right to decline to participate and to withdraw from the research once participation has begun; (3) the foreseeable consequences of declining or withdrawing; (4) reasonably foreseeable factors that may be expected to influence their willingness to participate such as potential risks, discomfort, or adverse effects; (5) any prospective research benefits; (6) limits of confidentiality; (7) incentives for participation; and (8) whom to contact for questions about the research and research participants' rights. They provide opportunity for the prospective participants to ask*

questions and receive answers. (See also Standards 8.03, *Informed Consent for Recording Voices and Images in Research*; 8.05, *Dispensing With Informed Consent for Research*; and 8.07, *Deception in Research*.)

(b) Psychologists conducting intervention research involving the use of experimental treatments clarify to participants at the outset of the research (1) the experimental nature of the treatment; (2) the services that will or will not be available to the control group(s) if appropriate; (3) the means by which assignment to treatment and control groups will be made; (4) available treatment alternatives if an individual does not wish to participate in the research or wishes to withdraw once a study has begun; and (5) compensation for or monetary costs of participating including, if appropriate, whether reimbursement from the participant or a third-party payor will be sought. (See also Standard 8.02a, *Informed Consent to Research*.)

#### **8.03 Informed Consent for Recording Voices and Images in Research**

Psychologists obtain informed consent from research participants prior to recording their voices or images for data collection unless (1) the research consists solely of naturalistic observations in public places, and it is not anticipated that the recording will be used in a manner that could cause personal identification or harm, or (2) the research design includes deception, and consent for the use of the recording is obtained during debriefing. (See also Standard 8.07, *Deception in Research*.)

#### **8.04 Client/Patient, Student, and Subordinate Research Participants**

(a) When psychologists conduct research with clients/patients, students, or subordinates as participants, psychologists take steps to protect the prospective participants from adverse consequences of declining or withdrawing from participation.

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

#### **8.05 Dispensing With Informed Consent for Research**

Psychologists may dispense with informed consent only (1) where research would not reasonably be assumed to create distress or harm and involves (a) the study of normal educational practices, curricula, or classroom management methods conducted in educational settings; (b) only anonymous questionnaires, naturalistic observations, or archival research for which disclosure of responses would not place participants at risk of criminal or civil liability or damage their financial standing, employability, or reputation, and confidentiality is protected; or (c) the study of factors related to job or organization effectiveness conducted in organizational settings for which there is no risk to participants' employability, and confidentiality is protected or (2) where otherwise permitted by law or federal or institutional regulations.

#### **8.06 Offering Inducements for Research Participation**

(a) Psychologists make reasonable efforts to avoid offering excessive or inappropriate financial or other inducements for research participation when such inducements are likely to coerce participation.

(b) When offering professional services as an inducement for research participation, psychologists clarify the nature of the services, as well as the risks, obligations, and limitations. (See also Standard 6.05, *Barter With Clients/Patients*.)

#### **8.07 Deception in Research**

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

*(b) Psychologists do not deceive prospective participants about research that is reasonably expected to cause physical pain or severe emotional distress.*

*(c) Psychologists explain any deception that is an integral feature of the design and conduct of an experiment to participants as early as is feasible, preferably at the conclusion of their participation, but no later than at the conclusion of the data collection, and permit participants to withdraw their data. (See also Standard 8.08, Debriefing.)*

#### **8.08 Debriefing**

*(a) Psychologists provide a prompt opportunity for participants to obtain appropriate information about the nature, results, and conclusions of the research, and they take reasonable steps to correct any misconceptions that participants may have of which the psychologists are aware.*

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

*(c) When psychologists become aware that research procedures have harmed a participant, they take reasonable steps to minimize the harm.*

#### **8.09 Humane Care and Use of Animals in Research**

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

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

*(c) Psychologists ensure that all individuals under their supervision who are using animals have received instruction in research methods and in the care, maintenance, and handling of the species being used, to the extent appropriate to their role. (See also Standard 2.05, Delegation of Work to Others.)*

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

*(e) Psychologists use a procedure subjecting animals to pain, stress, or privation only when an alternative procedure is unavailable and the goal is justified by its prospective scientific, educational, or applied value.*

*(f) Psychologists perform surgical procedures under appropriate anesthesia and follow techniques to avoid infection and minimize pain during and after surgery.*

*(g) When it is appropriate that an animal's life be terminated, psychologists proceed rapidly, with an effort to minimize pain and in accordance with accepted procedures.*

#### **8.10 Reporting Research Results**

*(a) Psychologists do not fabricate data. (See also Standard 5.01a, Avoidance of False or Deceptive Statements.)*

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

#### **8.11 Plagiarism**

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

#### **8.12 Publication Credit**

*(a) Psychologists take responsibility and credit, including authorship credit, only for work they have actually performed or to which they have substantially contributed. (See also Standard 8.12b, Publication Credit.)*

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

*(c) Except under exceptional circumstances, a student is listed as principal author on any multiple-authored article that is substantially based on the student's doctoral dissertation. Faculty advisors discuss publication credit with students as early as feasible and throughout the research and publication process as appropriate. (See also Standard 8.12b, Publication Credit.)*

#### **8.13 Duplicate Publication of Data**

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

#### **8.14 Sharing Research Data for Verification**

*(a) After research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release. This does not preclude psychologists from requiring that such individuals or groups be responsible for costs associated with the provision of such information.*

*(b) Psychologists who request data from other psychologists to verify the substantive claims through reanalysis may use shared data only for the declared purpose. Requesting psychologists obtain prior written agreement for all other uses of the data.*

#### **8.15 Reviewers**

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

## **XVI. 9. ASSESSMENT**

### **9.01 Bases for Assessments**

*(a) Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)*

*(b) Except as noted in 9.01c, psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions. When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions, and appropriately limit the nature and extent of their conclusions or recommendations. (See also Standards 2.01, Boundaries of Competence, and 9.06, Interpreting Assessment Results.)*

*(c) When psychologists conduct a record review or provide consultation or supervision and an individual examination is not warranted or necessary for the opinion,*

*psychologists explain this and the sources of information on which they based their conclusions and recommendations.*

#### **9.02 Use of Assessments**

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

*(b) Psychologists use assessment instruments whose validity and reliability have been established for use with members of the population tested. When such validity or reliability has not been established, psychologists describe the strengths and limitations of test results and interpretation.*

*(c) Psychologists use assessment methods that are appropriate to an individual's language preference and competence, unless the use of an alternative language is relevant to the assessment issues.*

#### **9.03 Informed Consent in Assessments**

*(a) Psychologists obtain informed consent for assessments, evaluations, or diagnostic services, as described in Standard 3.10, Informed Consent, except when (1) testing is mandated by law or governmental regulations; (2) informed consent is implied because testing is conducted as a routine educational, institutional, or organizational activity (e.g., when participants voluntarily agree to assessment when applying for a job); or (3) one purpose of the testing is to evaluate decisional capacity. Informed consent includes an explanation of the nature and purpose of the assessment, fees, involvement of third parties, and limits of confidentiality and sufficient opportunity for the client/patient to ask questions and receive answers.*

*(b) Psychologists inform persons with questionable capacity to consent or for whom testing is mandated by law or governmental regulations about the nature and purpose of the proposed assessment services, using language that is reasonably understandable to the person being assessed.*

*(c) Psychologists using the services of an interpreter obtain informed consent from the client/patient to use that interpreter, ensure that confidentiality of test results and test security are maintained, and include in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, discussion of any limitations on the data obtained. (See also Standards 2.05, Delegation of Work to Others; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.06, Interpreting Assessment Results; and 9.07, Assessment by Unqualified Persons.)*

#### **9.04 Release of Test Data**

*(a) The term test data refers to raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recordings concerning client/patient statements and behavior during an examination. Those portions of test materials that include client/patient responses are included in the definition of test data. Pursuant to a client/patient release, psychologists provide test data to the client/patient or other persons identified in the release. Psychologists may refrain from releasing test data to protect a client/patient or others from substantial harm or misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is regulated by law. (See also Standard 9.11, Maintaining Test Security.)*

*(b) In the absence of a client/patient release, psychologists provide test data only as required by law or court order.*

### **9.05 Test Construction**

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

### **9.06 Interpreting Assessment Results**

*When interpreting assessment results, including automated interpretations, psychologists take into account the purpose of the assessment as well as the various test factors, test-taking abilities, and other characteristics of the person being assessed, such as situational, personal, linguistic, and cultural differences, that might affect psychologists' judgments or reduce the accuracy of their interpretations. They indicate any significant limitations of their interpretations. (See also Standards 2.01b and c, Boundaries of Competence, and 3.01, Unfair Discrimination.)*

### **9.07 Assessment by Unqualified Persons**

*Psychologists do not promote the use of psychological assessment techniques by unqualified persons, except when such use is conducted for training purposes with appropriate supervision. (See also Standard 2.05, Delegation of Work to Others.)*

### **9.08 Obsolete Tests and Outdated Test Results**

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

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

### **9.09 Test Scoring and Interpretation Services**

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

*(b) Psychologists select scoring and interpretation services (including automated services) on the basis of evidence of the validity of the program and procedures as well as on other appropriate considerations. (See also Standard 2.01b and c, Boundaries of Competence.)*

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

### **9.10 Explaining Assessment Results**

*Regardless of whether the scoring and interpretation are done by psychologists, by employees or assistants, or by automated or other outside services, psychologists take reasonable steps to ensure that explanations of results are given to the individual or designated representative unless the nature of the relationship precludes provision of an explanation of results (such as in some organizational consulting, preemployment or security screenings, and forensic evaluations), and this fact has been clearly explained to the person being assessed in advance.*

### **9.11. Maintaining Test Security**

*The term test materials refers to manuals, instruments, protocols, and test questions or stimuli and does not include test data as defined in Standard 9.04, Release of Test Data. Psychologists make reasonable efforts to maintain the integrity and security of test materials and other assessment techniques consistent with law and contractual obligations, and in a manner that permits adherence to this Ethics Code.*

## XVII. 10. THERAPY

### **10.01 Informed Consent to Therapy**

*(a) When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers. (See also Standards 4.02, Discussing the Limits of Confidentiality, and 6.04, Fees and Financial Arrangements.)*

*(b) When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation. (See also Standards 2.01e, Boundaries of Competence, and 3.10, Informed Consent.)*

*(c) When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.*

### **10.02 Therapy Involving Couples or Families**

*(a) When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist's role and the probable uses of the services provided or the information obtained. (See also Standard 4.02, Discussing the Limits of Confidentiality.)*

*(b) If it becomes apparent that psychologists may be called on to perform potentially conflicting roles (such as family therapist and then witness for one party in divorce proceedings), psychologists take reasonable steps to clarify and modify, or withdraw from, roles appropriately. (See also Standard 3.05c, Multiple Relationships.)*

### **10.03 Group Therapy**

*When psychologists provide services to several persons in a group setting, they describe at the outset the roles and responsibilities of all parties and the limits of confidentiality.*

### **10.04 Providing Therapy to Those Served by Others**

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

### **10.05 Sexual Intimacies With Current Therapy Clients/Patients**

*Psychologists do not engage in sexual intimacies with current therapy clients/patients.*

### **10.06 Sexual Intimacies With Relatives or Significant Others of Current Therapy Clients/Patients**

*Psychologists do not engage in sexual intimacies with individuals they know to be close relatives, guardians, or significant others of current clients/patients. Psychologists do not terminate therapy to circumvent this standard.*

### **10.07 Therapy With Former Sexual Partners**

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

#### **10.08 Sexual Intimacies With Former Therapy Clients/Patients**

*(a) Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy.*

*(b) Psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances. Psychologists who engage in such activity after the two years following cessation or termination of therapy and of having no sexual contact with the former client/patient bear the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including (1) the amount of time that has passed since therapy terminated; (2) the nature, duration, and intensity of the therapy; (3) the circumstances of termination; (4) the client's/patient's personal history; (5) the client's/patient's current mental status; (6) the likelihood of adverse impact on the client/patient; and (7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a posttermination sexual or romantic relationship with the client/patient. (See also Standard 3.05, Multiple Relationships.)*

#### **10.09 Interruption of Therapy**

*When entering into employment or contractual relationships, psychologists make reasonable efforts to provide for orderly and appropriate resolution of responsibility for client/patient care in the event that the employment or contractual relationship ends, with paramount consideration given to the welfare of the client/patient. (See also Standard 3.12, Interruption of Psychological Services.)*

#### **10.10 Terminating Therapy**

*(a) Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service.*

*(b) Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship.*

*(c) Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate.*

#### ***History and Effective Date Footnote***

*This version of the APA Ethics Code was adopted by the American Psychological Association's Council of Representatives during its meeting, August 21, 2002, and is effective beginning June 1, 2003. Inquiries concerning the substance or interpretation of the APA Ethics Code should be addressed to the Director, Office of Ethics, American Psychological Association, 750 First Street, NE, Washington, DC 20002-4242. The Ethics Code and information regarding the Code can be found on the APA web site, <http://www.apa.org/ethics>. The standards in this Ethics Code will be used to adjudicate complaints brought concerning alleged conduct occurring on or after the effective date. Complaints regarding conduct occurring prior to the effective date will be adjudicated on the basis of the version of the Ethics Code that was in effect at the time the conduct occurred.*

*The APA has previously published its Ethics Code as follows:*

*American Psychological Association. (1953). Ethical standards of psychologists. Washington, DC: Author.*

*American Psychological Association. (1959). Ethical standards of psychologists. American Psychologist, 14, 279-282.*

*American Psychological Association. (1963). Ethical standards of psychologists. American Psychologist, 18, 56-60.*

*American Psychological Association. (1968). Ethical standards of psychologists. American Psychologist, 23, 357-361.*

*American Psychological Association. (1977, March). Ethical standards of psychologists. APA Monitor, 22-23.*

*American Psychological Association. (1979). Ethical standards of psychologists. Washington, DC: Author.*

*American Psychological Association. (1981). Ethical principles of psychologists. American Psychologist, 36, 633-638.*

*American Psychological Association. (1990). Ethical principles of psychologists (Amended June 2, 1989). American Psychologist, 45, 390-395.*

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

*Request copies of the APA's Ethical Principles of Psychologists and Code of Conduct from the APA Order Department, 750 First Street, NE, Washington, DC 20002-4242, or phone (202) 336-5510.*

Ethics Code 2002.doc 10/8/02

## COMMON CLINICAL ABBREVIATIONS AND SYMBOLS IN PATIENT'S CHARTS/FILE

@	at
a	before
AV	A.I.D.S. associated virus
abd	abduction/abdomen
ABG	arterial blood gas
A & B	apnea and bradycardia
a.c.	before meals
ad lib	as desired
adm	admission
A/G	albumin-globulin ratio
A.I.D.S.	acquired immune deficiency/immunodeficiency syndrome
AK	above knee
alb	albumin
ALL	allergy
alks,p'tase	alkaline phosphatase
AMA	against medical advice
amb	ambulatory
anes	anesthesia
angio	angiogram
AP & Lat	anteroposterior and lateral
AQ	achievement quotient
ARC	AIDS related complex
ARV	AIDS related virus
ASA	aspirin
AV	arteriovenous
AVVR	atrioventricular valve regurgitation
AWOL	away without official leave
AX	angle jerk
≅	approximate
b	born
Bab	Babinski
Bact	bacteria
BBS	bilateral breath sounds
BC/BS	Blue Cross/Blue Shield
BDI	Beck Depression Inventory
BDS	birth defects
BE	barium enema
b.i.d.	twice a day
BK	below knee
BJM	bones, joints, muscles

BM	bowel movement
BMT	Bone Marrow Transplant
BP	blood pressure
BS	bowel sound
B/S	breath sounds
c	with
C.	centigrade
CA	cancer, carcinoma
ca	calcium/chronological age
Cap	capsule
CAS	cardiac surgery
CBC	complete blood count
CBG	capillary blood gas
cc	cubic centimeter
CC	chief complaint
	Check
Δ	change
CF	cystic fibrosis
CHD	congenital heart disease
chol	cholesterol
Cl	chloride
cldy	cloudy
c. monitor	cardiac monitor
cm	centimeter
CNS	central nervous system
c/o	complaint of
CO	complaint of
conv	convergence
CO <sub>2</sub>	carbon dioxide
CP	cerebral palsy
CPAP	continuous positive airway pressure
CPR	cardio-pulmonary resuscitation
CSF	cerebrospinal fluid
C&S	culture and sensitivity
C/S	cesarean section
CT	chest tube
Ct, CT scan, CAT	computerized tomography
CVA	cerebrovascular accident
CVP	central venous pressure
CVS	clean-voided specimen
CXR	chest x-ray
SYS	cystic fibrosis
↓	decrease
DAT	diet as tolerated
D&C	dilation & curettage

d/c	discontinue
D/C	discharge
dil	dilute
DOA	dead on arrival
DOB	date of birth
DOC	doctor on call
DOE	dyspnea on exertion; date of evaluation
DPT	diphtheria, pertussis, tetanus
D/S	dextrose & saline
DTR	deep tendon reflex
DTV	due to void
D/W	dextrose & water
DX, Dx, dx	diagnosis
ECG, EKG	electrocardiogram
ECHO	enterocytopathogenic human orphan viruses
ECT	electroconvulsive treatment
EDC	endocrine
EEG	electroencephalogram
e.g.	for example
EMV	expired minute volume
ENT	ears, nose, and throat; otolaryngology
EOM	extraocular movement
eos	eosinophils
ER	emergency room
ERG	electroretinogram
ETOH	alcohol
eve.	evening
ext	extension
extrem	extremities
EYE	ophthalmology
f	frequency
F.	fahrenheit
F	father
	Female
FBS	fasting blood sugar
FFP	fresh frozen plasma
FH	family history
flex	flexion
for, bend	forward bending
FTT	failure to thrive
FUO	fever of unknown origin
f/u	follow up
g	gram
GB series	gallbladder series
GC	gonorrhea

GF&R	grunting, flaring, and retracting
GI	gastrointestinal
GIS	gastroenterology
gm/dl	grams per hundred millimeters
gms	gram(s)
GNS	general surgery
gr	grain
GTT	glucose tolerance test
gtt	drops
gyn	gynecology
h.	hour
H	husband
HC	head circumference
Hct	hematocrit
HEENT	head, eyes, ears, nose, throat
HEM	hematology
Hgb.	Hemoglobin
H.I.V.	Human immunodeficiency virus
HMO	Health Maintenance Organization
HO <sub>2</sub>	humidified oxygen
hpf	high-power field
HR	heart rate
ht.	Height
HTN	hypertension
h.s.	at bedtime
Hx	history
I & D	incision and drainage
I & O	intake and output
IA	intra-arterial
ICP	intracranial pressure
ICU	intensive care unit
IDS	infectious diseases
IM	intramuscular
in rot	in rotation
inv	inversion
IOFB	intraocular foreign body
i.e.	that is; namely
↑	increase (elevated)
Imp.	impression
IP	inpatient
IQ	intelligence quotient
IT	intrathecal
IV	intravenous
IVP	intravenous puch
IVH	intraventricular hemorrhage

JT	jejunostomy tube
K	potassium
Kg	kilogram
KJ	knee jerk
KUB	kidney, ureter and bladder
kV	kilovolt
L	left
L & A	light and accommodation
LA	left atrium
lab	laboratory
LFT	liver function test
LL	lower lid
LLE	left lower extremity
LLL	left lower lobe
LLQ	left lower quadrant
l/min	liters per minute
LMP	last menstrual period
LOA	leave of absence
LP	lumbar puncture
LUE	left upper extremity
LUL	left upper lobe
LUQ	left upper quadrant
LV	left ventricular
lymphs	lymphocytes
Lytes	electrolytes
	Male
M	mother
m	meter
M & T	myringotomy and tubes
MAPI	Millon Adolescent Personality Inventory
MCL	midclavicular line
MCM-II	Millon Clinical Multiaxial Inventory
med	medicine
mEq	milliequivalent (per liter, mEq/l)
mets	metastasis
Mg	magnesium
mg	milligrams
mg/dl	milligrams per hundred milliliters
MHC	Mental Health Center
ml	milliliter or milliliters (preferred over cc)
Mn	manganese
mod	moderate
mono	monocyte infectious; mononucleosis
MMPI (or MMPI-II)	Minnesota Multiphasic Personality Inventory
MS	multiple sclerosis

MSE	mental status examination
MVA	motor vehicle accident
N <sub>2</sub>	Nitrogen
N <sub>2</sub> O	nitrous oxide
Na	Sodium
NAD	no apparent distress
neb, htd. neb	nebulizer, heated nebulizer
NEO	neonatology
neph	nephrotomy
NG	nasogastric
NICU	Newborn ICU
NKA	no known allergies
nl	normal
NLA	neurology
NMJ	neuromuscular joint
NP	nasopharyngeal
NPO	nothing by mouth
NRC	normal retinal correspondence
N/S	normal saline
NSS	neurosurgery
NTA	nothing to add
NVD	normal vaginal delivery
N/V	nausea and vomiting
N/V/D	nausea, vomiting, diarrhea
1:1	one to one
O & P	ova & parasites, stool
O <sub>2</sub> , O <sub>2</sub>	oxygen
O <sub>2</sub> sat	oxygen saturation
obs	obstetrics or obstetrical
OBS	organic brain syndrome
occ	occasionally
OD	right eye
odont	odontectomies
OHID	oxygen tent
O.M.	otitis media
OOB	out of breath
OOP	out on pass
op	operation
OPD	outpatient department
OR	operating room
ORL	otorhinolaryngology (ENT)
orth, ORT	orthopaedics
OS	left eye
OT	occupational therapy
OU	both eyes

p	after
P	phosphorous
P & A	percussion and auscultation
P & V	percussion and vibration
PA	posteroanterior; Pulmonary Artery
p.c.	after meals
pCO <sub>2</sub>	partial pressure carbon dioxide
PE	physical examination
ped, pedi, peds	pediatrics
PEEP	positive end-expiratory pressure
PERLA	pupils equal, reactive to light & accommodation
PF	plantar flexion
PFT	pulmonary function test
pg	per gastric
pH	hydrogen ion concentration
PH	past history
PHP	posthospital plans
PI	present illness
PIV	peripheral intravenous
PKU	phenylketonuria
PLS	plastics
plts	platelets
PMH	past medical history
p.o.	by mouth
PO <sub>2</sub>	partial pressure oxygen
PPH	persistent pulmonary hypertension
p.r.	per rectum
PRBC	packed red blood cells
Premie	premature
prep	preparation
p.r.n.	as needed
prot	protein (total protein preferred)
psi	pounds per square inch
psy, psych	psychiatry, psychology
pt	patient
PT	physical therapy; prothrombin time
PTMDF	pupils, tension, media, disc, fundus
PUL	pulmonary
q	every
q 2 h	every two hours
q 3 h	every three hours
q 4 h	every four hours
q.a.m.	every morning
q.d.	every day
q.h.	every hour
q.h.s.	every night
q.i.d.	four times a day

q.n.s.	quantity not sufficient
q.o.d.	every other day
QR	Quiet Room
qs	quantity sufficient
R	Right
RA	right atrium
RAO	right anterior oblique
rbc	red blood cells
RBC	red blood count
re	regarding
REN	renal/dialysis
Rh+or-	rhesus blood factor
RHD	rheumatic heart disease
RLE	(R) lower extremity
RLL	right lower lobe
RML	right middle lobe
R/O	rule out
RPA, LPA	right and left pulmonary artery
RRE	round, regular, and equal
RT	respiratory therapy
RTC	return to clinic
RTH	radiation therapy
RTO	return to office
RUE	(R) upper extremity
RUL	right upper lobe
RUQ	right upper quadrant
Rx	treatment; treatment with medication
2	secondary to
s	without
S	suction
SC	subcutaneous
SCA	subclavian artery
sed. rate	erythrocyte sedimentation rate
S.G.	specific gravity
SH	social history; serum hepatitis
SIDS	sudden infant death syndrome
SLR	straight leg raising
SOB	shortness of breath
sol	solution
S/P	status post
SP	special precautions
SPA	serum protein analysis
SS	signs and symptoms
STAT	immediate and only once
strep	streptococcus
SV	single ventricle

SVC	superior vena cava
surg	surgery or surgical
S.W.	social worker
Sz	seizure
T & A	tonsillectomy and adenoidectomy
T & C	type and crossmatch
T & H	type and hold
tab.	Tablet
TAT	Thematic Apperception Test
TB	tuberculosis
TBA	to be announced
tbsp.	Tablespoon
TCO2	total (calculated) carbon dioxide
TENS	transcutaneous electrical nerve stimulator
t.i.d.	three times a day
TLC	tender loving care
TM	tympanic membrane
TP	total protein
TPR	temperature, pulse, and respiration
Tq	tourniquet
tsp.	Teaspoon
TTX	tumor therapy
TV	tidal volume
tx	transplant
TX, Tx	treatment
U	unit
UA	urinalysis
UDT	undescended testicles
UGI	upper gastrointestinal series
umb(i)	umbilical
UO	uninary output
URI	upper respiratory infection
uro, urol	urology or urological
US	ultrasound
V or VA	volt; vision or visual acuity
vag	vagina or vaginal
VC	vital capacity
VCO2	carbon dioxide production
VD	venereal disease
VDRL	Venereal Disease Research Laboratory
vert.	Vertebrae (D. vert – dorsal; L. vert – lumbar)
VF	volar flexion; vocal fremitus
vit.	vitamin when followed by specific letter
VO2	oxygen consumption
VS	vital signs

Vx	vertex
W	wife
WAIS-R	Wechsler Adult Intelligence Scale-Revised
WB	whole blood
WBC	white blood cell; white blood count
WD	well-developed
WDWN	well-developed, well-nourished
wk.	Week
WISC-III	Wechsler Intelligence Scale for Children-III
WN	well-nourished
WNL	within normal limits
WRAT	Wide Range Achievement Test
wt.	Weight
w/u	work up
y.o.	years old