

# Manitoba Psychologist

THE PSYCHOLOGICAL ASSOCIATION OF MANITOBA /  
L'ASSOCIATION DES PSYCHOLOGUES DU MANITOBA

*PAM is legally constituted by the Psychologists Registration Act (R.S.M. 1987) as the regulatory body for the practice of all branches of Psychology in Manitoba.*

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**Volume 27, Number 2**

**January, 2011**

## **Announcements of Meetings**

*Town Hall, February 22, 2011*

*Annual General Meeting, April 27, 2011*



Page 1

## **Registrar's Report**

*Telepsychology, mobility, registration of internationally educated applicants, profession-specific regulation and the RHPA, etc.*



Page 2

## **Special Ethics Section**

*Ohio Telepsychology; Ethical Behavior Basics; Informed Consent Resources; Tarasoff Duties and Independent Examinations*



Begins page 3

## Town Hall Meeting

There is growing awareness that the profession of psychology is far broader in scope now than ever before. In acknowledgement of this, PAM has begun to reconsider the approach we have been using for registering our members.

Executive Council strongly encourages all PAM members to attend this Town Hall, which will review proposed changes to the ways in which psychologists are registered.

**February 22, 2011**

**6:30 - 9:00 pm**

**Room A-106 Chown Building**

**UofM Bannatyne Campus**

## Annual General Meeting

The 2011 Annual General Meeting of the Psychological Association of Manitoba is set for April 27, 2011

Reception 5:30 pm

AGM 6:00 pm

Dinner 7:00 pm

Greenwood Inn

1715 Wellington Avenue

Further details to follow.

# Registrar's Report

Alan Slusky, Ph.D., C. Psych.

It brings me great pleasure to write to the membership to provide you with an update on the activities of PAM over the past months. PAM has been working diligently on a number of fronts, to meet challenges placed before it in the areas of telepsychology, mobility, the registration of internationally educated applicants, as well as continuing its efforts to develop profession specific regulation which will allow us to come under the newly proclaimed Regulated Health Professions Act.

PAM, along with other regulators, have been meeting on a regular basis with representatives from the office of the Manitoba Fairness Commissioner to examine the ways in which internationally educated applicants are assessed for registration. The OMFC has put into place a requirement that all applicants will now be tracked in terms of the timeframes required for registration, with an eye to ensuring fairness and transparency. New processes are being developed to track the timeframes for documentation to be received and collated, as well as for decisions to be made on an applicant's request for registration. Upcoming changes to the PAM website will enable those applicants who are educated outside of Canada to better understand the steps required for registration and to move through the whole process in a fashion which both respects their right for fair evaluation but is also in keeping with PAM's mandate of public protection. At present, given the relatively few number of internationally trained applicants that apply for registration with PAM, we are not anticipating that these new requirements will require an inordinately greater amount of resource allocation; however, this is something that will need to be monitored over time.

As a member of the Association of Canadian Psychology Regulatory Organizations (ACPRO) PAM has also been working on a national front to continue dialogue on the creation of standards for telepsychology practice. This is an issue that many of you have spoken about with me over the past year, and I am representing your views and concerns to this national body. Given the wide

variation in provincial legislation around the practice of Psychology, developing standards and practice guidelines which are both acceptable to all jurisdictions, and do not interfere with the mandated responsibilities of each psychology regulator, has proven challenging. However, work in this area will continue until a broader consensus can be reached, and members are advised to consult with the provincial psychology regulator in the jurisdiction in which you intend to practice (that is, the jurisdiction in which the client resides) to ensure that you are in compliance with all of that jurisdiction's practice regulations and rules.

Within the context of discussions with MASP, as well as other psychologists in the province, PAM has also begun to reconsider the approach used in registration of its members. There is a growing awareness that psychology as a profession is far broader in scope now than ever before; as an acknowledgement of this, we are considering changes to the ways in which members are registered.

The Agreement on Internal Trade also continues to hold the attention of PAM and other provincial Psychology regulators. All provincial regulators are monitoring this process with respect to potential unintended consequences of this agreement and are in regular and open communication with each other around how and if this agreement is impacting on each provincial regulator's mandate of public protection. Here in Manitoba, we have encountered few difficulties with AIT during the past 12 months and we remind prospective applicants that the spirit of this agreement is to facilitate mobility for already registered applicants, rather than to serve as a primary means for registration in a jurisdiction of intended practice. PAM Executive Council, and I as your Registrar, continue to be vigilant to potential abuses of this process, and in this regard are in regular contact with the Manitoba representative to the Federal Labour Mobility Coordinating Group.

A final area of focus for PAM over the past 12 months has been on efforts to provide input into the writing of the profession specific regulation which will allow Psychology to come under the newly proclaimed Regulated Health Professions Act. In this regard, representatives of PAM have been meeting now for many weeks with representatives of the Manitoba Association of School Psychologists. Discussions here have been both positive and productive. The Government of Manitoba has indicated to PAM that it wishes us to attempt to resolve its longstanding differences with MASP prior to consulting representatives of other practice areas. In particular, the Government has requested that all exemptions under the current Psychology Registration Act be removed, beginning with school boards. Given the progress that has been made to date in PAM's discussions with MASP, we are hopeful that the development of this regulation can proceed in the near future.

Within the context of discussions with MASP, as well as other psychologists in the province, PAM has also begun to reconsider the approach used in registration of its members. There is a growing awareness that psychology as a profession is far broader in scope now than ever before; as acknowledgement of this, we are considering changes to the ways in which members are registered. In order to provide PAM members with an opportunity to understand the approaches being considered by Executive Council, and to provide a venue for hearing members' thoughts about this process, we are planning a Town Hall Meeting for February 22, 2011 to consider this matter, and any other concerns current PAM members may have. Discussion promises to be interesting, and we strongly encourage all members to attend both the Town Hall Meeting and the AGM, now set for April 27<sup>th</sup>, 2011. (Details of the AGM will be sent soon).

Please feel free to contact me or any members of your Council with questions or concerns. We look forward to seeing you at both the Town Hall and the AGM.



# Special Ethics Section

## Ohio Telepsychology Guidelines

The Ohio Psychological Association Communications & Technology Committee (Excerpted with Permission of the Ohio Psychological Association)

*The Communications & Technology Committee of the Ohio Psychological Association recently updated its 2008 Telepsychology Guidelines, referring to a range of psychological services involving non-face-to-face communication through such media as landline telephones, cell phones, video conferencing, instant messaging, and with internet services including e-mail, fax, chat, blogging, video blogging, webinars, blackboards, social or professional networking, or web pages.*

*In its introduction to the updated Guidelines (approved by the OPA Board of Directors, April, 2010 - See [www.ohpsych.org/resources/1/files/Comm%20Tech%20Committee/OPATelepsychologyGuidelines41710.pdf](http://www.ohpsych.org/resources/1/files/Comm%20Tech%20Committee/OPATelepsychologyGuidelines41710.pdf)), the Committee noted that even as technology of all types, particularly communication technology, is rapidly becoming more prevalent in the practice of psychology, there is an ever-widening gap between the tools that psychologists use and professionally agreed-upon expectations. The authors note that, even as some psychologists view technology as a great benefit to practice (ability to treat disabled persons unable to attend the psychologist's office and those that live in rural areas, greater disclosure than in face-to-face exchanges, cost efficiency, etc.), the increased availability and use of technology will undoubtedly impact significantly the practice of, and training and scientific endeavors in psychology. Defining appropriate use of telecommunications in psychological assessment, testing, treatment, and research, and clarifying what preparatory training for psychologists need in order to provide services electronically are important, they say, as are sorting through the legality and ethics of providing services across legal jurisdictions and providing non-face-to-face supervision.*

*As PAM works with other Canadian Psychology Regulators (through ACPRO) toward finalizing telepsychology guidelines for use in the Provinces and Territories, we thought it might be useful to see what's being done south of the border.*

### OPA TELEPSYCHOLOGY GUIDELINES

The APA and other professional organizations have previously identified many of the issues addressed in these guidelines. These issues are identified in endnotes and documents listed in the References section. It is suggested that these telepsychology guidelines be read in conjunction with the APA Code of Ethics. There is some intentional redundancy between the guidelines and the APA Code of

Ethics standards to emphasize the application of those standards when practicing telepsychology.

**1. The Appropriate Use of Telepsychology:** Psychologists recognize that telepsychology is not appropriate for all problems and that the specific process of providing professional services varies across situation, setting, and time, and decisions regarding the appropriate delivery of telepsychology services are made on a case-by-case basis.

Psychologists have the necessary training, experience, and skills to provide the type of telepsychology that they provide. They also can adequately assess whether involved participants have the necessary knowledge and skills to benefit from those services. If the psychologist determines that telepsychology is not appropriate, they inform those involved of appropriate alternatives.

**2. Legal and Ethical Requirements:** Psychologists assure that the provision of telepsychology is not legally prohibited by local or state laws and regulations (supplements 2002 APA Ethics Code Sec. 1.02).

Psychologists are aware of and in compliance with the Ohio psychology licensure law (Ohio Revised Code Chapter 4732) and the Ohio State Board of Psychology "Rules Governing Psychologists and School Psychologists" promulgated in the Ohio Administrative Code.

Psychologists are aware of and in compliance with the laws and standards of the particular state or country in which the client resides, including requirements for reporting individuals at risk to themselves or others (supplements 2002 APA Ethics Code Sec. 2.01).

This step includes compliance with Section 508 of the Rehabilitation Act to make technology accessible to people with disabilities, as well as assuring that any advertising related to telepsychology services is non-deceptive (supplements 2002 APA Ethics Code Sec. 5.01). When providing telepsychology procedures psychologists employ reasonable efforts to assess a client's level of functioning in order to select appropriate online assessment measures. (supplements 2002 APA Ethics Code Sec. 9.02)

**3. Informed Consent and Disclosure:** Psychologists using telepsychology provide information about their use of electronic communication technology and obtain the informed consent of the involved individual using language that is likely to be understood and consistent with accepted professional and legal requirements. In the event that a psychologist is providing services for someone who is unable to provide consent for him or herself (including minors), additional measures are taken to ensure that appropriate consent (and assent where applicable) are obtained as needed. Levels of experience and training in telepsychology, if any, are explained (though few opportunities for such training exist at this time) and the client's informed consent is secured (supplements 2002 APA Ethics Code Sec. 3.10).

As part of an informed consent process, clients are provided sufficient information about the limitations of using technology, including

P.A.M. is currently working with other Provincial and Territorial regulators (through ACPRO) to finalize Canadian telepsychology guidelines.

potential risks to confidentiality of information due to technology, as well as any legally-required reporting, such as reporting clinical clients who may be suicidal or homicidal. This disclosure includes information identifying telepsychology as innovative treatment (supplements 2002 APA Ethical Principles 10.01b). Clients are expected to provide written acknowledgement of their awareness of these limitations. Psychologists do not provide telepsychology services without written client consent. Psychologists make reasonable attempts to verify the identity of clients and to help assure that the clients are capable of providing informed consent (supplements 2002 APA Ethics Code Sec. 3.10). When providing clinical services, psychologists make reasonable attempts to obtain information about alternative means of contacting clients and provide clients with an alternative means of contacting them in emergency situations or when telepsychology is not available.

Psychologists inform clients about potential risks of disruption in the use telepsychology, clearly state their policies as to when they will respond to routine electronic messages, and in what circumstances they will use alternative communications for emergency situations. Given the twenty-four-hour, seven-day-a-week availability of an online environment, as well as the inclination of increased disclosure online, clinical clients may be more likely to disclose suicidal intentions and assume that the psychologist will respond quickly (supplements 2002 APA Ethics Code Sec. 4.05)

4. *Secure Communications/Electronic Transfer of Client Information:* Psychologists, whenever feasible, use secure communications with clinical clients, such as encrypted text messages via e-mail or secure websites and obtain consent for use of non-secured communications.<sup>19</sup> Non-secure communications avoid using personal identifying information.<sup>20</sup> Considering the available technology, psychologists make reasonable efforts to ensure the confidentiality of information electronically transmitted to other parties.

5. *Access to and Storage of Communications:* Psychologists inform clients about who else may have access to communications with the psychologist, how communications can be directed to a specific psychologist, and if and how psychologists store information. Psychologists take steps to ensure that confidential information obtained and or stored electronically cannot be recovered and accessed by unauthorized persons when they dispose of computers and other information storage devices. Clinical clients are informed of the types of information that will be maintained as part of the client's record.

6. *Fees and Financial Arrangements:* As with other professional services, psychologists and clients reach an agreement specifying compensation, billing, and payment arrangements prior to providing telepsychology services (Supplements 2002 APA Ethics Code Sec. 6.04).

7. *Supervision:* The type(s) of communications used for distance supervision is appropriate for the types of services being supervised, clients and supervisee needs. Distance supervision is provided in compliance with the supervision requirements of the psychology licensing board. Psychologists should review state board requirements specifically regarding face-to-face contact with supervisee as well as the need for having direct knowledge of all clients served by his or her supervisee. Distance supervision is usually intended to supplement rather than replace face-to-face supervision.

8. *Assessment:* When employing psychological assessment procedures on the internet, psychologists familiarize themselves with the tests' psychometric properties, construction, and norms in accordance with current research. Potential limitations of conclusions and recommendations that can be made from online assessment procedures are clarified with the client prior to administering online assessments (Supplements 2002 APA Ethics Code 9.06).

*Expiration and Review Date:* These guidelines will expire in five years after their formal adoption unless reauthorized or replaced prior to that date.



## Seven Basics of Ethical Behavior

*Kenneth S. Pope Ph.D., ABPP & Melba J.T. Vasquez Ph.D., ABPP*

*Re-Printed with Permission*

We first published this list in our 1991 book, *Ethics in Psychotherapy and Counseling: A Practical Guide*, and have presented and discussed it in each edition.

Here are 7 fundamental assumptions about ethics:

1) Ethical awareness is a continuous, active process that involves constant questioning and personal responsibility.

Conflicts with managed care companies, the urgency of patients' needs, the lack of adequate support, the possibility of formal complaints, mind-deadening routines, endless paperwork, worrying about making

ends meet, exhaustion, and so much else can block our personal responsiveness and dull our sense of personal responsibility. They can overwhelm us, drain us, distract us, and lull us into ethical sleep. Our work requires constant alertness and mindful awareness of the ethical implications of what we choose to do and not do.

Maintaining ethical awareness includes acknowledging and taking into account our very human lack of perfection. All of us have weaknesses, vulnerabilities, and blind spots. The dramatic differences are not so much between those who have many human imperfections and those who have few but between those who are freely open--to

themselves and to others--about how their own short-comings affect their work, and those who tend to see others as inferior versions of themselves.

The ability to maintain ethical awareness also depends on our ability to take care of ourselves, to recognize when being tired, bored, unhappy, angry, scared, demoralized, or anxious hampers our work, and to do something about it. The chapter on "Creating Strategies for Self-Care" offers ideas on how we can recognize when our lack of enthusiasm, resilience, meaning, and joy in our work begins to make us less effective, and the steps we can take to prevent that from happening

or to turn things around it when it is happening.

2) Awareness of ethical codes is crucial, but formal codes cannot take the place of an active, thoughtful, creative approach to our ethical responsibilities.

Awareness of ethics codes is crucial to competence in the area of ethics, but the formal standards are no substitute for an active, deliberative, and creative approach to fulfilling our ethical responsibilities. Codes prompt, guide, and inform our ethical consideration; they do not shut it down or replace it.

Ethical practice never means following a code in a rote, thoughtless manner. Each new client, whatever his or her similarities to previous clients, is unique. Each situation is unique and constantly changing -- Time and events do not stand still. Our theoretical orientation, the nature of our community and the client's community, our culture and the client's culture, and so many other contexts shape what we see and how we see it. Every ethical decision must take these contexts into account.

The codes may steer us away from some clearly unethical approaches. They may shine a light on important values and concern. But they cannot tell us what form these values and concerns will take. They may set forth essential tasks, but they cannot spell out the best way to accomplish those tasks with a unique client facing unique problems in a specific time and place with limited resources.

3) Awareness of relevant legislation, case law, and other legal standards are crucial, but legal standards should not be confused with ethical responsibilities

One of the most common ethical rationalizations is to excuse some clearly unethical act by saying, "What I did broke no law." Ethical awareness avoids the comfortable trap of aiming low, of striving only to get by without breaking any law. Practicing "defensive therapy" -- making risk management our main focus -- can cause us to lose sight of our ethical responsibilities and the ethical consequences of what we say and do.

Though often compatible, the legal framework is different from the ethical framework. Ethical awareness requires clearly distinguishing the two, and alertness to when they conflict with each other.

4) We believe that the overwhelming majority of therapists and counselors are conscientious, dedicated, caring individuals, committed to ethical behavior. But none of us is infallible.

All of us can -- and do -- make mistakes, overlook something important, work from a limited perspective, reach conclusions that are wrong, hold tight to a cherished belief that is misguided. We're aware of many barriers between us and our best work, but we may underestimate or overlook some of those barriers. Part of our work is questioning ourselves. "What if I'm wrong about this?" "Is there something I'm overlooking?" "Could there be another way of understanding this situation?" "Are there other possibilities?" "Could there be a more creative, more effective, better way of responding?"

5) Many of us find it easier to question the ethics of others than to question our own beliefs, assumptions, and actions. It is worth noticing if we find ourselves preoccupied with how wrong others are in some area of ethics and certain that we are the ones to set them right, or at least to point out repeatedly how wrong they are.

It is a red flag if we spend more time trying to point out other peoples' weaknesses, flaws, mistakes, ethical blindness, destructive actions, or hopeless stupidity than we spend questioning and challenging ourselves in positive, effective, and productive ways that awaken us to new perspectives and possibilities. Questioning ourselves is at least as important as questioning others.

6) Most of us find it easier to question ourselves on those intriguing topics we know we don't understand, that we stumble onto with confusion, uncertainty, and doubt. The harder but more helpful work is to question ourselves about our casual certainties. What have we taken for granted and accepted without challenge? Nothing can be placed off-limits for this questioning.

Certainties can be hard to give up, especially when they've grown to be part of us. They become landmarks, helping us make sense of the world, guiding our steps. But perhaps an always-reliable theoretical orientation begins distorting our view of a new patient, leading us to interventions that make things worse. Or having always prided ourselves on the soundness of our psychological evaluations, we keep rereading our draft report in a case in which an unbiased description of our findings may bring about a tragic injustice, harming many innocent people, and begin to wonder if our feelings for

the client led us to shade the truth. Or the heart of our internship has been the supervision and we've made it a point to tell the supervisor everything important about every patient, except about getting so aroused every time with that one patient, the one who is not very vulnerable at all and doesn't really need therapy, the one we keep having fantasies of asking out after waiting a reasonable time after termination and then, if all goes well, proposing to.

We must follow this questioning wherever it leads, even if we venture into territories that some might view as "politically incorrect" or-- much more difficult for most of us-- "psychologically incorrect" (Pope, Sonne, & Greene, 2006).

7) As psychologists, we often encounter ethical dilemmas without clear and easy answers.

As we seek to help people who come to us because they are hurting and in need, we confront overwhelming needs unmatched by adequate resources, conflicting responsibilities that seem impossible to reconcile, frustrating limits to our understanding and interventions, and countless other challenges. We may be the only person a desperate client can turn to, and we may be pulled every which way by values, events, limited time, and limited options. Our best efforts to sort through such challenges may lead us to a thoughtful, informed conclusion about the most ethical path that is in stark contradiction to the thoughtful, informed conclusion of a best friend, a formal consultant, our attorney, or the professional groups we belong to. The personal responsibility each of us has for our ethical decisions and our acts cannot be shifted to someone else or to a professional group. There is no legitimate way to avoid these ethical struggles. They are part of our work.

Pope, K.S., Sonne, J.L., & Greene, B.G. (2006). *What Therapists Don't Talk About And Why: Understanding Taboos That Hurt Us And Our Clients*. Washington, DC: American Psychological Association.

Pope, K.S., & Vasquez, M.J.T. (2007). *Ethics in Psychotherapy and Counseling: A Practical Guide*, 3rd Edition. San Francisco, CA: Jossey-Bass, An Imprint of Wiley.



# Informed Consent in Psychotherapy & Counseling: Forms, Standards & Guidelines, & References

*Dr. Ken Pope recently updated his webpage of resources for thinking through the process of informed consent.*

[www.kspope.com/consent/index.php](http://www.kspope.com/consent/index.php)

## Forms



[links to a variety of forms](#) for informed consent, including:

[Sample Psychotherapist-Patient Contract](#), Sample Forensic Informed Consent Contract, Sample Outpatient Services Agreement for Collaterals from the American Psychological Association Insurance Trust

[Informed Consent for Psychotherapy](#), Note-taking form for psychotherapy, Agreement to work with attorney as a forensic expert, Informed consent for forensic assessment from Laura S. Brown, Ph.D., ABPP

[Adolescent Informed Consent for Psychotherapy](#), Clinical Consultation Contract, "Notice of Privacy Practices" (Informed Consent around Limits of Confidentiality); Confidentiality Contract (Couples Therapy) from the Center for Ethical Practice);

## Excerpts



Excerpts addressing informed consent from the [standards and guidelines](#) of professional associations (with links to the original documents) including:

American Association for Marriage & Family Therapy; American Association of Christian Counselors; British Association for Counselling & Psychotherapy; American Group Psychotherapy Association; American Mental Health Counselors Association; American Psychoanalytic Association; American Psychological Association; Canadian Counselling Association; Canadian Psychiatric Association; Canadian Psychological Association; European Federation of Psychologists' Associations and other organizations;

## Quotations



A diverse collection of quotations and information about informed consent from articles, books, and studies:

"Informed Consent Is More Than a Patient's Signature" by Daniel K. Sokol. *British Medical Journal*, vol. 339, August 27, 2009. Excerpt: "Too often 'consenting' a patient is reduced to the mechanistic imparting of information from clinician to patient or, worse still, the mere signing of a consent form, rather than the two way, meaningful conversation between clinician and patient it should be. If we can change this mindset and view obtaining consent as an ethical duty first and foremost, one that is central to respecting the autonomy and dignity of patients, then we will have taken a major step towards first class consent and uninterrupted lunches."

## More Quotations from [www.kspope.com/consent/index.php](http://www.kspope.com/consent/index.php)

"Consent" by John R. Williams. Chapter in *The Cambridge Textbook of Bioethics* edited by Peter A. Singer & A. M. Viens (Eds.). New York: Cambridge University Press, 2008. "Obtaining consent is not a discrete event; rather, it is a process that should occur throughout the relationship between clinician and patient.,,, Although the term 'consent' implies acceptance of a suggested treatment, the concept of consent applies also to the choice among alternative treatments and the refusal of treatment."

*Ethics in Psychotherapy & Counseling: A Practical Guide, 4th Edition* by Kenneth S. Pope & Melba J.T. Vasquez. San Francisco: Jossey-Bass/John Wiley, in press. "The right to informed consent reflects respect for individual freedom, autonomy, and dignity. It is fundamental to the ethics of therapy and counseling. The APA ethics code (see Appendix A) sets forth specific standards for informed consent.... Truscott and Crook (2004) note that 'informed consent is the most represented value in the Canadian Code of Ethics for Psychologists; (p. 55; the Canadian Code of Ethics for Psychologists is Appendix B)."

# Commentary: *Tarasoff* Duties Arising From a Forensic Independent Medical Examination

Thomas G. Gutheil, MD & Archie Brodsky, BA

Originally published in *The Journal American Academy of Psychiatry and Law* Vol. 38, No. 1 © American Academy of Psychiatry and the Law Reprinted in *Manitoba Psychologist* with Permission

Several jurisdictions have adopted the reasoning in *Tarasoff v. Regents of the University of California*,<sup>1-4</sup> defining a duty to third parties when a patient of a mental health professional threatens harm to another individual. The original decision stressed the role of "public peril" and the special relationship between treater and patient. Both the language of applicable cases and statutes and the implicit contexts in which such a duty arises are clinical in focus; that is, when present, the duty devolves on a clinician who is treating a patient.

Given that the relationship between examiner and examinee has been distinguished from the traditional doctor-patient relationship,<sup>5-7</sup> is there a comparable duty for the forensic examiner? Because that treater-examiner distinction is in dispute in some jurisdictions, a question might be raised as to whether an analogous rationale applies (i.e., is forensic evaluation the practice of medicine?). Assuming that some duty may, in fact, arise, the question remains open of what the duty may be and how it is discharged.

A thoughtful discussion of the specific relationship to mandated child abuse reporting appears in remarkable synchronicity in the excellent review by Kapoor and Zonana<sup>8</sup> (Abstract on next page). The authors note the tension between widespread requirements for mandatory reporting of child abuse and ethics-related concerns about medical confidentiality. The matter stands in contrast to *Tarasoff* requirements, which are highly variable from state to state and tend to emerge from particular features of the cases in question rather than from statutory mandates. The present article further explores these questions. The core question is couched in the following case example.

## CASE SCENARIO

In your private office, you are performing an independent medical examination (IME) for some civil or criminal forensic purpose (such as emotional injury, malpractice, competence, insanity, or employment disability). You have, at the outset, given the relevant warnings

about nonconfidentiality. At some point during the examination, the examinee makes a credible threat to harm or kill someone at some undesignated time.

Given that your professional relationship with this person is different from that of a doctor and patient (whether or not the difference would be recognized in a court of law), and given that almost all relevant statutes use the term patient rather than examinee, does a duty arise for you to take some action? If we assume that a duty does arise, further questions include the basis for the duty and the matter of whether there are negligence risks both for acting and not acting on a duty. In addition, the duty may differ for an examinee on the same side of the case that retains you versus an examinee from the opposing side. Finally, what action is appropriate?

## DISCUSSION

All can agree that if the examinee bolts from the room threatening imminent violence, the police should be called; however, the case example is different from that extreme. The following dimensions appear relevant.

## INFORMED CONSENT

A useful and protective anticipatory step would be to include the possibility of action in the informed-consent process for the examination itself, either orally or in written form. Thus, language may be used such as "I am not your doctor, but under certain circumstances I may have to act as though I were" or "If certain conditions arise that might raise a concern about your injuring yourself or someone else, I may have to intervene" or "to take steps to prevent that and to protect both that person and you." Of course, even if such a warning were not given, duties may arise in any case, perhaps contained within the basic warning about the nonconfidentiality of forensic examinations. The examinee has been warned that the examiner has permission to report certain information to certain parties, but does that imply a warning about a duty to report or take other action that also effectively

breaches confidentiality? In other words, is the basic warning about the limited confidentiality of an IME sufficiently comprehensive? In the service of confidentiality, an examinee may also be warned about not using any identifiable names.

Special emphasis may be laid on the importance of careful definition of warnings when forensic examiners repeatedly see certain populations—for example, in a fitness-for-duty examination, those whose work involves being armed, such as police officers, security guards, and the like. When common dramatic expressions of frustration are made in strong language that might be interpretable as threats, even when not intended as such, overreacting may result in severe damage to careers, even when the evaluation would not otherwise produce that result. Likewise, in some cases a cross-cultural perspective is needed to interpret exclamations such as "I'll kill that guy!"

## PROTECTION

Considering first the "duty to protect," note that both the threatener and the threatened are protected by responsive action. The potential victim is protected from the threatened violence, and the threatener is protected from the consequences of potential action, such as prosecution and its after-effects. For purposes of the examination, the examiner's alliance is with the healthy side of the examinee that does not wish to act in a way that produces dire consequences. If, after having been so warned, the examinee still evinces a threat, the threat is all the more credible and the examiner's actions more defensible if later challenged. Assessing whether the examinee appreciates and factors in the warning before issuing the threat allows an evaluation of the examinee's capacity for judgment and self-restraint. A better assessment of the level of risk involved may accrue from inquiring actively into the examinee's intent in making an open threat during an evaluation.

In essence, the essential protective role of clinician may be impossible to set aside, even

for forensic purposes. That is, the role of licensed health care provider acting within a professional capacity may give rise to a duty (whether conceived in ethical or legal terms) to avert harm. Massachusetts, for example, has such a statute. A medical professional may incur an irreducible duty founded in ethics, even when acting in a forensic role. This duty is as likely to arise from the medical professional's felt sense of mission as it is from external pressures or feared sanctions. To say, "In emergencies, I cannot forget that I am a doctor" is to move up the moral hierarchy from the narrowly legal to the clinical and ethical.

Moreover, the protection of society or of the general public may be a broad requirement that cuts across various role functions and triggers in each a duty to take action. Failure to act may be seen (in practice, if not with a clear legal basis) as turning the examiner into an accomplice of the examinee.

#### TREATER VERSUS EXPERT: ROLE FUNCTIONS

Whether the fine distinctions that forensic specialists make between clinical and forensic roles would be accepted by the larger society (particularly by judges and juries) if harm resulted is an open question. The examiner may well be seen, by some form of the "last clear chance" legal doctrine, to have had the best opportunity to avert the harm.

#### DUTIES TO THIRD PARTIES

The duty to third parties, the fundamental novelty of the *Tarasoff* case, may have derived from the principle, described in the Restatement (second) of Torts (Ref. 7, § 315) of a "special relationship" between the parties, presumably different from but parallel to the doctor-patient relationship, as presupposed by *Tarasoff*.

In a significant case, *Hopewell v. Adibempe*,<sup>9</sup> liability was found against a treater who inappropriately and maladroitly gave a *Tarasoff* warning, not to a potential victim, but to the personnel office of the victim's and threatener's company<sup>10</sup>—an unnecessarily wide breach of confidentiality. Its consequences were liability for that treater.<sup>10</sup> This case, arising from a clinical context, suggests that some circumspection about *Tarasoff*-type warnings is expected.

#### ACTING ON THE DUTY

Several actions may serve to discharge the duty. One approach would be to give the first warning or report to the retaining attorney; indeed, absent a statutory command (e.g., in the case of child abuse), one's first obligation is to the person who has hired the examiner (Griffith EEH, personal communication, September 2009). Before calling the police directly, the examiner should attempt to enlist

the attorney to take responsible action. The question arises as to whether the attorney, as well, should be informed and warned at the outset of retention of an examiner's potential duty to respond to a threat of violence by the client. This may avoid dismaying the attorney when, as a result of the examination, the client is in more trouble than before. However, absent any statutory provisions to the contrary, some jurisdictions (e.g., Maryland; Zonana H, personal communication, September 2009) take the position that a forensic examination falls under attorney-client privilege, which would preclude reporting. It is likely that mandatory reporting for child abuse, say, would still be required.

If the client being examined is from the opposing side, as is commonly the case in an IME, the situation with respect to the examiner's agency is more complex; notifying the opposing attorney as well as the examiner's retaining attorney would still seem a reasonable first step. If available, the examinee's treating professional should also be informed.

Kapoor and Zonana<sup>8</sup> offer a helpful four-point set of recommendations, with which we concur, to deal with the dilemma under consideration. The recommendations may be paraphrased as follows:

1. Know your statutory obligations.

## Forensic Evaluations and Mandated Reporting of Child Abuse

*Reena Kapoor, MD and Howard Zonana MD*

*The Journal of the American Academy of Psychiatry and the Law, Vol. 38 (2010)*

**Abstract:** Statutes requiring physicians to report suspected cases of child abuse create a potential conflict for psychiatrists working in the forensic setting. What happens in the case in which a forensic psychiatrist, during the course of an evaluation requested by a defense attorney, learns about child abuse perpetrated by the evaluatee? A complicated legal, ethics-related, and interpersonal dilemma emerges. Reporting the abuse may contribute directly to further legal harm to the evaluatee and place a strain on the relationship with the attorney. However, not reporting the abuse potentially involves ignoring a legal mandate and risking further harm to a child. This article first reviews mandated reporting statutes across the states. Next, the arguments for and against reporting are outlined. Existing solutions to the problem are reviewed, and several alternative solutions are explored. Finally, an approach to negotiating the dilemma that can be used by forensic psychiatrists in practice is suggested.



2. Think about confidentiality warnings, both to examinee and retaining attorney, in advance.
3. If the decision is made to report, discuss reporting obligations (including mandated ones) with the retaining attorney before making the report, to preserve the working relationship.
4. Report in a manner that parsimoniously discharges the obligation but does not deliberately cause harm to the examinee.

Whether giving a warning, taking other action, or deciding not to take action, the examiner will clearly benefit from the twin pillars of liability prevention: documentation and consultation.

While documentation would obviously be essential no matter which way the decision went, consultation is more problematic, since there might not be sufficient time or a consultant available to provide timely input. Thus, many such consults would occur after some action or no action had been taken. A warning given after some delay in obtaining a consult would still be potentially useful, although perhaps too late to prevent the harm in question.

#### CONCLUSION

The questions posed are a first step toward outlining principles and practice in the particular medicolegal situation envisioned here—one for which neither case law nor professional literature has established clear standards. Does that situation require newly

conceived principles or practices? In general terms, probably not. A normal sense of personal and professional responsibility is applicable in this context, as it is in others. First, avoid acts of commission or omission that would foreseeably shock the conscience of society (including licensing boards, ethics committees, judges, and juries). Second, do the least possible harm while taking steps to prevent others from doing harm.

The application of these principles is, of course, context-specific and case-specific. The discussion herein points to ways in which generally accepted (and in some cases clinically derived) principles of ethics and risk management can be fine-tuned to fit the situation described. Kapoor and Zonana's article indicates that the discussion here is not merely theoretical.

Future explorations may address whether the initial nonconfidentiality warning is sufficient to cover the subsequent reporting of threats made by the examinee and what constitutes the most responsible and effective sequence of actions to take when a credible, serious threat is made. Contributions to these explorations from clinical, ethics, and legal perspectives are welcomed.

#### ACKNOWLEDGEMENTS

The authors thank members of the Program in Psychiatry and the Law, James T. Hilliard, Esq., Eric Drogin, JD, PhD, Paul S. Appelbaum, MD, and Howard Zonana, MD,

for critical comments and Hébert Georges, MD, for raising the original question.

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Save this Date:  
February 22, 2011  
6:30 - 9:00 pm

PAM Town Hall Meeting  
Room A-106 Chown Building (UofM Bannatyne Campus)

Your Executive Council strongly encourages you to attend this Town Hall, which will review proposed changes to the ways in which psychologists are registered.

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*Manitoba Psychologist* is published twice each year in Spring and Fall by the Psychological Association of Manitoba (ISSN0711- 1533) and is the official publication of the Psychological Association of Manitoba. Its primary purpose is to assist P.A.M. in fulfilling its legal responsibilities concerning the protection of the public and regulation of psychology in Manitoba. It also seeks to foster communication within the psychological community and between psychologists and the larger community.

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