Is There a Slippery Slope? Considerations Regarding Multiple Relationships and Risk Management

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There are much anecdotal data regarding how boundary violations occur. Specifically, an informal consensus seems to have developed that such improprieties occur because of a notion commonly referred to as the "slippery slope of psychotherapy" (Gutheil & Gabbard, 1993). This notion implies that once a mental health professional crosses a boundary, a domino effect occurs whereby s/he is led through a rapid and increasingly serious series of violations at an almost exponential rate. In this article, we question the potential danger of this notion and argue that while such situations do arise, they are uncommon. We bring together ethics and research scholarship from a variety of sources to offer a more complex understanding of how such cases may arise and make recommendations regarding what practitioners can do to reduce them further.

Keywords: boundaries, ethical decision making, multiple relations, slippery slope, risk management

"The simplest and shortest ethical precept is to be served as little as possible and to serve others as much as possible."
—Leo Tolstoy

Gutheil and Gabbard (1993) used the phrase "slippery slope of psychotherapy" to help explain the development of boundary violations in psychotherapy. Some have argued that this idea has done more harm than good by causing practitioners to be needlessly apprehensive regarding even the slightest departure from traditional practice, lest it be the first step down the slippery slope to a boundary violation (Pope & Vasquez, 2007). Others have gone further and argued that practicing in such a cautious manner may actually be harmful to patients (e.g., Lazarus & Zur, 2002; Williams, 2002; Zur, 2007). In this article, we conclude that the slippery slope exists but that the frequency with which minor boundary crossings lead to major boundary violations is greatly exaggerated. Rather, we hold that psychologists may occasionally cross boundaries yet still practice safely. We begin by reviewing the extant data regarding disciplinary infractions and list our assumptions. Then we provide a selected historical overview regarding the issue of boundaries, placing it in a contemporary context. Next, we review the Ethics Acculuration Model (EAM) (Handelsman, Gottlieb, & Knapp, 2005), explain the notion of positive ethics (Handelsman, Knapp, & Gottlieb, 2002; Handelsman, Knapp, & Gottlieb, in press), and introduce the role of intuitive processes (Kahana, 2003) and motivation toward self-worth (e.g., Chugh, Bazerman, & Banaji, 2005) in ethical decision-making. Recent work on risk management is discussed next (Bennett et al., 2006), and we show how it can be used as an expanded framework for understanding ethical infractions. Finally, we synthesize these different strains of scholarly thought and conclude with recommendations for practitioners.

A Reality Check

In 2004, Kirkland, Kirkland, and Reaves published findings from the Association of State and Provincial Psychology Boards (ASPPB) database. They reported that between 1983 and 2001, there were 2,638 disciplinary actions taken by their member boards, for an average of 146.5 actions per year. Assuming that these data are based upon an approximate total of 100,000 psychologists in the United States and Canada (personal communication, Roberta Nutt, Association of State and Provincial Psychology Boards, March 25, 2008), the probability of an individual practitioner being disciplined in any given year would be ~.00145. However, this finding is generally considered to be an underestimate of the true incidence of psychologist misconduct for a number of reasons.

First, Van Horn (2004) showed that 2% of licensed psychologists are investigated by state licensing boards in any given year. Hence, the number of complaints, although not found meritorious,
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far exceeds findings of violation. Second, while some states, such as Texas and California, publish all findings of violation, some do not. For example, Minnesota engages in negotiated settlements whereby a licensee accepts discipline and remediation in exchange for the state board agreeing not to make the action public (personal communication, Gary Schoener, January 9, 2009). In such cases, a board may choose to reeducate, caution, or supervise a psychologist whose behavior has fallen below the standard of care, but based on federal peer review laws, may be required to keep the actions confidential (personal Communication, Eric Harris, January 11, 2009).

Finally, self-report survey data indicate that the incidence of misconduct far exceeds the number actually reported. An early study of this problem revealed that 4.58% of female patients became sexually involved with their own therapists (Pope & Feldman-Summers, 1992). More recently, Lamb, Catanzano, and Moorman (2003) found that 3.5% of male psychologists reported inappropriate sexual contact with former patients. As a result, it is not surprising that 28% of cases opened by the APA Ethics Committee (2008) in 2007 surrounded sexual and nonsexual dual relationships.

From these data we conclude that the profession should not be entirely reassured by the ASPPB findings because boundary violations clearly exceed the number reported. On the other hand, it remains true that the vast majority of psychologists practice safely, and even among those who are investigated, few are disciplined.

Assumptions

1. The slippery slope represents a potential vulnerability for all practitioners, but based on the findings above we assume that the overwhelming majority of psychologists practice safely and that it is extremely unlikely that they will ever be disciplined for boundary violations. We assume this to be true because they practice good boundary management, even if they employ what some may consider nontraditional techniques. Therefore, when they cross boundaries, they most likely do so in a thoughtful manner that is appropriate to the therapeutic context and pose little or no risk to patients, the psychotherapy process, or themselves.

2. There are a small number of practitioners in all professions who ignore professional standards, do not respect professional boundaries, act as they please, and exploit others. We contend that such persons are dangerous and should not be practicing.

3. There is a somewhat larger and more heterogeneous group that is more vulnerable to boundary violations based on a variety of factors we discuss below.

Boundaries: An Overview

Sexual Misconduct

The early history of psychotherapy is replete with examples of sexual relationships between patients and their psychotherapists (e.g., Kerr, 1993). This history may seem quite ancient today until one realizes that the APA did not prohibit sexual relations with patients until 1977 (APA, 1997), but this ban did not end the debate. For example, if it was not acceptable to have sexual relations with current patients, was it acceptable to become sexually involved with former patients? Apparently it was not; two surveys from the early 1980s found that many state regulatory boards were holding practitioners accountable for sexual involvement with current and former patients alike (Gottlieb, Sell, & Schoenfeld, 1988; Sell, Gottlieb, & Schoenfeld, 1986). These data, along with other forces, led the APA to modify the ethics code once again by making it all but impossible to engage in sexual relations with former patients (APA, 1992, Standard 407(b); APA, 2002, Standard 10.08). This step essentially ended the controversy regarding sexual relations, but it was only the beginning of the debate regarding the broader issue of professional boundary maintenance.

The Evolving Concept of Boundaries

With the issue of sexual relations resolved, the profession focused on what kinds of relationships practitioners could ethically have with current and former patients. It soon became obvious that this was a very complex problem that presented vexing ethical dilemmas, especially for those who worked in a variety of contexts such as rural areas, small religious organizations, lesbian/gay/bisexual/transgendered communities, the military, correctional settings, university settings, and other confined communities. It was during this period that three developments provided a major advance in the thinking of the profession. (For further reading, see Gottlieb, Younggren, & Murch, 2009.)

First, terminology changed. Originally, the term dual relations was changed to multiple relations (APA, 1992). This modification was helpful because it more accurately reflected the complexity of contemporary practice by emphasizing that practitioners could have a variety of relationships with the same patient. Second, the profession came to understand that such complexity was not tantamount to unethical behavior and that practitioners could have multiple relations that were not necessarily exploitive (Gottlieb, 1993; Younggren & Gottlieb, 2004). Third, the profession recognized that patients could also be harmed by a variety of nonsexual multiple relations.

Boundary Violations, Boundary Crossings, and the Slippery Slope

One would have expected the developments described above to have quelled the controversy, but this was not the case. For example, some authors (e.g., Ebert, 2006; Lazarus & Zur, 2002; Williams, 2002; Zur, 2007) passionately argued that the profession was still being too rigid and proscribing legitimate behavior that if withheld could harm patients. First, they contended that the rules restricted practitioners from practicing in nontraditional (i.e., nonpsychodynamic) ways and that such prohibitions precluded a more flexible approach to boundaries that could benefit certain patients. Second, they complained that such restrictive models created greater vulnerability to both civil actions and state licensing board complaints. Finally they believed that, unless some increased degree of flexibility in dealing with boundaries was permitted, the profession would be unable to develop effective treatments (Zur, 2007).
It is hard to understand this position given the existing literature. Sixteen years ago Guthiel and Gabbard (1993) introduced the notion of the slippery slope to explain how practitioners become sexually involved with patients. They described a gradual process, abstracted from physics, in which sexual acts were preceded by a series of boundary crossings that did not have negative results per se; rather, each had a desensitizing effect that made the next boundary crossing easier. Furthermore, they implied that this erosion was frequently something of which the practitioner was unaware and that at some point, as in physics, the momentum of the previous boundary crossings forced the professional into boundary violations.

A similar notion also exists in logic. Non causa pro causa refers to fallacious reasoning to a conclusion about causality (http://www.falacyfiles.noncause.html). As a syllogism it states that:

If A happens, then by a gradual series of small steps through B, C, . . . X, Y, Z will eventually happen, too.

Z should not happen.

Therefore, A should not happen either. (http://www.falacyfiles.org/slipstep.html)

The analogies from physics and logic argue that once one steps on the slippery slope that the descent into boundary violations is inevitable. We do not accept that appropriate boundary crossings are tantamount to stepping on the slippery slope or that they automatically lead to boundary violations. In fact, much literature exists to help practitioners avoid this. For example, in the same year that Guthiel and Gabbard published their work, Gottlieb (1993) proposed a model of ethical decision-making in which professionals might have multiple relations with consumers that avoided exploitation. Shortly thereafter, Smith and Fitzpatrick (1995) defined boundary crossing as "a nonpejorative term that describes departures from commonly accepted clinical practice that may or may not benefit the client" (p. 500). This definition helps to clarify the distinction between boundary crossings and boundary violations, reemphasized the fact that boundary crossings were not necessarily sexual or improper, and assisted practitioners in making judgments regarding what types of nontraditional and/or nontherapeutic contact might be appropriate and permissible.

From this brief review, we conclude that the relationships practitioners have with patients, and the boundaries they maintain, are complex and should not be fixed by rigid rules. We view this increased flexibility as a healthy development, reflective of the increased variety of services psychologists offer and the diversity of contemporary practice. On the other hand, these developments also create the possibility that practitioners will have more complex relationships with patients, and that these relationships will require more careful management and thoughtful decision-making.

This raises two questions: Are some practitioners more vulnerable to poor boundary management than others? Do others become more vulnerable in particular circumstances? We think the answer to both of these questions is yes, and we offer the information below as an exploratory framework.

A Broader View

Ethics Acculturation Model

Handelsman, Gottlieb, and Knapp (2005) adapted Berry's model of cultural adaptation and acculturation (Berry, 1980, 2003; Berry & Sam, 1997) to ethics training and proposed that students needed to integrate their personal, ethical, and value traditions with those of professional psychology. Berry's model employs two variables to explain the acculturation process. The first, Maintenance, refers to the degree to which students retain the ethical and value traditions of their culture of origin. The second variable, Contact and Participation, refers to the degree to which students adopted the norms and values of their new professional culture (Handelsman et al., 2005). Depending on the Maintenance of personal values and Contact and Participation with the new culture of psychology, students may, consciously or unconsciously, choose one of four strategies of ethical acculturation.

When students are relatively high on both Maintenance and Contact, they use an integration strategy. This is the best possible choice because it means that students can incorporate the ethical values of psychology and maintain their personal values. For example:

Dr. I. Ken See Clearly-Now was a prominent and respected member of his professional community. He offered very popular ethics workshops, and many colleagues consulted him as patients. When he was 40 years old, Dr. Clearly-Now went through a painful divorce. He found himself distracted, irritable, and having romantic fantasies about one of his young female patients. He realized what was happening to him and became terrified that he would harm her. As a result, he immediately put himself in treatment and asked a trusted colleague to consult with him routinely regarding how he was managing his patients, especially the one to whom he was attracted.

Dr. Clearly-Now realized that his fantasies represented a first step down the slippery slope; his insight helped him recognize his vulnerability so that he could manage the situation appropriately and protect his patient. We contend that colleagues such as he are the least likely to commit ethical infractions because their personal and professional values support each other and guide them to good decisions even when they are distressed.

Two other acculturation strategies represent less optimal alternatives. Separation is a strategy that is high in Maintenance but low in Contact and Participation (Berry & Sam, 1997). Here, practitioners who have not fully inculcated the values of professional psychology may be more likely to make professional decisions based on their personal values, believing that they do not need any additional rules to govern their professional behavior. Consider the following example:

Dr. Meiway Is Better came from an extremely tight-knit family. Her parents and many extended family members were involved in a successful business, and she attended school with many of her cousins. Dr. Better found the closeness of her family a great comfort, and as she grew into adulthood, came to appreciate it all the more. Yet,

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Despite her professional training regarding boundary maintenance and her intellectual understanding of its importance, it remained difficult for her to respect patient boundaries as much as some of her colleagues felt she should.

Is Dr. Better at risk for heading down the slippery slope? Is she already on it? If boundaries are not fixed, does the fact that Dr. Better draws them at a different place make her a danger? We think it unlikely. While she might be more likely than other practitioners to hug patients in distress, give or accept small gifts, or attend life-cycle events, her cultural values also taught her that there are certain interpersonal boundaries that must be maintained. It is this value that will keep her and her patients safe.

The second less than optimal strategy, assimilation (Berry & Sam, 1997), refers to an overidentification with professional standards to the extent that practitioners may lose many of their own personal values. In an effort to develop their professional identities, students may divorce themselves from their personal values in the belief that they are no longer necessary (Gottlieb, Knapp, & Handelsman, 2008). Those who adopt the assimilation strategy demonstrate literal compliance with rules and laws but lack a moral foundation that may lead them to “overly simplistic applications of our ethical principles” (Handelsman et al., 2005, p. 61). Consider the following example:

Dr. Ben A Flower-Child described himself as having been “raised by hippies.” While his parents always insisted that he attend school, they imposed few other restrictions on him. Despite his unstructured home environment, he was a conscientious student and was never in trouble with the law. He always hoped to help others and was pleased when he was admitted to a doctoral program in clinical psychology. As a second-year student, he found his ethics class very interesting. Issues were raised that he had never considered, and the ethics code and state board rules all made immediate sense to him; he felt he had found a professional and personal home. Yet, his supervisors sometimes found his rule adherence rather rigid and wondered why he could not entertain multiple perspectives in his treatment planning and ethical decision-making.

Dr. Flower-Child may maintain stricter boundaries with his patients than others, and doing so might not always be best for his patients. He may be the type of professional that Lazarus and Zur (2002), Williams (2002), and Zur (2007) had in mind when they criticized our professional standards. For example, Dr. Flower-Child’s position may restrict his ability to help some patients who might benefit from interventions with which he is not comfortable. We also worry that, lacking foundational personal values, he might be more vulnerable to boundary crossings if he were to become distressed. But, given the data (Kirkland et al., 2004; Van Horne, 2004), we do not think that even Dr. Flower-Child is highly likely to violate boundaries, but he may be more vulnerable to doing so than Drs. Clearly-Now and Better.

The fourth acculturation strategy is marginalization. This is the most problematic alternative as it represents low identification with both personal values and our professional culture. Individuals using this strategy have neither well-developed personal values nor have they internalized our professional ethics. These individuals may be lax about following legal requirements and minimize the importance of boundary maintenance. Two recent studies lend support to Barry’s model (Berry, 1980, 2003; Berry & Sam, 1997). Papadakis et al. (2005) found a strong relationship between those medical students who had difficulty in medical school as a result of “severe irresponsibility” and “diminished capacity for self-improvement” and those who later experienced disciplinary actions from state medical boards. A subsequent study by Papadakis, Arnold, Blank, Holmboe, and Lipner (2008) found a similar relationship in those internal medicine residents who exhibited “low professionalism.” Consider the following example:

Dr. Ornabie A. Trainwreck was raised in a chaotic home that left him with a variety of unmet emotional needs. He needed to be the center of attention so badly that at times he engaged in risky behavior, much to the consternation of others. He came to professional psychology somewhat later in life, having had a number of personal difficulties that delayed his educational progress. He was exceptionally bright, but he failed to inculcate psychology’s values and professional standards and followed them out of convenience. He enjoyed treating patients because he found it reinforcing, and he liked being in charge and the center of attention. While technically capable, his personal needs interfered with his objectivity and his unrealistic self-confidence prevented him from seeking assistance from colleagues.

Is Dr. Trainwreck at risk for boundary crossings that could slip into a boundary violation? Because of his poor insight and failure to have inculcated either a personal or a professional value system, we think he may be.

We believe that the vast majority of professional psychologists adopt an integration strategy and go on to useful lives and productive careers. For them, the risk of violating boundaries is minimal. The strategies of separation and assimilation may represent slightly increased risk, but even if these practitioners cross a boundary and step on the slippery slope, they are unlikely to go down it. But, to the extent that the findings of Papadakis et al. (2005) and Papadakis et al. (2008) apply to professional psychology, those who adopt the marginalization strategy may be the most dangerous. They may violate boundaries when it suits them with little or no regard for the consequences of their behavior. Such persons are a danger; they are more likely to slide down the slippery slope, and to do so rapidly, because they do not recognize its existence.

Practicing professional psychology can be very stressful work. When practitioners experience additional stress for personal reasons, they may become vulnerable to “spilling over the line” and heading down the slippery slope. The EAM provides a way to better understand who may be more vulnerable to boundary violations than others and why; two other strains of scholarly work may help us understand this problem at an even more sophisticated level.

Positive Ethics

Two additional areas of scholarship augment our thinking regarding the slippery slope. The first has been termed Positive Ethics (Handelsman et al., 2002; Handelsman, Knapp, & Gottlieb, in press). Handelsman et al. (2002) contended that ethics should be taught and practiced from a more positive or aspirational perspective, with the goal of shifting the emphasis from avoiding professional misconduct to a “more balanced and integrative approach that includes encouraging psychologists to aspire to their highest ethical potential” (Handelsman et al., 2002, p. 731). In this way, Handelsman and his colleagues believed that practitioners would
come closer to fulfilling their own personal goals, practice at a higher level of competence, and reduce the probability of ethical infractions. Dr. Clearly-Now exemplified this idea. Unfortunately, all psychologists may not have the knowledge and/or personal skills to pursue these goals. Drs. Better and Flower-Child might be somewhat more limited in this regard, but they still may work toward achieving their aspirational goals; Dr. Trainwreck does not feel the need to do so. We conclude that those who endeavor to practice from the perspective of positive ethics reduce even further the risks associated with the slippery slope.

**Intuitive Processes and Self-Serving Bias**

The General Principles in the Ethical Principles of Psychologists and Code of Conduct (APA, 2002) are drawn from philosophically based bio-medical ethical principles (e.g., Beauchamp & Childress, 2009). Using these principles, and various ethical decision-making models (e.g., Haas & Malouf, 2005), psychologists are taught that ethical reasoning should consist of a rational, deliberative, and quasi-legal, cognitive process that should lead one to the best possible solution. The EAM and positive ethics expanded the notion of ethical decision-making to include one’s cultural values and personal goals. Yet, this work stands in contrast to a well-developed body of empirical work generally termed behavioral economics. This research contains two relevant elements.

First, Kahneman and Tversky (1979) revealed a troubling state of affairs. They showed that individuals actually fail to acknowledge their own biases with regard to information gathering, hypothesis testing, judgments of probability and risk, and concepts of uncertainty. In addition, they demonstrated that we are computationally limited in this regard and that automatic, unconscious, and intuitive heuristics may play a much larger role in decision-making than we have previously believed. (For a summary see Kahneman, 2003.)

Second, much research has documented a self-serving bias in human decision-making (e.g., Messick & Sennis, 1979). Some scholars have argued that this bias leads to decisions that unconsciously favor the self (e.g., Chugh et al., 2005); others have gone so far as to argue that independent judgment, free of conflict of interest, is “impossible” (Baizerman, Morgan, & Lowenstein, 1997).

These findings are most relevant in matters of conflict of interest, where our personal needs and desires can cloud our professional judgment and potentially harm patients (Gottlieb, 2008; For further reading see Chugh et al., 2005).

The EAM and positive ethics appeal to our better selves, yet the findings from behavioral economics present an empirical reality that we cannot ignore. These two perspectives provide very opposing explanations of human behavior. Unfortunately, we know of no data that tests these theories with regard to boundary violations. Until such data are available, we suggest a model of risk management that incorporates these ideas.

**Risk Management**

Recently, a sophisticated model of risk management was offered by Bennett et al. (2006) that relied on Bloom’s Taxonomy. They proposed that risk was a function of four independent factors: patient characteristics, context or setting, potential disciplinary consequences, and psychotherapist factors, all of which must be considered in deciding whether to engage in a specific type of patient interaction. Instead of a cookbook that leads to a reductive answer, their model asked ethical decision makers to “judiciously apply and integrate ethically based risk management principles in their day-to-day clinical decision making” (Bennett et al., 2006, p. 8).

Bloom (1956) and his colleagues viewed the goal of education as teaching students the ability to develop conceptual, integrative, and reflective skills that could be applied to solve real world issues. The taxonomy contains six levels. Level 1, Knowledge, entailed remembering learned information that was largely memorized. Bloom’s Level 2, Comprehension, required learners to translate material from one form to another or explain and summarize it. Level 3, Application, involved the ability to use learned information in specific situations. Both knowledge and comprehension are its prerequisites. Level 4, Analysis, described being able to break down material into its components for better understanding. Level 5, Synthesis, referred to the “ability to combine information to create meaningful structures. . . . Whereas learners at the application level applied principles routinely and mechanically, learners at the synthesis level applied strategies based on overarching principles” (Bennett et al., 2006, p. 8). Finally Level 6, Evaluation, entailed the ability to judge the value of a given response. That is, one should be able to provide good reasons for a decision, including the potential consequences of it.

The Bennett et al. (2006) formula teaches us that ethical decision-making is a complex, multi-factorial process in which unambiguously right or wrong answers are seldom available. The denominator of the formula is the III defined “psychologist factors.” We propose that this notion be expanded to incorporate the EAM, positive ethics, intuitive processes, and self-serving bias. Doing so will broaden and deepen this concept and may foster more ethical behavior.

Bloom’s taxonomy, the EAM, positive ethics, and the work on intuitive processes and self-serving bias all result from differing lines of research and are not directly comparable. For example, Bloom’s taxonomy represents a hierarchy of intellectual activity whereas the EAM is a culturally based categorical system. Positive ethics is derived from biomedical aspirational principles, whereas intuitive processes and the self-serving bias are the result of empirical work in social psychology and behavioral economics. Despite these differences, we propose that each may be useful when thinking about ethical decision-making. For example, if Dr. Flower-Child goes no further than Bloom’s Level 2, does not aspire to practice from the perspective of positive ethics, and is not sufficiently aware of his own self-serving bias, he may be at risk for boundary violations as we noted above. On the other hand, Dr. Better may be less likely to slide down the slippery slope if she operates at a higher level on Bloom’s Taxonomy, aspires to practice more positively, and has greater awareness of her limitations and understanding of her own motives.

**Recommendations**

We have drawn from differing strains of research to argue that boundary management is a far more complex and nuanced process than we have previously thought. If we are right, we will have advanced the thinking in this area. At the same time, what we have
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proposed is theoretical; hence, it is more difficult to make concrete recommendations that will improve practice and benefit practitioners. In a previous article, we (Younggren & Gottlieb, 2004) offered some recommendations regarding more effective management of multiple relationships including adequate documentation, obtaining informed consent, employing consultation, and the use of a patient oriented decision-making process. Given the more complex picture of boundary management described here, such recommendations remain necessary, but they are not sufficient and require elaboration.

1. No informed consent document can anticipate all the ethical dilemmas regarding boundary management that a practitioner may encounter. This is because effective patient care is the result of a complex interaction of numerous, elusive, and sometimes ill-defined variables. When practitioners are personally distressed, conflicts of interest may arise of which they may be unaware. Such a circumstance can challenge their ability to maintain boundaries. Nevertheless, developing a comprehensive informed consent document that anticipates some of these issues can help frame the boundaries of the relationship and foster discussion about them that is useful for patients and practitioners alike. Furthermore, practitioners should remember that informed consent is a process (Pope & Vasquez, 2007) that should be revisited whenever the clinical presentation or the practitioner’s personal circumstances change.

2. Peer consultation groups are an excellent way to help professionals function at higher levels. Not only are they useful for improved clinical care, but they can be particularly beneficial as a risk management tool when a distressed colleague can take advantage of the numerous resources offered by trusted group members. Such groups encourage the integration strategy and foster positive ethics; at their best, they can identify cognitive errors resulting from intuitive processes and self-serving bias that may represent the first step down the slippery slope. (For further reading, see Pope, Sonne, & Greene, 2006). Because there is a very low probability that vicarious liability would result from participating in such groups, psychologists should feel free to consult freely and frequently.

3. When boundary management issues have been identified, it is important to document a consultant’s suggestions in the patient’s record. When such notes include relevant ethical principles and errors in thinking, such documentation helps establish a standard of care for the consultant’s conduct. When consultation addresses serious concerns and significant issues, consultants are wise to keep their own record of the consultation.

4. A number of years ago, one of us proposed that practitioners develop their own practice ethics policies (Gottlieb, 1997). Creating such a document is intended to increase consistency in decision-making and sensitize practitioners to the common ethical dilemmas that are likely to arise in their practice niches. But, creating such a policy has an additional advantage. It can increase a practitioner’s awareness of when s/he deviates, or is considering deviating, from his/her usual and customary policies and procedures. Hence, an ethics policy can also serve as an early warning sign that may help practitioners slow down and more thoroughly consider their feelings and motives before acting.

5. Existing ethical decision-making and risk management models rely on rational and quasi-legal processes (e.g., Haas & Malouf, 2005). Recent models have taken psychotherapist factors into account (e.g., Bennett et al. 2006), and we have tried to expand the components of that element. While all of these developments are helpful, they remain theoretical. It is now time for our research colleagues to begin testing these models. The first question is whether we have isolated all relevant variables. If we have, the next task is to determine which ones best contribute to predicting behavior. For example, proposals have been made to teach and train the EAM and positive ethics to reduce ethical infractions (Gottlieb et al., 2008). But, for example, will the influence of the self-serving bias overwhelm these efforts, or can these approaches help to reduce it? Until such findings become available, practitioners may still have difficulty identifying conflicts of interest for themselves. In the interim, the role of consultation groups, personal psychotherapy, and ethics consultants cannot be over-emphasized as they play a vital role in the identification and prevention of these pitfalls.

6. Professional competence must include an understanding of how boundary crossings may change when working in a multicultural context. Failing to cross certain boundaries due to rigid rule adherence, when doing so is culturally consistent for certain patients, risks harm and is unnecessary.

7. The practice of professional psychology entails risk. Not everything one does has a positive outcome or will pass without criticism. At the same time, it is a valuable and rewarding endeavor. To approach it with anxiety based on the apprehension of sanctions can stifle professional growth and compromise patient care. We encourage psychologists to avoid this trap by using the message of positive ethics to aim high. Doing so will improve our lives and the quality of care we provide.

8. As we noted at the outset, the vast majority of psychologists provide good care and are seldom disciplined. Yet, we know that at different times and for various reasons, each of us is vulnerable to heading down the slippery slope toward ethical infraction. There is no test to measure ethics acculturation, the extent to which we practice positive ethics, or how vulnerable we are to conflicts of interest and making decisions based on intuitive processes and self-serving bias. Therefore, it behooves us to practice positive ethics by not only
taking care of ourselves but caring for our colleagues. It is not just a good thing to do; it is the right thing.

Conclusions

What then of the slippery slope? We conclude that it exists but that it is neither so steep nor as slippery as many fear. While boundary violations are relatively uncommon among professional psychologists (Bennett et al., 2006), our analysis suggests that some practitioners are more vulnerable than others, and infractions can occur whenever a practitioner loses sight of his/her professional responsibilities and/or personal motives. But, who are these practitioners? Under what circumstances are they more likely to offend? We do not know the answers to these questions, but we think that the ideas presented here provide tantalizing clues that we hope other scholars will pursue.

The quote with which we began this article is a restatement of the Judeo-Christian tradition regarding the expectations of humility, justice, and good works. At the same time, it is an elegant and poetic aphorism regarding conflicts of interest and the aspirational goals of positive ethics. So long as we remember that in choosing our profession we made a decision to serve others and have our needs met by those whom we do not serve, we will fulfill our professional obligations, help others, and serve society.

References


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**Call for Nominations:**

**Sport, Exercise, and Performance Psychology**

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