A MIXED METHODS ANALYSIS OF THE ETHICS OF BEHAVIORS AND ATTITUDES TOWARDS MAKING REFERRALS IN PSYCHOTHERAPY

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Jonathan J. Entis, MA

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Dissertation Committee:

William Sanchez, Ph.D., Advisor

Robert Volpe, Ph.D.

Mary Ballou, Ph.D.
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Literature Review:
Ethics and Making Referrals in Psychotherapy

Abstract

This review explores the ethics of making referrals in psychotherapy. Particular attention is paid to discriminatory referrals, or referrals made for reasons of bias against salient aspects of a patient’s identity, and their lack of substantive investigation within the literature. The review begins with a brief history of ethics and ethics education within the professional field of psychology, gives an overview of theoretical frameworks for evaluating ethical decisions, and summarizes some of the research on ethics in clinical practice. Finally, an overview of referrals within the context of psychotherapy and the existing research on their ethicality is offered.
CHAPTER ONE:

Ethics and Making Referrals in Psychotherapy

Psychology does not produce nuclear warheads, nor does it produce the apocalyptic birds which may take them to a selected target, but psychology is concerned with human decisions. If the concept of sin, or any similar concept of the ethically negative, has any meaning at all, it should be of interest to us as psychologists.

-Robert F. Creegan

This review covers the existing literature related to the ethics of making referrals in psychotherapy. It begins with an overview of the modern history of ethics and ethics education in professional psychology and describes different theoretical frameworks for attending to ethical problems. Theories covered include virtue and principle ethics, utilitarianism, relativism, nonrational ethics, feminism and social constructionism. The chapter moves on to explore the history of research on ethics in psychology. The topic of referrals is then introduced in depth, with a discussion of the nature of referrals in psychotherapy, existing research on their use by therapists, their use in other professions, and their ethical implications. Of particular focus is a category of referrals we label discriminatory referrals. These are referrals made by therapists who choose not to work with a patient because of bias against some salient aspect of that patient’s identity, such as sexual orientation, race/ethnicity, gender, or religious affiliation.

History of Ethics in Applied Psychology

Ethical guidelines for professional psychologists are maintained by the American Psychological Association’s (APA) Ethical Principles of Psychologists and Code of Conduct, also known as the Ethics Code, an ever-changing document most recently reformulated in 2002 with amendments incorporated in 2010. The current version is the tenth revision since the 1953
publication of the original Ethics Code. But even that first document was the result of extensive iteration and deliberation.

The APA was founded in 1892 and incorporated in 1925, but it did not have a process for adjudicating ethical complaints until the 1938 formation of the Committee on Scientific and Professional Ethics. This temporary committee operated on an informal basis, and by 1940 its members recommended the creation of a written code (Pope & Vetter, 1992). Nevertheless, it was not until 1947 that a separate body, the Committee on Ethical Standards for Psychologists, began formulating written guidelines. Rather than rely on the opinions of a small group of experts, the APA took the rather unprecedented approach of calling on all members to submit descriptions of critical incidents with ethical implications of which they were aware (Pope & Vetter, 1992). Collection and analysis of these accounts, submitted by more than 2,000 APA members, directly led to the drafting of the first Ethics Code (Nagy, 2011). The unique, empirical nature of this process was pivotal; here was a set of rules formulated not in a top-down hierarchy typical of professional organizations but in a democratic and inherently scientific manner.

The original Ethics Code, published in 1953, was 171 pages and comprised “six sections, 310 rule elements, 162 principles, and 148 subprinciples” (Nagy, 2011, p. 31). An extensive but unwieldy document, it was next revised in 1959 to make it shorter, less redundant, and include matters of professional etiquette. This version, which consisted of a preamble, the titled principles and a brief description of each, followed by specific expectations of conduct, served as the template for all subsequent revisions. Over the years, emerging issues of cultural and professional relevance, such as drug use, advertising, and computer technology, have been integrated into the Code (Nagy, 2011).
It is crucial to note that the Ethics Code was never meant to stand in perpetuity. The 1953 version was originally intended to remain for three years, although the revision was not published for six. Subsequent revisions have lasted up to a decade but the APA has demonstrated commitment to renewal and reevaluation. For example, the 1992 revision added an aspirational ethics section (APA, 1992), and the 2002 version addressed the use of technological forms of communication (APA, 2002).

The iterative nature of the Code is particularly relevant to a discussion of the ethics of making referrals. As will be discussed in depth later in this review, the current version of the Ethics Code (APA, 2002, but with amendments made in 2010) has no guidelines on making referrals, other than a prohibition on taking a monetary kickback or fee-splitting for referring a client to a colleague. Plenty of principles included in the Ethics Code, such as those of competence and discrimination, appear to relate to this issue; however, they are at times contradictory or ambiguous. This issue, troublesome now, may be a future target for revision. Unfortunately, the APA has stopped basing its Ethics Code revisions directly on critical incidents reported by members. Nevertheless, the spirit of empiricism is alive as broad polls and scientific research are still utilized as a foundation for, if not the substance of, amendments and modifications. Therefore, it is this author’s hope that this review will play at least a small part in the reassessment of the guidelines surrounding making referrals.

Ethics Education

Of course, the quality of ethical decision making is perhaps more dependent upon a strong educational foundation than it is upon comprehensive written guidelines. Surprisingly, the APA did not require psychology graduate programs to include ethics training for
accreditation until 1979, a result of an emerging scientific literature and growing awareness of ethical violations by therapists (Welfel, 1992). Indeed, in 1956, De Palma and Drake published the results of two independent surveys indicating that very few graduate programs in psychology offered a course dedicated to professional ethics. But even after the APA requirement the change did not occur overnight. That first year, 1979, only 55% of programs taking part in a major survey required students to take an ethics course (Tymchuk et al., 1979, as cited in Welfel, 1992, p. 182). Many programs persisted in offering only informal instruction or elective coursework in ethics. Nevertheless, by 1990, a sea change had occurred. In a dissertation by Vanek (1990, as cited in Welfel, 1992), all of the 209 respondents from APA-accredited clinical and counseling psychology graduate programs reported that they included ethics training in their curriculum.

But gaps in ethical training still exist in APA-accredited programs. A study by Welfel (1992) showed that pre-doctoral internship training directors asked to rate their interns on ethical preparedness and competence were by and large satisfied with overall ethicality but critical in a number of areas. Welfel writes,

At the other end of the continuum, they rated lowest the interns’ competency with ethical issues with clients who are HIV positive, followed by fee-setting arrangements, involuntary commitments, and therapy with gays and lesbians. None of these content areas were highly ranked in Vanek’s survey of ethics faculty’s teaching priorities. However, given the projections regarding an AIDS epidemic for the decade ahead, the potential for serious harm to clients when fee setting and involuntary commitment issues are not handled responsibly, and the real discrimination that individuals with a gay,
lesbian, or bisexual life-style face in today’s society, a strong argument can be made for giving each of these topics greater attention in the curriculum. (p. 186)

It is not surprising to note that the topics given low priority by teachers are the same ones with which students struggle. While this author is not aware of data on more recent changes to ethics training, the APA and many professional psychologists have certainly adjusted their approach to the aforementioned ethical guidelines. For example, in 2000 the APA published Guidelines for psychotherapy with lesbian, gay, and bisexual clients. This document gives detailed instructions for the ethical treatment of these populations. Regarding therapy with HIV positive patients, numerous articles and books have been written documenting the tenets of good practice (Anderson & Barret, 2001; Rubenstein & Sorrentino, 2008; Weinstein, 2001). Aside from fee setting, the major issues in which directors felt students were deficient related to difference and discrimination. While no mention of referrals was made, it does not take a leap of imagination to see how discomfort with sexual orientation or AIDS might lead to a discriminatory referral. Thus, analogous to Welfel’s conclusion, it seems that the lack of attention to referrals in APA guidelines (and thus we can safely assume in much of ethics courses, which are primarily based on the Ethics Code) presents a cause for concern regarding students and future professionals.

**Theoretical Frameworks for Addressing Ethical Questions**

One of the foundations of ethics education and complex decision making is familiarity with various theoretical frameworks for addressing ethical problems. Although a comprehensive review of all or even most of these frameworks is beyond the scope of this paper, a brief overview of some germane theories is presented.
Virtue vs. Principle Ethics

One of many available starting points for understanding differences in ethical perspectives is given by the divergence of principle ethics and virtue ethics. Jordan and Meara (1990) teased apart these foci by explaining their relevance to ethics pedagogy. According to the authors, graduate and continuing education coursework as well as academic literature usually frame ethical issues as dilemmas, or “situations requiring an active choice between competing claims; the related purpose of ethical analysis is a rational and equitable solution of the dilemma” (Jordan & Meara, 1990, p. 107). Thus, psychologists are instructed to deploy ethical principles for solving problems. Jordan and Meara (1990) label this process principle ethics, or as they say, “approaches that emphasize the use of rational, objective, universal, and impartial principles in the ethical analysis of dilemmas” (p. 107). In contrast, virtue ethics describes an emphasis on the person as a whole and his or her historical virtues, bringing in line professional decisions with personal characteristics and values. These are not mutually exclusive philosophies, but rather disparate ranges of focus. In other words, principle ethics emphasizes precedent and written guidelines while virtue ethics encompasses a more humanistic and holistic approach. While neither is inherently better or worse than the other, there are inherent limitations to each. Of particular relevance to making referrals, which are only tangentially alluded to in the codes with a hefty amount of contradiction, is the fact that principle ethics can be confounded by conflicting principles. As Jordan and Meara (1990) write, “By definition, ethical principles seek grounding in a universal context freed from individual bias, and yet the definitive nature of quandaries places principles in direct conflict with each other. The question then becomes ‘Which principle(s) will prevail?’” (p. 108).
A more effective means of ethical development might be a synergy of principle and virtue ethics. That is, graduate programs and professional communities look for individuals with integrity and strong moral character at the outset and train them in objective principles to guide their decision making when internal constitution does not suffice. Knapp and colleagues (2013) touch upon this in their work on what they term the *dark side of professional ethics*, or the attitudes and behaviors psychologists consciously believe to be ethical although would likely be viewed as unethical by their colleagues. Knapp and colleagues (2013) suggest that emerging psychologists engage their new professional culture much as an immigrant would his or her adopted land, with varying processes of acculturation and assimilation in an Ethics Acculturation Model (EAM; Handelsman, Gottlieb, & Knapp, 2005). While some psychologists are successfully able to integrate their pre-existing personal belief systems and the ethical frameworks of the profession, others blindly follow their own values and moral codes without regard to professional guidelines, and still others rigidly adhere to professional strictures and denounce their former beliefs. Knapp and colleagues (2013) advocate for psychologists to make conscious attempts to link their attitudes and behavior with professional guidelines as well as personal ethical theory, in essence a meeting of principle and virtue ethics. They also advocate for greater transparency and consistent discussion of ethical cases with supervisors and colleagues.

**Utilitarianism**

Utilitarianism is a general precept, usually identified with John Stuart Mill (1861, 1957), that argues that acts which lead to the greatest good for the greatest number of people are the most ethical. As an example, allowing one man to die to save another would be unethical
because there is no net benefit: one man dies and one lives. But allowing one man to die in order to save 10,000 is ethical because the value of one person is worth less than that of 10,000. But numerous problems exist with this framework, especially regarding its use by psychologists. Psychologists have strong professional and ethical obligations to their patients that cannot be valued quantitatively. While a utilitarian may view the worth of multiple individuals as higher than that of one individual, psychologists cannot weigh the value of one patient against others. They are duty-bound and morally-bound to protect each of their patients. Thus, utilitarianism has limited value in psychotherapy.

*Cultural and Individual Relativism*

Another basis for understanding ethics is relativism, either of the cultural or individual variety. Relativism posits the inexistence of absolute moral principles. People are the creators of morality, and as arbiters they often disagree. Cultural relativism suggests that the opinions of the majority of individuals in a society form that society’s moral or ethical code. Problems abound in this theory. First, according to this theory, acting incongruously with the mores of one’s society is seen as immoral or unethical. But oftentimes one may act in an odd or eccentric manner without transgressing any moral or ethical boundaries. Moreover, cultural norms, although held by a majority, are sometimes unethical. Nazi Germany and antebellum America are just two examples of institutionalized and culturally sanctioned immorality. Carroll, Schneider, and Wesley (1985) summarized the inherent failings of cultural relativism,

Now it may be true that most people in fact approve of those acts which are right and disapprove of those that are wrong. Our society approves of psychologists’ maintaining confidentiality and disapproves of experimentation on people without their consent. But
social approval is not the reason why an act has moral worth nor is the moral worth of an act (its rightness) determined by its social acceptability. Rather an act’s social acceptability ought to be determined by its moral worth and its moral worth ought to be the reason why it is approved of by the society. Thus we need an independent criterion for “right” in order to determine whether some behavior ought to be accepted in a society and in order to morally evaluate social values. (p. 6-7)

Arguments for cultural relativism become particularly contentious when evaluating contemporary practices with nearly opposite levels of social approval across cultures. For example, female genital mutilation is common practice in many African countries. Yet to many Americans the practice is seen as barbaric and a gross infringement of women’s rights. While there are African opponents of the practice and American proponents, the issue is divided, if not neatly, along cultural lines. Thus, social acceptance does not clarify the rightness or wrongness of the act.

Similar problems exist with personal relativism. Like cultural relativism, this theory puts forth the notion that objective morality and ethicality do not exist. But in contrast to cultural relativism, individual relativism suggests that societal majorities are not bastions of integrity. Instead, individuals must look to their inner feelings to determine right and wrong (Carroll, Schneider, & Wesley, 1985). The trouble with this perspective is that cognition is sidelined while emotions determine the ethicality of behavior. As moral truth does not exist, individuals can only appeal to their feelings in the moment about what is right; they are not able to base their decisions on ethical knowledge or principles because these only stand if one allows for objectivity, which this theory does not. Again, Carroll, Schneider and Wesley (1985) clarify the problems with individual relativism,
What is objectionable about personal relativism is not so much its emphasis on a personal perspective in making moral decisions but its disregard of thinking as a necessary element in making such decisions. Thinking, as distinct from feeling, entails careful consideration of the facts, along with the ability to give a rational justification for one’s decision. We don’t demand that feelings be consistent but we do require consistency in decision making. Hence consistency is required of a person’s moral life—the way in which one harmonizes one’s actions and tends to evaluate ethical situations, make moral judgments, and act on those decisions. (p. 8)

The facts that there is no consistency and no basis for rationality in personal relativism preclude it from being a realistic moral framework for any profession. Especially in psychotherapy, where the stakes are high for unethical behavior, relativism of either the cultural or personal type is too unstable for sound practice. Relativism is ripe for opportunism and sophistry. After all, any action can be defended as ‘feeling’ moral to its actor. Without the confines of reason or consistency, behavior is unmoored from any objectively defined moral anchor.

**Nonrational Ethics**

Rogerson and colleagues (2011) catalogue a number of nonrational processes that they contend influence ethical decision-making. They cite Kitchener (1984, 2000) as perhaps the first to suggest that ethical decision-making follows two levels: intuition and critical evaluation. The intuitive level is automatic and based on pre-existing knowledge and response patterns. The critical-evaluative level is a rational, logical exploration of the situation in context based on an assemblage of theoretical and philosophical principles. Later, Kahneman (2003) refined this
theory to account for rapid, automatic and affectively driven decisions as opposed to slow and thoughtful evaluative judgments. Kahneman also posited that people use mental shortcuts, or heuristics, whenever possible in the course of their ethical decision-making. Rogerson and colleagues (2011) compile these studies to suggest that affect is always intimately tied to cognitive processes, thus negating the possibility of dispassionate logic. At heart, ethical reasoning is a multidetermined phenomenon that relies on rational and nonrational processes. Rogerson and colleagues (2011) recommend psychologists be self-reflective and introduce self-doubt into their decision-making, seek alternative perspectives, slow their response patterns to stall automatic reactions, and question the role that emotion plays in their judgment.

Feminist Ethics

A recent field of ethics with a broad range of applications far beyond women’s issues, feminist ethics represents a gendered attempt at neutralizing inequality and iniquity. Although feminist ethics arose out of the women’s liberation movement in the second half of the twentieth century, it is universal and pansexual in its aims. In her anthology on the topic, Mary Brabeck (2000) offers these five themes as the core of feminist ethics:

1. The assumption that women and their experiences have moral significance
2. The assertion that attentiveness, subjective knowledge, can illuminate moral issues
3. The claim that a feminist critique of male distortions must be accompanied by a critique of all discriminatory distortions.
4. The admonition that feminist ethics engage in analysis of the context and attend to the power dynamics of that context
5. The injunction that feminist ethics require action directed at achieving social justice.

(p. 18)

Feminist ethics go beyond these themes and many more could likely be added, but these five represent an abridged overview that bears particular relevance to the topic of referrals. First, the valuing of women and their experiences is integral to making appropriate referrals. Discrimination against women within the field of mental healthcare is not a distant historical fact. For example, to this day, controversy ensnares the disproportionately high number of women receiving diagnoses of borderline personality disorder (BPD) and post-traumatic stress disorder (PTSD), and the difficulties women diagnosed with BPD face in getting appropriate treatment (Becker, 2000). Oftentimes, diagnoses of BPD make it more likely a woman will be seen as a risky patient and referred to another provider. Second, the proposition that subjective knowledge can clarify moral issues is apt in a discussion of referrals. Referral decisions can be murky while ethics codes and crystallized knowledge can fail to provide direction. In these situations, attention to nuance, context, and resistance to reductionism can provide moral guidance. The third theme, that feminist ethics entails a correction of all discriminatory behavior, is perhaps most applicable to the discussion at hand. Discriminatory referrals may be made for any number of reasons. By placing equal emphasis on all types of discrimination, feminist ethics would be an especially sharp lens through which one can view the practice of referrals. Similarly, feminist ethics’ attention to context is germane to any discussion of referrals because of the inherent power differential between therapist and patient. The power to treat, diagnose, and refer are embedded within the profession yet these processes often remain mysterious to patients. A feminist approach to referrals would value an open discussion of the reasons for and processes immanent in referrals, with an emphasis on equality between therapist
and client. Last, the social justice framework of feminist ethics is particularly well-suited to a study of referrals because patients may need greater advocacy in their relationship to providers. Referrals are a system-wide issue and any problems are likely to benefit from increased exposure at the level of policy and research.

*Social Constructionism*

Social constructionism is another recent approach to ethical analysis in the professions. Born out of the postmodern movement that grabbed hold of psychology in the second half of the twentieth century, social constructionism rejects absolute certainty and objectivity. Instead, it sees everything, even reality, as a co-construction of human experience, interaction and language (Gergen, 1985). But unlike relativism, moral truths do exist outside of societal mores or personal feeling states; they are created through relationships and interactions. Guterman and Rudes (2008) describe therapists who align with social constructionism as viewing themselves like participant-observers intricately connected to the social constructions of reality, such as ethical codes, that give form to the profession. For social constructionists, intentionality is the biggest component of ethical behavior, as Guterman and Rudes (2008) make clear:

We suggest that intentionality is a logical resolution to the problems of both radical subjectivism and radical objectivism that we consider to be untenable and that present the field with philosophical challenges, particularly in the domain of ethics. Pure subjectivism leads to a solipsistic worldview that holds that the self can only know its own (i.e., subjective) perceptions. Objectivism is based on the dubious notion that it is possible to access knowledge that is independent of the knower….We suggest, however,
that a resolution to the schism between subjectivism and objectivism lies in defining ethics with intentionality as a basis. (p. 140)

Thus, the authors posit that acting with intention, integrity, and beneficence are the most salient indicators of ethical behavior. The Ethics Code is not to be abandoned wholesale, but rather recognized as a mutable and socially constructed document. Critical to its relevance are its adaptability and capability for change. Crucial for therapists is their ability to know that the Code cannot be substituted for intentionality and a sophisticated understanding of context and the construction of meaning in human relationships.

This review of ethical theories has covered only a subsection of extant models. It has served to indicate the complexity of thought on the topic of ethics, particularly as it relates to psychotherapy. Much of the literature on ethics in the field of psychology is not based on a strict reading of any one theory but rather an admixture of many approaches. While this has the advantage of flexibility, it does make a nuanced understanding of the work more difficult. This will become clear as I delve into the history of research on ethics in psychology.

**History of Research on Ethics in Psychotherapy**

Comparing physicists, who stumbled upon ethical problems through the dangerous results of some of their experiments, and psychologists, Lynn wrote in 1959, “Psychologists, particularly applied psychologists, are automatically immersed in ethical issues by the nature of their subject matter even though they lack the knowledge, such as physicists possess, which brings to a science extreme control over nature” (p. 630). The literature on ethics in professional psychology goes back at least as early as the 1940s and ‘50s (Hobbs, 1959; Meehl, 1947; Sargent, 1945; Schwebel, 1955). Fascinatingly, many of the problems psychologists were
grappling with back then still face us. For example, Schwebel (1955) attempted to answer the
question of why psychologists behave unethically and arrived at hypotheses such as personal
gain, inadequate training and experience, and gross insensitivity among others. In 1956,
Warnath published an article detailing problems for counseling psychologists, including how to
balance the patient quota demands of one’s institutional employer with providing the best care to
each client, how to maintain both research and clinical activity, and—most relevant to our
discussion—how closely, and blindly, should one follow the Ethics Code? This last question is
especially pertinent. But despite these and many more inquiries into the ethical conundrums of
professional psychology, it was not until the late 1970s that quantitative research into the ethical
behavior of practicing psychologists made headway.

Of particular interest to researchers was sexual activity between therapists and clients,
perhaps due both to its grossly unethical nature and sensationalism. In a study by Holroyd and
Brodsky (1977), the authors disseminated a survey about erotic and nonerotic physical contact
with patients to a random sample of APA member psychologists. Surprisingly, 5.5% of male
and 0.6% of female respondents indicated they had had sexual intercourse with current patients,
and an extra 2.6% of males and 0.3% of females had had sexual intercourse with patients within
3 months of termination. In addition, 10.9% of males and 1.9% of females reported having
erotic contact with patients. There were no differences across theoretical orientations. A study
by Pope, Levenson, and Schover (1979) found that 12% of male and 3% of female psychologist
members of APA Division 29 (Psychotherapy) reported sexual contact with their clients.

In a landmark study that included, but went beyond, sexual misconduct, Pope, Tabachnik,
and Keith-Spiegel (1987) issued a survey consisting of 83 behaviors to an APA mailing list of
psychologists. Participants were asked to rate on a five-point scale how frequently they engage
in each behavior and how ethical they believed it to be, respectively. The behaviors ranged from the innocuous “using self-disclosure as a therapy technique” to the reprehensible “engaging in erotic activity with a client” (Pope, Tabachnik, & Keith-Spiegel, 1987, pp. 995-996). Results indicated that psychologists’ behavior was generally aligned with their beliefs. That is, they reported rarely or never engaging in behaviors that they viewed as unethical. Interestingly, the rates of sexual misconduct were lower than previous studies, with only 1.9% of respondents reporting sexual activity with clients and 2.6% reporting erotic activity that may not have involved physical contact. The authors cautioned that the discrepancy between these and prior results could be due to strengthened reluctance to admit to serious misconduct, an actual decrease in the behaviors, or random sampling error. But in a later work Pope, Keith-Spiegel, and Tabachnik (2006) indicated that across studies the self-reported frequency of sexual relationships between therapists and clients usually hovers between 5% and 10%.

While the study did not directly look at referrals, it did include a lone question that is tangentially related to this issue. The item read, “Accepting only male or female clients” (Pope, Tabachnik, & Keith-Spiegel, 1987, p. 995). An inherent problem with this item is the incongruity between its wording, which is an absolute (“only”), and the wording of the frequency rating scale, which includes never, rarely, sometimes, fairly often, very often, and not applicable. It seems implausible that a psychologist would sometimes or rarely only accept male or female clients; “only” implies a fixed pattern. Yet 3.7% reported doing this rarely, 2.4% sometimes, 0.2% fairly often, and 1.1% very often. The vast majority (83.8%) of participants reported never engaging in this behavior. Interestingly, only 11% rated this behavior as unquestionably unethical while 34.6% rated it as unquestionably ethical. It would seem that while most respondents did not discriminate based on sex, their reasoning was not due to ethics but other
factors. Still, due to the imprecision of the item, there is a significant limit to what can be gleaned from the results.

Pope and others went on to use the same instrument with minor adjustments in numerous subsequent studies, such as testing psychologists’ beliefs and behaviors as educators (Tabachnik, Keith-Spiegel, & Pope, 1991) and their attitudes towards technology (McMinn et al., 1999). Most of these surveys have a return rate of approximately 50% and surprisingly revealing responses. One particular study used a minimally modified version of the same items and scale but asked participants to evaluate the extent to which a behavior was good or poor practice instead of its ethicality or frequency in their own practice (Pope, Tabachnik, & Keith-Spiegel, 1988). Somewhat expectedly, the results of this study indicated that criteria for good practice are more stringent than for ethics. In other words, plenty of items were rated as poor practice but not necessarily unethical.

In a slight departure from the formula, Gibson and Pope (1993) sent out a survey with similar items to counselors (adjusting some items for relevancy) but asked respondents to rate the behaviors as either ethical or unethical, replacing the previous Likert-type scale with a dichotomous format. Respondents then were asked to rate their level of confidence in their response on a zero to 10 scale. Again the item “Accepting only male or only female clients” appeared. But this time 64% of respondents labeled the behavior as ethical with a mean confidence of 7.4 (standard deviation=2.4). While the response format no longer poses problems of plausibility, there is no assessment of the frequency of engagement in the behavior to compare beliefs and practices. Still, the results seem to indicate that the majority of counselors do not believe opening their practice solely to one sex is unethical. We can only guess at the rationale, be it competence and training experience, comfort level, or anything else.
In an attempt to focus solely on dual relationships of the sexual and nonsexual variety, Borys and Pope (1989) sent out two different versions of the same survey to a random sample of psychologists, psychiatrists, and social workers. Both surveys listed the same behaviors, such as “accepting a gift worth under $10” or “going out to eat with a client after a session,” but one version asked participants to rate how ethical they believed each behavior to be while the other version asked how often they engaged in each behavior. In this way the authors eliminated any possible contamination arising from rating both their behavior and their beliefs (although their results did not end up indicating significant differences from studies asking participants to rate both). The results indicated that there were no significant differences across the professions regarding sexual activity, nonsexual dual relationships, social involvements, or financial involvements with patients. The data also pointed to greater ethical scrutiny on the part of psychodynamic clinicians compared to other theoretical orientations. On the whole, psychodynamic practitioners tended to view multiple relationships of a professional, social, or financial nature as more unethical than did those of other orientations. Finally, in both sexual and non-sexual dual relationships, male practitioners were on the whole less scrupulous; they were more apt to rate as ethical and engage in dual relationships of a professional, social, financial, or sexual nature than their female counterparts.

Using a distinct methodology from Pope and his colleagues, Conte et al. (1989) published a study of psychotherapists’ ethics in which respondents were asked to complete a 10-item survey indicating on a four-point scale whether each item constituted acceptable practice, inappropriate practice, unethical practice, or grounds for malpractice. But this scale could be interpreted as conflating appropriateness and ethicality, two discrete concepts. In addition, the most severe rating, grounds for malpractice, introduces a confounding legal element.
In a return to the original method employed by the creators of the 1953 APA Ethics Code, Pope and Vetter (1992) asked psychologists to “describe, in a few words or more detail, an incident that you or a colleague have faced in the past year or two that was ethically challenging or troubling to you” (p. 398). Participants offered 703 incidents in 23 categories. Areas that received the greatest number of troubling incidents included, in descending order, confidentiality, dual relationships, pay and fee settings, and education/training issues. Interestingly, the only mention of referrals reported in the study are dilemmas involving kickbacks for making referrals to colleagues or friends, referring to lower-cost therapists rather than reducing rates, and other financially related issues. Discrimination only arose as an issue in graduate program diversity and shock on the part of patients to find a clinician of color.

More recent work has focused on the ethics of psychologist involvement in detainee interrogations. Pope and Gutheil (2009) argue that the 2002 APA Ethics Code departs from the basic ethical standards established after the Nuremberg Trials. The 2002 revision of the Code (APA, 2002) gives the highest authority to the law in a conflict of interest between professional ethics and legal statutes, a major problem according to authors of this polemic because of the prevalence of psychologists in interrogations in places like Abu Ghraib and Guantanamo Bay prisons. Whereas the American Psychiatric Association (Sharfstein, 2006) has come down firmly against psychiatrist involvement in prisoner interrogations, the American Psychological Association has championed the unique skill sets possessed by psychologists in assisting this war effort (Lewis, 2006). Pope and Gutheil challenge this direction taken by the APA and offer a number of alternative, ethical manners of resolving conflicts of interest between government and professional ethics.
It is clear that the issue of ethics has been of great importance to psychologists for decades. Moreover, research involving elaborate surveys, gathering of critical incidents, and other means have aided in the development of a firmer understanding of psychologist practices and beliefs. But despite the array of existing literature, there remains scant empirical questioning of psychologists’ attitudes and behaviors regarding making referrals. The next section will explore this issue in depth.

**Introduction to Referrals**

Making a referral in the context of psychotherapy is the act of finding a better-suited therapist for a prospective patient. “Better suited” may mean more training in a particular area, more experience, better time compatibility between patient and therapist, different fee structure or something else. It is similar to making a referral in the medical profession but bears a few noteworthy differences. First, medical doctors tend to categorize themselves rigidly by specialization and therefore patients expect to be referred to a dermatologist for skin problems or a cardiologist for heart concerns. In contrast, psychologists often opt to treat a wide variety of clientele and often their areas of specialization do not have proper professional names like oncologist or nephrologist. Thus, a patient may be getting treatment from a psychologist with extensive training in grief but not know that this area represents the mainstay of the clinician’s practice.

A second major distinction between referrals in psychotherapy and the medical profession is the nature of the problems that merit the referral. While more open to psychological disorder than in the past, Occidental society still stigmatizes mental illness to a much greater extent than physical illness (if this dichotomy between mental and physical illness
can even be made, which many would argue it cannot). Thus, patients approach psychotherapy differently than they do other areas of healthcare. There is a delicateness to the whole operation, a self-consciousness that many have about seeing a therapist that requires acute sensitivity to all aspects of the process, especially making referrals to see a different clinician. A patient opening up to a therapist for the first time may be loath to go through the process of initial self-disclosure all over again. This is not to minimize the embarrassment or discomfort that can arise with certain medical problems, but only to emphasize the emotional delicacy of psychotherapy.

Indeed, one can imagine not only the emotional harm but the potentially grave physical harm that could come to a patient with a severe physical ailment who is refused treatment because of latent or explicit discrimination.

But just as in the medical profession, making referrals is an integral part of psychotherapy. Referrals can and should be made for a number of reasons, including lack of availability, having a multiple relationship with a prospective client, presenting problems outside of the clinician’s scope of practice, or treatment failure. Sometimes patients request referrals if they do not feel they are compatible with a clinician or they want to try a new approach. But recent news stories have highlighted an entirely different rationale for making referrals that smacks of discrimination and bias.

The Case of Julea Ward and the Ethics Codes

Julea Ward is a former counseling graduate student and devout evangelical Christian. One afternoon in 2009, Ms. Ward’s supervisor told her that she would be working with a gay client. Ms. Ward informed her supervisor that she considered homosexuality a sin and would prefer that the man be referred to another counselor. The supervisor did as Ms. Ward asked but
promptly began steps to have her expelled for unethical behavior. Ms. Ward sued her university for religious discrimination and lost, but subsequent appeals have prolonged the case and thrown it into the national spotlight (Oppenheimer, 2012). One question that reflexively arises from the episode is: do therapists have the right to choose who they treat?

On a broad scale, the answer to that question is relatively simple: yes. Therapists are under no ethical or legal obligation to see any one particular client or take on any one particular case. However, the bases for making a referral are of the utmost importance. In fact, the ethics codes of both the APA and the American Counseling Association (ACA) give ample description of acceptable reasons to abstain from treating certain individuals. At the broadest level, both sets of guidelines proscribe clinicians from working with individuals whom they feel unable to treat effectively. The ACA’s Code of Ethics Standard A.11.a. (2014) states:

If counselors lack the competence to be of professional assistance to clients, they avoid entering or continuing counseling relationships. Counselors are knowledgeable about culturally and clinically appropriate referral resources and suggest these alternatives. If clients decline the suggested referrals, counselors discontinue the relationship. (p. 6)

But how does one ascertain the limits of professional capability? What does it mean to treat effectively? To unpack these concepts, both the ACA and APA have further divided grounds for referral into issues of competence, conflicts of interest, and multiple or exploitative relationships. Since this review centers on making inappropriate referrals and not failing to make referrals when appropriate, I will not discuss conflicts of interest and multiple relationships at length.

Competence refers to the ability to render appropriate services to the client. A therapist’s competence is determined by his or her education and certification, training with specific mental
health concerns and treatments, knowledge of particular therapeutic techniques, understanding and familiarity with diverse cultures and belief systems, as well as other dynamic factors. Barring extraordinary circumstances, therapists who are not well versed in the presenting problems, available treatments, or cultural backgrounds of their clients are advised to make referrals. According to the ACA’s Code of Ethics Standard C.2.a. (2014):

Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Whereas multicultural counseling competency is required across all counseling specialties, counselors gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse client population. (p. 8)

The APA is even more detailed in its prescription for working within one’s scope of practice. For example, the APA Ethical Principles of Psychologists and Code of Conduct (2002) reports in Standard 2.01:

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. (p. 1063-1064)

Most commentators seem to agree that Ms. Ward’s actions were unethical (Barstow, 2011; Shallcross, 2010), especially because she was a trainee, a career stage where future psychologists are expected to lack competence, get exposure to complicated problems and environments, and work with diverse populations (Standards F.2.b and F.6.b of the American Counseling Association Code of Ethics, 2005, as cited in Koocher & Keith-Spiegel, 2008; American Psychological Association [APA], 2002).

While Ms. Ward’s case may be fairly straightforward, the codified rules on making referrals are not. Nagy (2005, as cited in Shiles, 2009) illuminated the central conflict within the APA’s Ethics Code: Standard 2.01(b) suggests that when psychologists are unfamiliar or uncomfortable with a client they should either attempt to obtain the requisite understanding or make an appropriate referral to avoid harming the client through malpractice (p. 1064). But giving equal value to enhancing competence and making referrals is problematic. First, it suggests that both are equally acceptable when in reality the former entails effort on the part of the therapist and the latter potentially entails feelings of rejection or worse on the part of the client. Second, this standard inadvertently grants a specious defense to clinicians attempting to justify discriminatory referrals. For example, Ms. Ward argued that she believed she was acting in the client’s best interest because her intolerance of his lifestyle would prevent her from giving him adequate care. Clinicians not wanting to work with African American clients because of their racist beliefs could come up with a similar justification that their attitude may harm potential Black clients. But these spurious claims represent sophistry in the guise of altruism, for clinicians avoiding clients for their identity are engaging in the most basic form of
discrimination. One could easily imagine the same logic being employed by anyone from medical doctors to hair stylists: “I cannot work with that person because my bias would lower my work standards.” Maybe so, but that violates major tenets of the Civil Rights Act of 1964 and the Fourteenth Amendment of the United States Constitution.

In Ms. Ward’s case, she knew nothing about the client except that he was gay. Thus, her referral was tantamount to a refusal to administer treatment for reasons of discrimination. Both the APA and the ACA have firm guidelines against such behavior. The ACA’s Code of Ethics Standard C.5. (2014) decrees:

Counselors do not condone or engage in discrimination against prospective or current clients, students, employees, supervisees, or research participants based on age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital/partnership status, language preference, socioeconomic status, immigration status, or any basis proscribed by law. (p. 9)

Similarly, Principle E of the APA Ethics Code’s (2002) General Principles admonishes: 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. (p. 1063)

In addition, Standard 3.01 admonishes psychologists not to engage in discrimination based on factors of identity, “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” (APA, 2002, p. 1064).

Thus, making a referral—in effect refusing to serve someone—because of identity traits is both against United States discrimination law, APA Principle E and Standard 3.01 but in keeping with Standard 2.01(b). Shiles (2009) has also suggested that mental health providers often rationalize discriminatory referrals by alluding to the Ethics Code’s mandates against harming the client or practicing beyond one’s competence. The fact that the Ethics Code is ambiguous enough to allow such posturing illuminates the need for greater clarification in professional standards.

**Existing Research on Referrals**

Currently, there are no quantitative studies on the ethicality of making referrals or the frequency of discriminatory or generally unethical referrals in psychotherapy. Literature searches on a number of prominent databases (PsycArticles; PsycINFO; PubMed; Web of Science) using a variety of combinations of the key terms “ethics,” “referral,” “refer,” “psychotherapy,” “psychology,” “therapy”, and “discrimination” led to not a single empirical study involving the ethics of making referrals. There is a single article (Shiles, 2009) on the topic but it does not present any quantitative data. Instead, it reviews some of the theoretical reasoning behind why such studies are necessary. To summarize the central argument, making a referral solely to alleviate therapist discomfort can be categorized as discriminatory practice. Even in cases where level of competence is the deciding factor, psychologists must be sure that they exhausted other possibilities and are acting in the best interest of the client before they refer.
Shiles (2009) offers explanations for the gap in the literature on making referrals, citing prejudice, collusion, denial, rationalization, and the “glorification of referral in the psychological literature” (p. 147). Interestingly, Shapiro and Ginzberg (2003) evaluated the ethics of accepting referrals and came up with the same conclusion as Shiles. In their article on psychotherapists’ tendencies to accept referrals that are either a poor fit or come with ethical dilemmas (it is worth noting that they did not discuss discrimination or related reasons for not accepting referrals), Shapiro and Ginzberg (2003) suggest that there is a general lack of professional interest in examining this issue perhaps out of greed, defensiveness, or fear.

Nevertheless, there are a small number of studies exploring referral behavior although not in the context of ethics or appropriateness. Lott et al. (1999) investigated the effects of age and gender on referrals to university counseling services in light of statistics showing a disproportionately higher number of female clients. Using a survey consisting of vignettes about college students with personal problems, students, staff and faculty from three universities were asked to choose one of seven referrals options. Results indicated that the gender of the referral recipient was not important but rather the gender of the referral provider. In other words, men were less likely to refer a college student, regardless of gender, than women. In addition, older individuals were more likely to refer than their younger counterparts. While the implications of these results are unclear, it is apparent that distinctions do exist in referral making behavior and this can be in part accounted for by individual differences.

Relatedly, Ford and Hendrick (2003) looked at the ways psychologists handle clinical situations involving conflicting sexual values between clients and themselves. The authors mailed out a survey to 1,000 members of either the APA or the American Association for Marriage and Family Therapy asking about sexual values and how they respond when feeling
personally uncomfortable working with clients. Of the 314 returned and usable surveys, 40% of respondents reported that when confronted with personal discomfort, they would refer the client to a different therapist rather than discuss the issue with the client (25%), a supervisor or a colleague (18%), or seek further knowledge about the issue (4%) or engage in self-examination (4%). Somewhat surprisingly, the authors write of the results, “It appears that therapists tend to be aware of their personal values and make efforts to keep their values from having a negative impact on their clients” (Ford & Hendrick, 2003, pp. 84-85). While the data do suggest that therapists are aware of their values, the fact that the most common response to personal discomfort due to conflicting sexual values is to refer does not indicate that therapists make appropriate efforts to keep their values from having a negative impact on clients. Moreover, making a referral because of discomfort with another person’s sexual choices is precisely the kind of discrimination Standard 3.01 of the APA Ethics Code procribes.

Orr, Catalan, and Longstaff (2004) investigated the discrepancy in referrals to psychological services between HIV-positive heterosexual and gay men in a hospital in London, United Kingdom. According to the results, HIV-positive heterosexual men (HM) were nearly three times less likely to be referred for specialist mental health care than their gay counterparts, were less likely to be diagnosed as depressed, and were more likely to be diagnosed with a substance abuse disorder. Gay male patients were more likely to receive a formal psychiatric diagnosis. Nevertheless, no differences were found between the two groups in terms of mental problems and social difficulties except that HM had more difficulties with bereavement than gay men. Some suggested explanations for these results are hospital professionals’ unfamiliarity with the variety of cultural and ethnic backgrounds of HM, HM may be less able to articulate their mental distress, and there may be more stigma in ethnic groups with populations of HM.
Regardless of these possible rationales, the clear message from this study is that referrals are not administered equally.

**Referrals in Other Professions**

Due to the limited number of studies that exist on the ethics of referrals in psychotherapy, it is worth looking at the literature on this issue in other professions. Tobias et al. (1982) explored why ethnic minority children are disproportionately referred for special education. After reading a series of vignettes, teachers were asked whether they would refer the student in the story for special education. The data indicated that White teachers were more likely to refer students while Hispanic teachers were more likely to want the student to remain. Moreover, regardless of their ethnicity, teachers were more likely to refer students from ethnic backgrounds different than their own to special education. However, these results were not replicated in a follow-up study (Tobias, Zibrin, & Menell, 1983). The follow-up data suggested that Black and White teachers were more likely to refer male students to special education while Hispanic teachers were more likely to refer female students. It is worth noting that the follow-up study changed a number of aspects of the survey and the subject pool (the first study had been administered to secondary school teachers while the follow-up was given to primary school teachers).

In the medical field, Bachman and Freeborn (1999) examined the use of referrals amongst a group of physicians in the Kaiser Permanente Health Maintenance Organization (HMO). Their results indicated that older physicians made fewer referrals than younger doctors. Moreover, physicians who perceived their workloads to be too high had higher referral rates than those who perceived their workloads to be too low/just right (8.8% vs. 6.1%). In addition,
physicians with more female and older patients had higher referral rates. Somewhat surprisingly, burnout, as assessed by the Tedium Index, a frequently used measure of chronic pressure, was not significantly correlated with referral rate.

In the legal profession, a study by Varela and colleagues (2011) looked at whether defense attorney referrals for competence to stand trial (CST) evaluations are influenced by clients’ English language proficiency. The authors constructed vignettes in which fictional clients had varying degrees of English language fluency and salient mental illness. The words of the Spanish-speaking clients were translated into English by an interpreter (and were displayed coherently in the vignette). Nevertheless, participants (all practicing defense attorneys) rated Spanish-speaking defendants as less mentally ill than their English-speaking counterparts and were less likely to be referred for CST evaluations. The authors suggest the results could indicate an overcorrection effect, in which Whites (the majority of participants were White) describe minority characteristics as favorable, or it could indicate less compassion and activated stereotypes about criminality amongst immigrants (Varela et al., 2011).

These few studies, in both mental healthcare and other professions, point to a collection of limited but compelling evidence indicating both the existence of discriminatory referral practices and a disturbing lack of data involving them. Clearly, further research is needed to both ascertain the underlying factors contributing to unethical referrals and explore the attitudes and behaviors of psychologists in the particular contexts that give rise to them.
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A Mixed Methods Analysis of the Ethics of Behaviors and Attitudes Towards Making Referrals in Psychotherapy

Abstract

Making referrals to other providers in mental healthcare is a common and necessary practice for psychotherapists. Yet there exist a large number of reasons for making referrals and not all of them are in the patient’s best interest. Recent news stories have shed light on discriminatory referrals, in which clinicians have referred out clients whose lifestyle choices or identity factors they find incompatible with their own. Moreover, current professional ethical guidelines are at times contradictory and vague regarding this issue. This study investigates the attitudes and behaviors of psychologists regarding making referrals. We designed and administered a survey on the ethics of referrals, the Self-Assessment of Referrals Ethics (SARE), to a random sample of psychologists licensed to practice in Massachusetts (N=106). Our findings suggest that psychologists make referrals for a large number of reasons, including but not limited to scope of practice, goodness of fit, remuneration, risk, professional issues, and client welfare. Many of these themes were also raised as psychologists’ primary concerns and dilemmas when making referrals. Our results also suggest that many psychologists feel that the APA Ethics Code (APA, 2002) provides insufficient guidance for difficult referral decisions. Possibly due to insufficient power or underreporting, we found that attitudes and behaviors towards making referrals were largely uncorrelated, partly because nearly all respondents denied making referrals for discriminatory reasons. However, although our results do not indicate that psychologists often make generally unethical or discriminatory referrals, the data do suggest that permissive attitudes towards these types of referrals are associated with work environment and time spent with colleagues. Finally, we discuss our findings, the limitations of our study design and possibilities for further research.
A Mixed Methods Analysis of the Ethics of Behaviors and Attitudes Towards Making Referrals in Psychotherapy

Referrals are an integral part of any psychotherapist’s practice. Although they may occur more or less frequently depending on the clinician and the work environment, their use improves the chances that a patient will receive the best possible treatment. A number of circumstances can instigate a referral, from lack of training or experience in a patient’s presenting issue to scheduling incompatibility. But a recent news story involving a counselor-in-training has shed light on an altogether different rationale for making referrals. Julea Ward, a former student in a counseling psychology graduate program at Eastern Michigan University, referred a prospective client—before the first session—upon hearing he was gay and struggling with relationship issues. Ms. Ward claimed that her Christian sensibilities deemed homosexuality immoral and volitional. She was promptly expelled from her program for violating ethical principles against discrimination, but in an ironic twist, she sued the university for unlawful religious discrimination. After a number of trials, Eastern Michigan University decided to settle the suit, but clarified that their decision was not due to contrition but rather a desire to avoid costly future trials that would weigh on taxpayers’ wallets and students’ morale (Dorsey, 2012). Despite the closure of this particular case, the issue of discriminatory referrals persists.

Surprisingly, research on discriminatory or otherwise unethical referrals is almost non-existent. Articles that do concentrate on referral decisions in psychotherapy (see for example Lott et al., 1999; Orr, Catalan, & Longstaff, 2004; Wood & Wood, 1990) mostly treat ethical issues obliquely. Literature searches on a number of prominent databases (PsycArticles; PsycINFO; PubMed; Web of Science) using a variety of combinations of the key terms ethics, referral, refer, psychotherapy, psychology, therapy, and discrimination, led to not a single
empirical study on the ethics of making referrals. There is one article (Shiles, 2009) that expounds on discriminatory referrals but it does not present any quantitative data. Presenting some of the theoretical reasoning behind why such studies are necessary, the central argument asserts that making a referral solely to alleviate therapist discomfort can be regarded as discriminatory practice. Even when level of competence is the deciding factor, psychologists should ensure that a referral is in the best interest of the client.

Shiles (2009) suggests that this lacuna in the literature is due to prejudice, collusion, denial, rationalization, and the “glorification of referral in the psychological literature” (p. 147). But her discussion of the inherent equivocations within the treatment of this issue by the American Psychological Association’s (APA, 2002) Ethical Principles of Psychologists and Code of Conduct, also known as the Ethics Code, provides more convincing rationale for the lack of data. It appears feasible that because of conflicting information in the Ethics Code, at times psychologists may not even know their actions are condemned by professional standards.

That psychologists have worldviews and values that may on occasion conflict with those of their patients is a foregone conclusion. As Shiles (2009) writes:

The belief that psychologists can be completely objective and value-free is no longer the predominant perspective held in the field of psychology. Rather, it is now accepted that psychologists have values and that these values are infused throughout their professional work. (p. 142)

But how should psychologists navigate discrepancies between their attitudes and those of their clients, or even more contentious, their attitudes and identity characteristics of their clients? The APA’s Ethics Code has not been clear on the best course of action. Principle E: Respect for People’s Rights and Dignity of the APA Ethics Code’s (2002) General Principles admonishes:
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. (p. 1063)

This principle implies awareness of possible psychologist bias and a charge that that bias should not be allowed to influence professional practice. Not only are psychologists supposed to eliminate the effect of said bias on their work, they are exhorted to condemn others who do not abide by this principle. This would seem to suggest a zero-tolerance attitude towards discriminatory referrals. But in an apparent contradiction, Standard 2.01(b) states:

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. (APA, 2002, p. 1063-1064)

Thus, it would appear that psychologists have two options when faced with clients with cultural, individual, or role differences: either obtain the necessary competence or make a referral. A nuanced but critical difference between Principle E and Standard 2.01(b) is the omission of the
term *bias* from the latter’s wording. Principle E suggests that psychologists may not
discriminate against clients. Making a referral because a client’s identity or lifestyle is
discomfiting would be discrimination and thus is disallowed. But Standard 2.01(b) speaks only
of *competence*, not bias. It suggests competence with identity factors such as sexual orientation
or multiculturalism is just as important as competence with presenting symptomology.
Therefore, psychologists are urged either to obtain competence in these areas or make a referral.
Crucial to the consistency of the Ethics Code is that such a referral would be made solely out of
awareness of incompetence coupled with an inability to overcome this, *not* because of prejudice.
But some, like Ms. Ward, have alleged that bias begets incompetence and thus is a reasonable
cause for making a referral. As Shiles (2009) writes, “It is my belief that, currently,
discriminatory referral practices within the field of psychology may be rationalized as ways of
avoiding harming the client and working outside of one’s competence while going unchallenged
by the psychology community” (p. 144).

Indeed, some studies have inadvertently pointed to unethical referral behavior. For
example, Ford and Hendrick (2003) examined how psychologists behave when confronted with
conflicting sexual values between clients and themselves. In their sample, the most common
response (40% of participants) to personal discomfort was to refer the client to a different
therapist rather than discuss the issue with the client (25%), a supervisor or a colleague (18%),
seek further knowledge about the issue (4%) or engage in self-examination (4%). Bizarrely, the
authors write of the results, “It appears that therapists tend to be aware of their personal values
and make efforts to keep their values from having a negative impact on their clients” (Ford &
Hendrick, 2003, p. 84-85). While the data do indicate that psychologists are cognizant of their
values, the fact that the most popular response to personal discomfort due to conflicting sexual
values is to refer does not suggest that therapists make appropriate efforts to keep their values from having a negative impact on clients. Moreover, making a referral because of discomfort with another person’s sexual choices is precisely the kind of discrimination the APA Ethics Code prohibits in Principle E (APA, 2002). The data and the fact that the authors attest to respondents’ good practice is alarming both because it presents a significant rate of referrals due to therapist discomfort and because it suggests confusion about the Ethics Code. The dearth of literature on this topic may well be contributing to this confusion.

Shiles (2009) effectively argues why an open discussion of the existence of discriminatory referrals and reformed professional guidelines are needed. For one, professional psychology places a great deal of importance on issues of diversity and tolerance. These topics appear prominently in various guidelines and reports (APA, 2002, 2003, 2007, 2010, 2012). For example, in 2012, an APA presidential taskforce was formed to report on the prevention and reduction of discrimination of people whose identities are marginalized in the United States (APA, 2012). Moreover, the APA’s Guidelines on multicultural education, training, research, practice, and organizational change for psychologists (2003) states, “We base our premise on psychologists’ ethical principles to be competent to work with a variety of populations (Principle A), to respect others’ rights (Principle D), to be concerned to not harm others (Principle E), and to contribute to social justice (Principle F; APA, 1992)” (p. 7).

Another reason that the issue of discriminatory referrals is so pertinent to psychology in America today is the ever expanding diversity of the American population. According to the United States Census Bureau (2012), the non-Hispanic white population is expected to rise to 199.6 million in 2024 and then slowly decrease to 179 million in 2060. In that time the Hispanic population is projected to double from 53.3 million in 2012 to 128.8 million in 2060, at which
point one in three Americans will be Hispanic. The Asian population is also expected to more than double in this time period, from 15.9 million to 34.4 million. Meanwhile, the black population is also projected to increase, from 41.2 million to 61.8 million. In total, minority ethnic and racial groups, now 37%, are projected to grow to 57% of the total population by 2060. Psychologists with biases against non-majority groups may soon find themselves unable or unwilling to treat a majority of the population. The solution forward is not to accept discriminatory referrals as being in the best interest of patients but instead to strengthen and broaden the competencies and tolerances of current and future practitioners. This is in keeping with Standard 2.03 of the Ethics Code (2002): “Psychologists undertake ongoing efforts to develop and maintain their competence” (p. 1064).

**Feminist Ethics and Referrals**

Feminist ethical theories further shed light on why the issue of discriminatory referrals is inherently an ethical discussion. Feminist ethics are pansexual in their focus on universal respect, equality, and equanimity, but it must be noted that they are not a cohesive, unified field of thought; a number of variants co-exist. Indeed there “are multiple feminisms, such as liberal, Marxist, radical, relational, and postmodern…” (Brabeck, 2000, p. 18). But, according to Brabeck (2000) five overarching themes cut across the different schools of feminist ethical thought:

1. The assumption that women and their experiences have moral significance
2. The assertion that attentiveness, subjective knowledge, can illuminate moral issues
3. The claim that a feminist critique of male distortions must be accompanied by a critique of all discriminatory distortions.
4. The admonition that feminist ethics engage in analysis of the context and attend to the power dynamics of that context
5. The injunction that feminist ethics require action directed at achieving social justice.

(p. 18)

The last three of these injunctions are particularly relevant to a discussion of referrals. First, feminist ethics critique and analyze all aspects of discrimination. Second, feminist ethics investigates the power dynamics of context. The power dynamics of the therapy relationship, and especially the referral context, are complex, multifaceted, and unbalanced. Last, feminist ethics aims for social justice, germane to an investigation of where appropriate boundaries of professional discernment end and discrimination begins.

While feminist ethical theories do not directly address referrals, we can ground our understanding of this issue in their general spirit of respect for all persons, individual empowerment, and transparency in power dynamics. Perhaps the most pertinent question to ask is whether making a discriminatory referral is even an ethical question. The APA Ethics Code (2002) is equivocal, and one could argue (as Ms. Ward did) that a therapist would be unable to provide adequate care to an individual whose cultural background or other salient identity feature made the therapist uncomfortable. Why, according to a feminist ethics framework, would a referral in this case be an ethical consideration?

First, the third of the aforementioned feminist ethical principles states discriminatory distortions of all types must be critiqued. To sanction the refusal to treat for reasons of bias would be tantamount to complacency and a violation of this principle. Second, data from Ford and Hendrick (2003) suggests that therapists who refer when they feel uncomfortable often do so without having an open conversation with their patient. Thus, a hidden discourse of intolerance
exists outside of patients’ awareness and contributes to a larger culture of patriarchy and oppression. An illumination of this discourse speaks to the feminist ethical precept of investigating power contexts and flattening hierarchies wherever possible. Even if the actual reason for referral were openly discussed with the patient, it could understandably contribute to feelings of rejection and abandonment on the part of the patient. Last, therapists are service providers; to deny service, not for reasons of competence but of bias, is to discriminate unlawfully. Feminist ethics makes it clear that psychologists must work towards creating an environment of increased social justice, where illegal discrimination in mental healthcare is eliminated.

**Goals and Directions of the Current Study**

The current study aimed to initialize empirical research on the ethics of referrals in psychotherapy. While a large swath of unexplored territory exists around this issue, this project focused on certain key points. Broadly, this study attempted to answer the following questions:

1. What are the reasons psychologists make referrals? And more specifically, how often do they make discriminatory or otherwise unethical referrals?
2. What are psychologists’ beliefs about the ethics of making referrals?
3. Is there an association between psychologists’ beliefs and behaviors regarding making referrals?
4. How do work setting and time spent with colleagues affect psychologists’ attitudes and behavior regarding making referrals?
5. What are the most important factors psychologists consider when making referrals?
6. What are psychologists’ primary concerns when making referrals and how do they address them?

7. Is the Ethics Code (APA, 2002) sufficiently helpful to psychologists struggling with referral decisions?

The current lack of knowledge on these issues made *a priori* hypothesizing difficult. Perhaps one of the most important contributions this study makes is the proliferation of data in an otherwise impoverished field of research. Questions one, two, five and six were exploratory in nature and it was hoped that respondents would bring to light important preliminary information regarding the frequency and rationale behind their decisions to refer, as well as the most difficult referral situations they have faced. Still, some hypotheses were put forward for questions three, four and seven:

3. It was hypothesized that attitudes and behaviors towards unethical (both discriminatory and generally unethical) referrals are associated. That is, psychologists who make unethical referrals would have more permissive attitudes.

4. It was hypothesized that psychologists working in private practice would be more permissive and more likely to engage in unethical (discriminatory and generally unethical) referrals than their counterparts at hospitals, clinics, college counseling centers and other environments. The effects were hypothesized to be associated with time spent with colleagues. The reasoning behind this hypothesis was that professionals with greater interaction and visibility would have more opportunity for consultation, more oversight, and more social pressure to comply with the Ethics Code (APA, 2002).
7. It was hypothesized that the APA’s Ethics Code (2002) is insufficiently helpful for making difficult or complex referral decisions. The Code is overly vague and at points contradictory regarding discrimination in referrals.

**Methods**

**Participants and Recruitment Procedures**

The survey was sent out, via postal mail and electronic mail, over the course of two months, to a random sample of psychologists currently licensed to practice in the state of Massachusetts. The names and addresses of these individuals were obtained from the Massachusetts Office of Consumer Affairs and Business Regulation. This office provided a database of all psychologists licensed to practice in Massachusetts to the researcher for a fee of $30. The database includes mailing addresses, names, license numbers, and other relevant professional information. The database does not include email contact information.

An *a priori* power analysis was conducted using G*Power 3 software (Faul et al., 2007) based on the statistical tests (ANOVAs and correlations) that we anticipated using to analyze the data. Expecting a medium effect size, an alpha of 0.05 and power of 0.80, the minimum number of subjects suggested was 135. It must be noted that due to violations of assumptions of ANOVA, we used alternative statistical tests with looser assumptions and more power. Return rates for similar questionnaires have typically been between 30% and 50% (Gibson & Pope, 1993; Pope, Tabachnik, & Keith-Spiegel, 1987; Pope, Tabachnik, & Keith-Spiegel, 1988), but it must be noted that those surveys were administered over two decades ago, often had monetary or other incentives for respondents, and were sent via postal mail only. Nevertheless, given these
historical response rates, and the high cost of sending surveys via postal mail (nearly $4 per
respondent factoring in photocopying, printing, envelope, and postage stamp costs), a random
sample of 650 psychologists taken from the database was generated with the hope of receiving at
minimum 135 responses.

Of the 650 psychologists randomly selected for the sample, email contact information
was obtained on 400 using basic Google searches. Respondents whose email information was
not findable received copies of the survey and cover letter in the mail. Lower than expected
response rates (total N=70) led us to send out surveys to another 350 potential respondents (154
received mail surveys and 196 received web surveys), of which 36 returned surveys. Thus, of
the 1000 potential respondents in total, 106 completed the survey (total response rate=10.6%;
mail response rate=19.3%; web response rate=4.7%). See Results and Discussion Sections for a
full treatment of this issue.

Detailed demographic information on the final sample of 106 respondents is given in
Table 1. Briefly, the sample contained 69 women (65.1%), 35 men (33%), and two respondents
who did not give their sex. While this is a significant gender difference, it is consistent with
national averages. According to the Current Population Survey published by the United States
Bureau of Labor Statistics (as cited in National Science Foundation, 2013), as of 2011 women
represented 71.1% of psychologists in the labor force. Agewise, the sample was negatively
skewed, with 77.4% over the age of 45. The sample was similarly negatively skewed on years
practicing, with 65.4% having practiced over 20 years. This information is more difficult to
assess against the larger population because detailed age information is not available at either a
national or state level for practicing psychologists. According to the National Science
Foundation (2012), in 2008 over 40% of workers with doctorates in science and engineering
(S&E) occupations were over 50 years old, while the median age for S&E workers holding a doctorate was 47. Nevertheless, the S&E fields are varied and psychologists represent only a fraction of S&E degree holders. Making direct comparisons more complicated, the cutoffs for these averages were <30, 30-50, and >50, whereas in our study respondents identified as 18-30, 31-44, 45-60, 61-75, or over 75. Thus, there could be a significant number of respondents in our study who were between the ages of 45 and 50, and would have thus made the age distribution more similar to the national averages for S&E workers. Licensed psychologists may also be older on average than many other S&E workers because of high rates of graduates taking post-doctoral positions (National Science Foundation, 2012). Thus, we cannot definitively determine if our sample is older than the Massachusetts population of practicing psychologists, but it is likely quite similar.

Regarding work environment, 69 respondents (65.1% of the sample) primarily work in private practice; 12 respondents (11.3%) work in a hospital, 7 (6.6%) work in a community mental health center; 6 (5.7%) work in a university or school counseling center; 11 (10.4%) work in another environment (some examples were prisons, rehabilitation centers and the VA). Again, comparing these numbers to national or state averages is difficult. According to the Bureau of Labor Statistics, nearly a third of psychologists are self-employed, but these figures include professionals working in non-clinical fields such as academia, administration, and government (Bureau of Labor Statistics, 2012). The vast majority (68.9%) of respondents endorsed spending one to 15 hours per month interacting with colleagues, while 12.3% said they spend 16 to 30 hours per month with colleagues, 8.5% spend 31 to 45 hours, 4.7% spend more than 45 hours, and only 4.7% said they never interact with colleagues.
Measures

We developed a survey for this study that we called the Self-Assessment of Referral Ethics (SARE). The SARE is a self-report survey designed to assess the extent to which psychologists make referrals as well as measure their beliefs about the ethicality of these decisions. The structure of the instrument was based on the questionnaire developed by Pope, Tabachnik, and Keith-Spiegel (1987) to measure the beliefs and behaviors of psychologists working as psychotherapists, along with several edits based on Dillman’s tailored design method (Dillman, 2000). Variations of this questionnaire have been used in subsequent studies on ethics in psychology and related fields (Borys & Pope, 1989; Pope, Tabachnik, & Keith-Spiegel, 1988; Tabachnik, Keith-Spiegel, & Pope, 1991). Throughout its modifications the survey has maintained its essential architecture involving a list of behaviors and a Likert-type scale that respondents use to indicate both how often they engage in each behavior and how ethical they believe it to be. Interestingly, Pope & Gibson (1993) decided to abandon the earlier Likert-type scales for a dichotomous response format when assessing the behaviors and beliefs of counselors, explaining that the previous scale tended to produce responses falling within a ‘yes’ or ‘no’ pattern. Nevertheless, the use of a dichotomous response format restricts the range of possible answers and was not used for this instrument.

Conceptually, the SARE is divided into three parts, although it appears as a streamlined survey of 13 questions. The first section comprises two questions, each listing the same 12 behaviors associated with referral-making decisions and their rationales. In the first question, participants are asked to rate on a five-point scale how many times in the past five years they have engaged in each behavior. The scale allows participants to indicate never, 1 or 2 times, 3 to 5 times, 6 to 8 times, or >8 times. The second question lists the same behaviors but asks
respondents to rate how ethical they believe each behavior to be, also on a five-point scale, spanning completely unethical, somewhat unethical, somewhat ethical, completely ethical, or don’t know.

The ethical principles detailed in the APA’s Ethics Code (2002) served as the basis for the each item in the SARE. Some of the behaviors comply with ethical principles while others are gross violations. The varying degree of ethicality is based on what is most clearly prohibited by the Ethics Code (APA, 2002). Four main categories of question were constructed. First, the SARE lists generally ethical referral rationales, such as scope of practice, belief that a patient would be better helped by another clinician, and the possibility of a dual relationship. For example, the first item reads, “[Making a referral] because a client’s presenting problem falls outside of your area of expertise or competence.”

Second, the SARE presents discriminatory referrals based on discomfort with components of the patient’s identity, such as sexual orientation, ethnicity, and religious beliefs. For example, the seventh item reads: “[Making a referral] because of discomfort with a client’s religious or spiritual affiliation.” Third, one generally unethical item was constructed based on the implicit prohibition in current and past Ethics Codes (APA, 1992, 2002) that psychologists do not abandon patients, or terminate therapy when patients cannot pay for services. This prohibition is implicit in the most recent (2002) version of the APA Ethics Code, where Standard 10.10 (a) posits the only acceptable reasons for ending treatment are lack of benefit to patient, harm to patient, or threat of danger to provider. This injunction was written explicitly in the 1992 version of the Ethics Code (APA, 1992): “Standard 4.09(a): Psychologists do not abandon patients or clients (See also Standard 1.25e, under Fees and Financial Arrangements)”. Yet another contradiction within the Code must be noted: Standard 6.04(d) reads, “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.” The meaning of this precept is vague, though, because discussion, not termination or referral, is the objective. Given Standard 10.10 and the general spirit of the Code, limitations to services should not be interpreted as terminating or referring a patient, especially when financial limitations would present serious barriers to beginning a new treatment relationship with another provider and thus likely lead to ostensible abandonment.

Possible courses of action within the bounds of ethical treatment could be reducing the frequency of services, bartering for services as indicated in Standard 6.05, or temporarily interrupting services as indicated in Standard 3.12. The SARE item we constructed based on this prohibition reads, “[Making a referral] because a client may stop being able to pay for services or has stopped paying for services.” It is important to note that it would be ethical to refer a patient for financial reasons before services begin, but the question was deliberately worded “may stop being able to pay or has stopped being able to pay” to indicate the existence of a time when payment was possible, therefore relegating the referral to the category of abandonment. As Koocher and Keith-Spiegel (2008) write, “Once service has begun, the provider must consider the obligations for continuity of care due to the client” (p. 164).

Last, the SARE includes a group of questions that are ethically vague and do not neatly fit into any of the other criteria, dealing with issues of scheduling conflicts, erotic attraction, personality clashes, and fear of litigation. For example, the sixth item reads, “[Making a referral] Because a client has an annoying or difficult personality.” One question that appeared to confuse some respondents asked about making a referral in the context of past or ongoing sexual contact with a client. The question was designed to assess if respondents thought it ethical to make a referral once the initial ethical transgression (having sexual contact with a client) was irrevocably
made. Nevertheless, a number of respondents described their confusion about whether the question was asking if sexual contact or the referral post-sexual contact was unethical. We consider this in greater depth in the Results section.

The second part of the SARE, comprising questions three through six, asks participants to respond in a more open format. This section was designed to elicit the most personal and comprehensive responses from participants. Questions were constructed to foster a collaborative relationship with respondents in which they are able to go beyond the confines of the forced-choice questions of the first part. The aim was for participants to generate thoughtful responses and share their unique experiences and concerns about the referral process. Because referrals are understudied, we hoped these questions would produce valuable information about referrals not previously considered.

The third part of the SARE, made up of the final seven questions, asks participants about demographic information using a multiple-choice response format. We designed this component to tease out potential relationships between therapist experience and background with their attitudes and behaviors. In particular, we were interested in the relationship between work setting, time spent with colleagues, and ethical decision-making. There was reason to believe that we would see differences across professional environments. For example, Gibson and Pope (1993) reported that counselors in private practice are more likely to endorse as ethical “Terminating counseling if the client cannot pay,” “Avoiding certain clients for fear of being sued,” “Raising the fee during the course of counseling,” and “Charging for missed appointments” (p. 334). The authors suggest that a possible explanation is decreased financial security among those in private practice. Nevertheless, a separate question about income was
excluded from the SARE because of data suggesting such questions are aversive and may decrease survey response rate (Dillman, 2000).

There are other reasons why work setting may influence referral decisions. Our hypothesis was that work setting affects the total amount of time spent interacting with colleagues. Psychologists in private practice may have less opportunity for peer consultation. Research has shown that social influence—more likely to exist in institutional and group work environments than private practice—has a profound effect on attitudes and behaviors (Cialdini, 2005). In addition, prior research has shown that people are more likely to make unethical decisions when their identity is concealed (Festinger et al., 1952; Singer et al., 1965; Zhong et al., 2010). Although psychotherapists in private practice are not anonymous, their work occurs in greater seclusion than practitioners in hospitals, university counseling centers, or community mental health settings. To tease apart these phenomena, the SARE asks about time spent with colleagues and other professionals in addition to work setting.

Reliability and validity were not assessed because of the limitations of the survey format. Asking respondents to complete the survey multiple times or fill out an additional survey was not feasible. Moreover, measuring criterion-related validity was a problem because the SARE is distinct—in content but not in form—from other ethics surveys. Because of the paucity of empirical studies on referral making behavior and attitudes, there are no extant surveys that could be used to establish concurrent validity with the SARE.

**Quantitative Data Analysis Procedures**

We numerically coded all of the responses to the SARE save for the four qualitative questions. For frequency of behaviors, 1=never, 2=1 or 2 times, 3=3 to 5 times, 4=6 to 8 times,
and 5=more than 8 times. For attitudinal ratings, 1=completely unethical, 2=somewhat unethical, 3=somewhat ethical, 4=completely ethical. For our third hypothesis, “Don’t Know” (DK) responses to attitudinal ratings were eliminated from correlational analyses. DK responses were distributed completely at random across the dataset, confirmed by Little’s Missing Completely at Random (MCAR) test ($\chi^2=143.157$, df=182, $p=0.985$). Meanwhile, our fourth hypothesis utilized a composite score set on a continuous scale as a mean of responses to four items categorized as generally unethical or discriminatory.

Missing data was a minor problem in this study. Overall, 2.61% of the dataset was missing value-wise, while 18.87% was missing case-wise and 0% variable-wise. The pattern of missing data did reach significance ($\chi^2=429.62$, df=275, $p<0.000$) for Little’s Missing Completely at Random (MCAR) Test (Little, 1988). Nevertheless, the much less stringent missing at random (MAR) is the more appropriate underlying assumption of multiple imputation, and while the impossibility of determining MAR has been documented (Mackinnon, 2010), the missing data represented a relatively small percentage of the overall dataset (2.61%), suggesting multiple imputation would be an appropriate technique to increase power and reduce bias. We used a logistic regression model of multiple imputation in SPSS 21 (5 imputations) because all of the variables were ordinal (only the composite score was continuous). This procedure was administered on both independent and dependent variables. Multiple imputation datasets were used only to address the third and fourth research questions.

The first two research questions were exploratory in nature. They asked: 1) Why do psychologists make referrals, and specifically how often do they make discriminatory or otherwise unethical referrals?; and 2) What are psychologists’ beliefs about the ethics of making
referrals? These questions were addressed using descriptive statistics, histograms and frequency tables on the original, non-imputed data.

The third research question was hypothesis-driven: *It was hypothesized that attitudes and behaviors towards discriminatory and generally unethical referrals would be associated. That is, psychologists who make unethical referrals will have more permissive attitudes.* The logic of this hypothesis was based on well-known theories of compatibility between attitudes and behaviors, such as the theories of reasoned action (TRA; Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975) and planned behavior (TPB; Ajzen, 1988, 1991), which have been shown to explain between 19% and 38% of the variance in behaviors (See Sutton, 1998 for a review). Because of problems with missing data, we performed multiple imputation to correct bias and avoid reducing our power. We then used pooled data collected from our multiple imputation model for these analyses. As a preliminary step, the data were tested for assumptions of linearity, normality, and homoscedasticity. Much of the data for frequency of engagement in referral behaviors (as opposed to ethicality ratings) was severely restricted in range and failed tests of these assumptions. Therefore, we calculated non-parametric Spearman’s Rho correlation coefficients to assess association between responses to the first two questions of the SARE. To deflate the Type I error rate, we used a Bonferroni-corrected alpha of 0.0042, and because of the large number of items in the first two questions, we generated composite scores for ethical and discriminatory items (“Because a client may stop being able to pay for services or has stopped paying for services” was the only generally unethical item). For ratings of ethicality (Question 2), these composites had sufficiently large Cronbach alpha scores (0.77 for ethical and 0.98 for discriminatory composite scores). But the Cronbach alpha scores for Question 1 composites
(frequency of behaviors) were low (0.62 for ethical and 0.41 for discriminatory composite scores), thus individual items were used to calculate Spearman’s rank order coefficients.

The fourth research question was also hypothesis-driven: *It was hypothesized that psychologists working in private practice will be more likely to be permissive of and engage in discriminatory and generally unethical referrals than their counterparts working in other environments. The effects were hypothesized to be associated with time spent with colleagues.*

Again, we used pooled data from our multiple imputations for this analysis. The data for frequency of behaviors were severely restricted in range, with over 95% of participants reporting never having engaged in five of the thirteen listed behaviors, and over 80% reporting never having engaged in eight of the listed behaviors. Thus, we modified this hypothesis and subsequent data analysis to look only at attitudes towards these behaviors, which showed greater range. We tested our hypothesis using Hayes’ (2012) PROCESS for SPSS bootstrapping mediation model of regression, with a composite of unethical and discriminatory attitudes as the outcome (continuous variable), workplace environment (dichotomous variable: private practice vs. other) as the predictor, and hours spent interacting with colleagues (treated as continuous) as the mediator. The internal consistency of the composite score used as the output exceeded the appropriate threshold (Cronbach’s alpha=0.82). As per Hayes’ recommendations, we set our model to 5000 bootstrap sample, 95% confidence intervals, and a standard p-value of 0.05. Because Hayes’ PROCESS macro for SPSS 21 does not run with multiply imputed data, we performed the test first on the original data and subsequently on each imputation data set; the results were pooled according to Rubin’s formula (1987). This model was particularly well-suited to our data because it does not assume a normal distribution. It is also more powerful than other mediation models and works well with small samples. We followed Hayes’ (2012)
recommendation of using the 95% bias-corrected bootstrapped confidence interval as a measure of the significance of the indirect effect in the mediation model. In the process of running these regression analyses, we evaluated and verified the assumptions of independence of errors, normal distribution and homoscedasticity of the residuals.

**Qualitative Data Analysis Procedures**

Qualitative data collected from the SARE was analyzed using thematic analysis (Aronson, 1994; Braun & Clarke, 2006). Braun and Clarke outlined six major steps required for comprehensive thematic analysis. These are: becoming familiar with the data; generating initial codes; searching for themes; reviewing themes; defining and naming themes; producing the report. These steps were all executed using Microsoft Excel without the aid of qualitative analysis software packages because of the considerable complications these programs present to first-time users (Saldaña, 2012). Within thematic analysis, both deductive and inductive methods are applicable. Here, a bottom-up, or inductive approach was taken with the data because of the largely exploratory nature of the questions. The advantage of this type of qualitative analysis is that it does not operate from a preconceived epistemological framework and is thus open to the wide range of responses that may be generated by respondents.

**Results**

**Multimodal Analysis**

Chi-square analyses with survey mode as grouping variable (web or mail) were performed on all survey questions to determine if they culled from different populations. Because of the large number of contrasts an alpha of 0.01 was used. All results failed to reach
significance, indicating the samples were part of the same population. As expected, a chi square analysis revealed a significant difference in response rate between these modes \( \chi^2(1, N=1000) = 54.22 \), with a significance level less than 0.000.

**Quantitative Data Analysis**

*Research Question 1:* The first research question asked what are the reasons psychologists make referrals, and more specifically, how often do they make discriminatory or otherwise unethical referrals? The first question of the SARE was designed to broadly answer this question by asking psychologists how many times in the last five years they had made referrals for various reasons. See Table 2 for a complete listing of the percentage of psychologists responding in each category of Question 1.

Frequencies of referrals based on ethical rationales (Because a client’s presenting problem falls outside of your area of expertise or competence; Because a client might get better care from another clinician; Because of a possible dual relationship with a client) varied across subcategories but were generally the most commonly selected reasons for referring. The data on the number of referrals made because patient issues fall outside of the respondent’s scope of practice were negatively skewed \((M=3.52, SD=1.25)\), indicating psychologists often make referral decisions based on this reasoning. In fact, this was the most commonly endorsed rationale for referring. The data on the number of referrals made because of the belief that a client might get better care from another clinician were slightly positively skewed, \((M=2.83, SD=1.37)\), with nearly half of respondents (47.1%) indicating they had used this rationale either never or 1 or 2 times in the past five years. Further, more than three quarters of respondents
(83.6%) indicated that they never made referrals because of a possible dual relationship with a client or only 1 or 2 times in the past five years ($M=1.92, SD=1.09$).

Frequencies of referrals based on discriminatory reasoning showed a restricted range with a very high degree of positive skewness. In this sample, 96.2% of respondents said they never made a referral in the past five years because of discomfort with a client’s religious or spiritual affiliation ($M=1.03, SD=0.17$), while 2.8% said they had done so 1 or 2 times in the past five years. Similarly, 97.2% of respondents indicated they never made a referral in the past five years because of discomfort with a client’s ethnicity or cultural background ($M=1.02, SD=0.14$), while 1.9% indicated having done so 1 or 2 times in the past five years. Finally, 96.2% of respondents said they never made a referral in the past five years because of discomfort with a client’s sexual orientation ($M=1.04, SD=0.31$), while only 0.9% acknowledged having done so 1 or 2 times in the past five years.

The frequency of referrals made because a client may stop being able to pay or has stopped paying for services, the only item implicitly prohibited by professional ethics codes, was very positively skewed, but with a significant amount of range across the sample ($M=1.5, SD=0.96$). In the past five years, 67.9% of respondents indicated never having made a referral for this reason, while 17.9% admitted having used this rationale 1 or 2 times, 6.6% said they had done so 3 to 5 times, 0.9% indicated doing so 6 to 8 times, and 3.8% said they had done so more than 8 times.

Finally, frequencies of referrals made for various ethically ambiguous reasons were predictably scattered. Data on referrals made because of a scheduling conflict ($M=3.80, SD=1.52$) were negatively skewed, and the mode of 5 (>8 times in the past five years) suggested this was a common reason for referring patients. More than half (58.5%) of respondents said
they have never in the past five years made a referral because a client had an annoying or difficult personality ($M=1.54$, $SD=0.81$), while 28.3% endorsed having done so 1 or 2 times, 8.5% 3 to 5 times, none 6 to 8 times, and 1.9% more than 8 times. Nearly all (98.1%) of respondents endorsed never having made a referral in the past five years because they were sexually attracted to a client ($M=1.01$, $SD=0.10$), while 0.9% said they had done so 1 or 2 times in the past five years. No other responses to this question were given. Again, nearly all (98.1%) of respondents said they had never made a referral because of past or ongoing sexual contact with a client ($M=1.0$, $SD=0.0$), the only response to this item. Last, 81.1% of respondents indicated never having made a referral in the past five years because of fear of being sued ($M=1.27$, $SD=0.67$), while 12.3% said they had done so 1 or 2 times, 3.8% 3 to 5 times, 0.9% 6 to 8 times, and another 0.9% more than 8 times.

*Research Question 2:* The second research question asked what are psychologists’ beliefs about the ethics of making referrals? Question 2 of the SARE was designed to provide some clarity on this issue, asking respondents to rate their beliefs about the ethics of the same referral rationales presented in Question 1. See Table 3 for a full listing of the percentage of psychologists responding in each category of Question 2.

Psychologists’ ratings of the ethicality of items conforming with the APA Ethics Code (2002) ([Making a referral:] Because a client’s presenting problem falls outside of your area of expertise or competence; Because a client might get better care from another clinician; Because of a possible dual relationship with a client) were highly negatively skewed and restricted in range, meaning they rated ethical rationales as being ethical in their opinion. Most respondents (91.5%) said they believed making a referral because a client’s presenting problems falls outside of their area of expertise or competence ($M=3.83$, $SD=0.67$) was completely ethical, while 0.9%
said it was somewhat ethical, another 0.9% said it was somewhat unethical, and a surprising 4.7% said it was completely unethical. Similarly, 94.3% of respondents said they believed making a referral because a client might get better care from another clinician \((M=3.93, SD=0.38)\) was completely ethical, while 1.9% said they thought it was somewhat ethical, 0.9% said it was somewhat unethical, and another 0.9% said it was completely unethical. Meanwhile, 84.9% of respondents indicated they believed making a referral because of a possible dual relationship with a client \((M=3.79, SD=0.69)\) was completely ethical, while 3.8% thought it was somewhat ethical, 2.8% thought it was somewhat unethical, 3.8% thought it was completely unethical and 0.9% said they did not know.

Psychologists’ ratings of the ethicality of discriminatory referral decisions ([Making a referral:] Because of discomfort with a client’s religious or spiritual affiliation; Because of discomfort with a client’s ethnicity or cultural background; Because of discomfort with a client’s sexual orientation” was bimodal, with the major mode being “completely ethical” and the minor mode being “completely unethical.” 22.6% of respondents said they thought making a referral because of discomfort with a client’s religion \((M=2.57, SD=1.26)\) was completely ethical, while 19.8% thought it was somewhat ethical, 21.7% thought it was somewhat unethical, 25.5% thought it was completely unethical, and 4.7% did not know. A similar but not identical pattern of responses was observed for ratings of how ethical psychologists believed it was to make a referral because of discomfort with a client’s ethnicity or culture \((M=2.45, SD=1.30)\), with 19.8% saying they thought it was completely ethical, 16.0% saying they thought it was somewhat ethical, 22.6% believing it to be somewhat unethical, 30.2% believing it to be completely unethical, and 5.7% saying they did not know. Last, 18.9% of respondents believed that making a referral because of discomfort with a client’s sexual orientation \((M=2.34, \ldots)\).
SD=1.22) was completely ethical, while 17.0% thought it was somewhat ethical, 24.5% thought it was somewhat unethical, 31.1% thought it was completely unethical, and 2.8% said they did not know.

The one item designed to conform with the APA’s prohibition of abandoning clients for financial reasons showed (M=2.92, SD=1.27) unexpectedly varied responses. 29.2% of psychologists rated this referral rationale as completely ethical, 31.1% said it was somewhat ethical, 20.8% said it was somewhat unethical, only 6.6% said it was completely unethical, and 7.5% said they did not know.

Psychologists’ ratings of the ethicality of referral rationales designed to be ethically ambiguous differed greatly across items. 80.2% of respondents said they thought making a referral because of a scheduling conflict (M=3.87, SD=0.59) was completely ethical, while 6.6% said they thought it was somewhat ethical, 3.8% said they believed it to be somewhat unethical, 0.9% said they believed it to be completely unethical, and 4.7% said they did not know. In comparison, 21.7% of respondents rated making a referral because a client has an annoying or difficult personality (M=2.66, SD=1.12) as completely ethical, while 25.5% rated it as somewhat ethical, 30.2% rated it as somewhat unethical, 16.0% rated it as completely unethical, and 3.8% said they did not know. Further, 66.0% of respondents thought making a referral because of sexual attraction to a client (M=3.64, SD=0.83) was completely ethical, while 13.2% thought it was somewhat ethical, 8.5% thought it was somewhat unethical, 2.8% thought it was completely unethical, and 4.7% did not know. 10.4% of respondents said it was completely unethical to refer because of past or ongoing sexual contact with a client (M=3.76, SD=1.03), while 0.9% thought it was somewhat ethical, 72.6% thought it was completely ethical, and 9.4% said they did not know. Importantly, there was some confusion about the phrasing of this item and some
respondents indicated that although they responded to the item as “completely unethical,” they were identifying the sexual contact, not the referral, as the unethical component. Last, 20.8% of respondents thought making a referral because of fear of being sued ($M=2.92$, $SD=1.27$) was completely ethical, 15.1% thought it was somewhat ethical, 35.8% thought it was somewhat unethical, 10.4% thought it was completely unethical, and 14.2% did not know.

**Research Question 3:** We hypothesized that attitudes and behaviors towards discriminatory and generally unethical referral rationales would be associated. Spearman’s rank correlation coefficients were used on pooled data from our multiple imputation model to test this hypothesis as well as to explore the relationships between attitudes and behaviors on other items on the SARE. Spearman’s rank correlation coefficients, rather than Pearson product-moment correlation coefficients, were used because the data for behaviors did not meet the statistical assumptions of normality, linearity, and homoscedasticity and did not improve with log transformations. DK responses were eliminated from analyses. Composite scores were created for ethical and discriminatory items to reduce the Type I error rate. Results from these analyses are presented in Table 4. Item 4 ([Making a referral] Because a client may stop being able to pay for services or has stopped paying for services), which we constructed as the only generally unethical item on the SARE, showed a significant relationship between attitudes and behaviors ($n=97$, $\rho=0.387$, $p<0.000$). There was a significant correlation between attitudes and behaviors on Item 6 ([Making a referral] Because a client has an annoying or difficult personality) ($n=101$, $\rho=0.402$, $p<0.000$). A significant correlation was also found between attitudes and behaviors on Item 12 ([Making a referral] Because of fear of being sued) ($n=90$, $\rho=0.321$, $p=0.002$). All other correlations failed to reach significance. 100% of respondents answering Item 11 ([Making a referral] Because of past or ongoing sexual contact with a client) endorsed never having engaged
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in that behavior, ruling out correlated attitudes and behaviors.

Research Question 4: We hypothesized that psychologists working in private practice would have more permissive attitudes towards generally unethical and discriminatory referrals, and that the effect would be mediated by hours spent interacting with colleagues. We used a bootstrapping regression model of mediation (Hayes, 2012; Preacher & Hayes, 2004) based on a simple mediation model, in which X influences Y directly and indirectly, and the direct and indirect effects of X are derived from two linear models ($M = i_M + a_i X + e_M$ and $Y = i_Y + c' X + b_1 M + e_Y$). Unstandardized indirect effects were computed for each of 5000 bootstrapped models to test this hypothesis with work site as the predictor (private practice vs. other), hours spent interacting with colleagues as the mediator, and a composite of the generally unethical and discriminatory items as the outcome (the mean value of four ratings using the scale 1= completely unethical, 2=somewhat unethical, 3=somewhat ethical, 4=completely ethical). See Figure 1 for an illustration of this mediation model. The total effect ($c_1$) of the model was statistically significant ($c_1 = 0.527$, $SE = 0.183$, $p = 0.0056$), indicating that psychologists working in private practice rated generally unethical and discriminatory items as more ethical (a mean rating of 0.527 higher, or more skewed towards a rating of ethicality, than their counterparts working in other environments). The direct effect ($c_{1\gamma}$ was not statistically significant but approached the trend level, ($c_{1\gamma} = 0.342$, $SE = 0.184$, $p = 0.074$), but the indirect effect ($a_ib_i$) was significant ($a_ib_i = (-0.598)(-0.322) = 0.193$, Boot SE = 0.0794, LLCI = 0.0513, ULCI = 0.445, $p < 0.05$). The 95% confidence interval indicates significance, as Hayes (2012, p. 13) explains, “Recent recommendations tell us to base inference about the indirect effect not on the statistical significance of the paths that define it ($a_i$ and $b_i$), but, rather, on an explicit quantification of the indirect effect itself and a statistical test that respects the nonnormality of the sampling
distribution of the indirect effect.” In this analysis the confidence interval is entirely above zero (lower limit confidence interval=0.0414, upper limit confidence interval=0.446), indicating a significant mediation. We can interpret our results as indicating that, on average, psychologists working in private practice rated unethical (both generally unethical and discriminatory) items as (0.193 points) more ethical than their colleagues working in other environments, as a result of the effect of hours spent interacting with colleagues. Psychologists working in private practice spent on average less time with colleagues (.598 units of 15 hour intervals less time) than their counterparts working in other environments, and those who spent less time interacting with colleagues rated generally unethical and discriminatory items as more ethical, $b_1=-0.322$.

Nevertheless, it must be noted that our mediator was not, strictly speaking, continuous, even though we treated it as such. While we did not violate assumptions of the model (Hayes, 2009, 2012), caution must be taken in interpreting the amount of time with colleagues that is meaningful in this interaction because each unit was a collapsed 15 hour per month interval.

**Qualitative Data Analysis**

Responses to qualitative questions from the SARE were analyzed using thematic analysis. This section of the survey was designed to answer these research questions: What are the most difficult aspects of making referrals? What are the primary concerns of psychologists making referrals and how do they address them? Is the Ethics Code (APA, 2002) sufficiently helpful to psychologists struggling with referral decisions? The results are organized by research question, and each theme is outlined and illustrated with examples below.
Research Question Five. We asked respondents, what are the most important factors you consider when you make a referral? This open-ended question was designed to elicit responses about how and why psychologists make referrals, as well as what they prioritize in their decision making process. Responses encompassed a large range of data points, but the majority fell into the following five themes: Scope of practice; goodness of fit; ethics; risk; remuneration. These themes are presented in brief along with relevant quotations from respondents. See Figure 2 for a graphic representation of themes and subthemes.

Scope of practice. The vast majority of respondents referenced some aspect of scope of practice as being among the most important factors they consider when making a referral. Responses categorized under this theme shared a focus on issues of expertise, efficacy, and the nature of the client’s presenting problems. These answers tended to center around beliefs about the respondents’ own competence (subtheme: competence of referral source) compared to the perceived expertise of the therapist to whom they were referring (subtheme: expertise of referred therapist), fit between the client’s presenting problems and clinician expertise (subtheme: client’s presenting issues), the theoretical orientation of the clinician to whom they were referring (subtheme: theoretical orientation of referred therapist), and if the referral was solely for adjunctive therapy rather than primary therapy (subtheme: adjunctive therapy). For example, one respondent said the most important factor she considers when making a referral is, “Matching the patient with a provider that will offer the most efficacious treatment for their presenting problem.” Another respondent wrote, “Some patients need specialists for, say, trauma or eating disorders. Some need specialized interventions (e.g., EMDR). I refer out if I don't have the specialized knowledge/experience to help them enough…Many referrals are for couple's therapy or other adjunctive modalities.”
Goodness of fit. By far the second most common theme embedded in the responses was related to goodness of fit or match quality between clinician and patient, irrespective of issues of expertise. Whereas scope of practice responses were primarily focused on questions of competence, goodness of fit as a theme centered on questions of personality or style (subtheme: patient’s personality), comfort with prospective therapist’s gender, ethnicity, religion or other identity factors (subtheme: identity factors of referred therapist), logistics of availability and scheduling (subtheme: availability), the respondent’s interest in working with a particular patient (subtheme: referral source’s desire to work with patient), and an overall feeling of harmony between clinician and patient, without specific reference to skill, knowledge or expertise (subtheme: “good match” between patient and referred therapist). For example, one respondent wrote:

I want to be sure that clients get the best possible help possible. If a limitation in the form of a bias or lack of comfort on my part arises when someone interviews me or calls asking to begin treatment I am ethically obligated to refer them to someone who does not carry such obstacles. This is why I have developed a fairly careful screening process involving up to a month of consultation sessions in order to determine that both parties believe that the fit is a good one which would be conducive to treatment.

Another respondent wrote of an intangible feeling of “fit” as being highly important:

My "fit" with a client and a client's "fit" with me. I don't assume a client wants to see me for treatment until we've met. I always ask if they're comfortable with me and let them know my comfort level and ability to work with them.
Remuneration. Approximately one third of respondents mentioned remuneration as a crucial consideration when making referrals. This theme included responses indicating the psychologist would refer out when a patient could not pay their fee (subtheme: payment) or had health insurance they did not accept (subtheme: insurance). One respondent wrote, “If a new referral and client has no insurance, or can't pay, I will refer them to someone who can see them given their financial circumstances.” Another respondent concisely summarized this issue, “Unfortunately in this day and age the number one consideration for my clients is insurance.”

Ethics. A significant minority of respondents mentioned ethical concerns as being critical to their process of making referrals. They indicated that they considered possible multiple relationships with prospective clients (subtheme: multiple relationship) and the ethics of the therapist to whom they were referring (subtheme: ethics of referred therapist). One respondent wrote that the most important factors he considers are the “clinician's competence, expertise and proven trustworthiness (e.g., ethics).” Another wrote, “Most of my referrals occur because I am uncomfortable treating members of the same family or close friends to a patient.”

Risk. The last theme identified dealt with the level of risk presented by the patient. Respondents highlighted two particular types of risk they considered, namely client’s risk of harm to self or others (subtheme: client level of risk), and their own fear of being sued by a client (subtheme: fear of being sued). One respondent wrote: “Legal issues (potential of being sued)”. Another indicated safety as a primary concern: “Safety--some clients need a psychiatrist with admitting privileges as well as a therapist.” Meanwhile, another wrote, “When transference, client behavior, is inappropriate (e.g., threatening, disrespectful of boundaries, inappropriate)….If a different form of intervention is needed to stabilize an unstable client.”
Research Question Six. We asked survey respondents, what concerns do you have when you make a referral? How do you address them? Six themes were identified across responses. Four of the six themes also appeared in Question three, although with a slightly different composition of subthemes. Each is described and illustrated with example quotations below. See Figure 3 for a graphic display of themes and subthemes.

Client welfare. The majority of respondents indicated they were most concerned about the well-being of the client whom they were referring. They articulated worries about the client feeling abandoned or rejected by them (subtheme: client’s feelings of abandonment), the client actually seeing the new therapist (subtheme: client follow-through), the importance of giving the client multiple referrals from which to choose (subtheme: give more than one option), helping clients with the transition to a new therapist (subtheme: assist with transition), communicating directly with clients about the referral process and checking in to evaluate how the referral progressed (subtheme: communication with clients), and communicating with the referred therapist about the patient both ahead of time and after to check-in (subtheme: communication with referred therapist). For example, one respondent wrote of how she attempts to handle client feelings of abandonment:

Patient's experience of the referral—do they feel rejected, do they understand the reasoning, can I find them a better fit? I am fairly open about this, I tend to put the onus on me ("I don't have the right expertise," "I'm not available when you need me to be").

Another respondent wrote how client follow-through is her primary concern and how she addresses this issue:
Patient not following through. I address by following up and working to facilitate new relationship as best I can. For example, if I am referring for couple's counseling, I will obtain a release of info and correspond/talk to the clinician prior to the first session. That way there is a known connection between me and the 'new' therapist.

**Scope of practice.** As with Question Three, the majority of respondents alluded to some aspect of scope of practice as being a primary concern when making referrals. Many of the same subthemes emerged, as well, including the client’s presenting issues, the expertise of the therapist to whom they were referring, and the theoretical orientation of the new therapist. One respondent listed her primary concern and method of alleviating this concern as, “Is the person I am referring to competent and likely able to help that person? I may call the therapist and talk about that subject before referring the client (without identifying the client, of course).” Note that this response was also coded for the subtheme of communication with referred therapist under the general theme of client welfare because of the way the respondent addressed her concern.

**Goodness of fit.** Goodness of fit, which along with some of the same subthemes (patient’s personality, availability, identity factors of referred therapist, and “good match” between patient and referred therapist) also emerged as a prominent theme in responses to Question Three, was a concern for more than a third of respondents. One respondent wrote, “I ask who the client might feel comfortable with, male or female? Gay or straight? Spirituality? Older or younger? Active or quieter? Etc.”

**Remuneration.** Remuneration, with subthemes of payment and insurance, emerged as a concern for many respondents. They expressed worry over being paid or referring financially
insolvent patients to other providers likely to be out of network. This theme was well
summarized by one respondent who listed her sole concern as being financial: “Payment--few
referrals take insurance.”

**Professional issues.** A high number of respondents mentioned interprofessional issues as
being of primary importance. Mostly this appeared as concerns about knowing the quality of
other therapists’ work or having a sufficiently large referral network (subtheme: familiarity with
other clinicians). Two related subthemes were being able to refer within a practice or clinic
(subtheme: referring within practice) and strengthening professional relationships through
referrals (subtheme: professional relationships). For example, one respondent wrote:

> Being in a new town now, my concern is that I don't personally have even an
> acquaintance with many clinicians to know anything about their skills, ethics, and
> personal style. It is harder now to have confidence in my referral discernment. In
> my former town, I knew lots of therapists, could suggest potential good-fit
> referrals as needed for most people calling me.

Another respondent voiced her concerns about knowing the quality of other therapists’
work, “One never knows the quality of a colleague unless you've supervised them, and even
then, unless you've watched their tapes.”

Meanwhile, another respondent wrote of the potential benefits to professional
relationships that referrals can bring, “I may be thinking about whether they need the business,
whether our relationship will be strengthened by virtue of my making a referral to them.”

**Risk.** Again the subthemes of client level of risk and fear of being sued emerged. One
respondent told a particularly evocative story of perceived threat from a patient and how she
reacted:
The most difficult referral I ever made was for an ongoing patient whom I became increasingly frightened of as he became violent in my office and verbally threatened my family. I referred him to a wonderful therapist, but he remained angry about being referred. In this instance, my discomfort weighed more heavily on my mind than the patient's desires. I let him know that the fear I felt made me unable to work with him productively.

**No Concerns.** A small minority voiced having no concerns about making referrals or never making referrals at all. For example, one respondent wrote of having no worries about the referrals process, “None. If I make a referral I am making one for a good reason - my caseload is not completely full and so I don't make them often.”

**Research Question Seven.** We aimed to assess whether psychologists feel the APA Ethics Code and the extant professional literature are sufficiently helpful to guide decision making regarding referrals or whether there is a gap in professional resources. We asked, is there an aspect of the referral-making process in psychotherapy that you feel is not adequately covered by professional literature and the Ethics Code? Responses were widely disbursed amongst a range of themes, including: Generally inadequate coverage, goodness of fit, professional issues, remuneration, adequate coverage, and do not know. Themes and subthemes are described below with illustrative quotations taken from the responses. Figure 4 presents a graphical representation of themes and subthemes.

**Generally inadequate coverage.** Many responses indicated that the Ethics Code and available literature do not adequately cover the issue of making referrals. These responses suggested the Code was generally vague, although this was both voiced as a negative and a
positive (stating the ambiguity allows more room for clinical judgment). One respondent wrote, “It seems like there is very little actually covered by the APA code when it comes to referral--mainly--if you don't have the necessary knowledge, get it, and people can't get paid for referrals.” Another respondent wrote, “Overall, I think patient/therapist boundaries are not covered thoroughly enough, which causes problems at time of referral.” Still another respondent indicated that the Ethics Code is purposely vague, “The ethical rules are fairly vague and do not seem to be limiting.”

**Goodness of fit.** A significant number of responses spoke to specific facets of the referral making process they felt were inadequately covered, in particular the goodness of fit between therapist and client and what should be done when the fit is not good. Subthemes included issues of discomfort with the patient’s personality, feeling safe around the patient, countertransference reactions, and patient identity factors. One respondent wrote:

Yes - far as I know, I don't recall reading about personal feelings about clients, such as the discomfort with their orientation, race, religion, etc. I suppose one isn't supposed to have such feelings, but they do exist and might get in the way of good therapy.

Another respondent wrote:

Cultural issues and considerations should be addressed more specifically, with specific guidelines and examples. With refugees and other trauma survivors, trust and safety issues must be considered in terms of the referral.

**Professional issues.** Professional issues reemerged as a prominent theme in this question after also appearing in the responses to Question Four. Here, the responses focused on having an adequate referral network or knowing of available, high-quality therapists. Some respondents
suggested that a referral database be established for therapists to update with information about area of expertise and availability. One respondent wrote, “It would be nice to have a database that indicates whether someone is taking referrals, what sorts of patients they will and won't accept, but no one would want to update availability in real time.”

**Remuneration.** Again the issue of remuneration, specifically getting paid for services and navigating the complexities of managed health care, emerged in the data. One confused respondent wrote:

> The relationship between insurance coverage changes and referrals is not totally clear to me. I usually lower my fee significantly rather than discontinue an existing treatment relationship. I personally find it unethical to refer an ongoing patient because they can't pay a full fee but do not believe it's unethical according to APA

**Adequate coverage.** A third of respondents wrote that they did not feel that the Ethics Code or literature were lacking adequate coverage. Most of these responses were phrased simply as “No” or “Not that I can think of.”

**Do not know.** Somewhat surprisingly, approximately a third of respondents who answered this question indicated they did not know if this issue was adequately covered by the literature or the Ethics Code. Most responses were phrased as simply, “I don’t know.” But some revealed a lack of attention to this issue in general. One respondent wrote, “I really haven't given it much thought. I'm comfortable with the way I work.” Another put it more succinctly: “I have no idea about the literature on this!”
Finally, we asked respondents: Is there anything you feel it is important to know about making referrals that has not been addressed? If so, please provide whatever information you feel comfortable sharing. This question was the most unstructured and was designed to capture data that was not expressly pulled for by *a priori* hypotheses. But the themes that appeared in the responses were consistent with answers to the previous questions. They are presented here in brief with relevant quotations only where the subthemes are significantly different than those from previous questions. Figure 5 presents a graphical representation of the themes and subthemes.

**Client welfare.** The most pervasive theme in this set of data was client welfare. Responses categorized under this theme involved checking in on clients after a referral was made (subtheme: follow up), working with clients who return after a failed referral (subtheme: returns), discussing the referral with the client to make him or her feel comfortable about the process (subtheme: communication with client), and discussing the referral with the new therapist (subtheme: communication with referred therapist). One respondent wrote of how comprehensive this process can be:

> Depending on the context, referring sometimes requires more than giving a name and contact information. Clients sometimes need more support and assistance to follow up on referrals. It can be too easy to believe one did his job just by handing off a name and number.

Another respondent indicated the importance of investigating this issue but with a greater focus on client care:

> It should always be part of supervision and follow-up. The principal concern and objectives of all care of others should be more deeply addressed in this
questionnaire. In raising the important question of referrals you are beginning to do a great service to the profession. But the goal of all patient care is implicitly never to hurt the patient by any of your actions.

**Scope of practice.** Again scope of practice appeared at the forefront of respondents’ minds. These responses covered client’s needs (subtheme: client’s presenting issues), the expertise of the therapist receiving the referral (subtheme: expertise of referred therapist), and the complexities of referring solely for adjunctive therapy (subtheme: adjunctive therapy).

**Goodness of fit.** The intangibles of “fit” or “match” were voiced in this section of the survey as well. Subthemes included client comfort with therapist identity factors and therapist comfort with client identity factors. One respondent wrote of how much of this depends on the client’s preferences, “Some questions depend on client, e.g., for some clients it is important to client that you understand their religion, culture, or sexual preference, etc., with others, it is not.”

**Professional issues.** Many respondents mentioned professional issues as being at the core of their referral making decisions. Responses ranged from issues about referral network (subtheme: familiarity with other clinicians) to how important consultation is to the process. One respondent spoke of how challenging it can be to build a referral network:

One thing that is rarely mentioned is the professional network that needs to be developed and maintained in order to make referrals. I do spend time maintaining my professional relationships so that I can make and get referrals from people who know me well and understand how I work. I did not know in grad school that I would need to attend to that factor, though it becomes clear very quickly in private practice.
Remuneration. Nothing new emerged about the topic of remuneration when considering referrals, but the frequency of its mention throughout the survey made it clear just how important this issue is to many. One respondent summarized what he saw as a major gap in the professional ethical guidelines and reiterated it in this section, “The importance and complexity of payment (i.e., insurance coverage).”

Discussion

This study explored the ethics of referrals in psychotherapy by probing the beliefs and behaviors of psychologists making referrals. A particular focus of this inquiry was discriminatory referrals, or referrals made to alleviate therapist discomfort with salient patient identity factors. This topic has not previously been the subject of empirical research and this study marks a preliminary investigation into an important issue. As the population of the United States becomes increasingly diverse (US Census Bureau, 2012) and tolerance and multicultural competence continue to be cornerstones of the APA’s mission (APA, 2002, 2003, 2007, 2012), the need to address discrimination in all aspects of psychotherapy becomes critical. In this study, quantitative and qualitative data were collected using a survey on a sample of psychologists licensed to practice in Massachusetts to examine fundamental questions about the quandaries, decisions, and challenges psychologists face when making referrals. A summary of the results, an interpretation of the findings, implications for clinical practice and professional policy, and a discussion of the limitations of the current study and potential directions of future studies are presented below.

The first research question asked, why do psychologists make referrals and how frequently do they make discriminatory or otherwise unethical referrals? To address this
question we collected survey data on how often in the past five years respondents had made referrals for various reasons. The results showed that the most common reasons psychologists had referred patients in the past five years were because of scheduling conflicts, limitations in competence, and belief that a client would get better care from another clinician. The next most frequent rationale was a possible dual relationship with a client. It should be noted that three of the four most commonly utilized rationales were part of the subset of items designed to follow the explicit pronouncements of the APA Ethics Code (2002), suggesting that psychologists by and large refer patients for reasons sanctioned by professional guidelines. Nevertheless, only two-thirds of respondents endorsed never having made a referral in the past five years because a client could no longer pay or may stop being able to pay for services. This rationale could be said to constitute abandonment for financial reasons, proscribed by professional guidelines (APA, 1992, 2002; Behnke, 2009). More ethically ambiguous but still disconcerting, nearly 20% of respondents said they have referred in the past five years because they were afraid they might be sued. Also surprising, only a slight majority (57.7%) of respondents said they have never in the past five years referred a patient for having an annoying or difficult personality. Nevertheless, nearly all respondents (between 96.2% and 97.1%) denied having made a referral for discriminatory reasons (i.e., based on client’s religion, ethnicity or sexual orientation), although a notable minority endorsed having done so one or two times in the past five years (between 1% and 3%). Overall, these results intimate that psychologists primarily rely on ethically sound rationales for referrals, never or very rarely use discriminatory rationales, but do sometimes make referrals based on generally unethical or ethically ambiguous reasoning. These reasons tended to be based on remuneration (e.g., fear of being sued, patient stops being able to pay) and therapist discomfort (e.g., patient has annoying or difficult personality).
The second research question investigated psychologists’ attitudes about the ethicality of the same referral rationales. In their investigation of psychologists’ beliefs about what constitutes good and poor practice using a similarly constructed survey, Pope, Tabachnik, and Keith-Spiegel (1988) separated the items endorsed as unquestionably poor or unquestionably good practice by 80% or 60% of respondents. Looking at our data in the same manner, we see that only three rationales were rated as completely ethical by at least 80% of respondents. These were referrals made because of limitations in competence, a belief that another clinician would better serve the client, and the possible existence of a dual relationship with a client. Importantly, these were the three items designed to most closely adhere to the prescriptions of the APA Ethics Code (2002). When we lower the threshold to 60%, we add referrals made because of a scheduling conflict and those made because of sexual attraction to a client. Studies have shown that psychotherapists react to their own feelings of sexual attraction to clients with shame, guilt, anxiety and embarrassment and often seek to deny or avoid them, perhaps making referral an appealing option (Barnett, 2014; Ladany, Klinger, & Kulp, 2011; Pope, Tabachnick, & Keith-Spiegel, 1986; Pope, Keith-Spiegel, & Tabachnick, 2006). It is interesting to note that the four rationales most commonly rated as completely ethical (limitations to competence, belief that client would be better served by another clinician, possible dual relationship, scheduling conflict) were also the four most frequently endorsed rationales for behavior used in the last five years. This consistency between ethical attitudes and behaviors is in keeping with prior studies (Pope, Tabachnick, & Keith-Spiegel, 1987, 1988).

Perhaps more interesting, none of the items on the survey received a rating of completely unethical by even a third of respondents. The justification most consistently rated as completely unethical was making a referral because of discomfort with a client’s sexual orientation (31.7%),
followed by discomfort with a client’s ethnicity or cultural background (30.8%), then discomfort with a client’s religious or spiritual affiliation (26%). These results are particularly startling given the wholesale denial of acting on these rationales discovered in the data from the first research question. It appears that psychologists have relatively permissive attitudes about making referrals, even if they do not act on them. Or, perhaps psychologists are more willing to admit to controversial ideas than actions. Also of note, nearly 60% of respondents thought that referring when a patient stopped being able to pay or may stop being able to pay for services was completely or somewhat ethical, compared to only 27.9% who thought it was completely or somewhat unethical. These results were surprising because this behavior could be considered client abandonment. Last, it is worth noting that issues of remuneration, which were some of the more frequent motivations for referrals made in the past five years, seemed to elicit a great deal of variation and confusion (“Don’t Know” was given as a rating by 13.5% of respondents for fear of being sued and 7.7% of respondents for patient has stopped or may stop being able to pay for services) amongst psychologists. Overall, the results suggest that psychologists are more uniform in their labeling of behavior as completely ethical compared to completely unethical, have fairly permissive attitudes towards making referrals (as inferred from the lack of a majority rating any behavior as completely unethical), and have some ambivalence about the ethicality of making referrals based on issues of remuneration.

Our third research question aimed to investigate the relationship of attitudes and behaviors towards making referrals. In particular, we hypothesized that attitudes and behaviors towards unethical (both discriminatory and generally unethical) referrals would be associated. Our underlying theory was that psychologists with more permissive attitudes would be more likely to engage in unethical and discriminatory acts. This hypothesis was consonant with the
well-known theory of reasoned action (TRA; Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975), which suggests that attitudes and perceived norms are the best predictors and determinants of social behavior (for a review see Sutton, 1998). Nevertheless, the results only partially confirmed our hypothesis. Attitudes towards the only generally unethical item were indeed significantly correlated with engagement in that behavior (as were three of the ethically ambiguous items). But attitudes towards discriminatory referrals were not significantly correlated with engagement in those behaviors. More than 96% of respondents reported never having engaged in any of the behaviors categorized as discriminatory, severely restricting the range and explaining the highly insignificant correlations. Whether these data are accurate representations of behavior patterns or whether they represent underreporting is unknown.

While the surveys were returned and scored anonymously, lingering concerns about anonymity may have prompted some respondents to underreport their behaviors. This also may have contributed to the fact that no respondents endorsed having made a referral because of past or ongoing sexual relations with a client. Considering data on therapist-client sexual relations have shown a prevalence of up to 12% for male therapists and 3% for female therapists (Pope, Levenson, & Schover, 1979), it is unclear how to interpret these findings. In addition to underreporting, it is possible that we simply did not pick up on this phenomena in the population because our sample contained two-thirds women, who are less likely to engage in these behaviors (Holroyd & Brodsky, 1977; Pope, Levenson, & Schover, 1979; Pope, Tabachnik & Keith-Spiegel, 1987), that we simply did not have a large enough sample to detect these behaviors, or that Massachusetts has fewer of these occurrences (past studies were on the national level). In addition, it is possible that some respondents may have made discriminatory referrals for reasons they were not completely aware of, in line with research on implicit attitudes.
and social cognition (for a review see Greenwald & Banaji, 1995). At this point these hypotheses are speculative and it is our hope that further research will elucidate these questions.

Another of our hypotheses was that psychologists in private practice would engage in more generally unethical and discriminatory referrals and have more permissive attitudes towards them than their counterparts treating patients in other sites. Gibson and Pope (1993) found that therapists in private practice are more likely to endorse as ethical behaviors such as terminating services when patients can no longer pay, avoiding certain patients for fear of being sued, and raising the fee during services or charging for missed appointments. The authors did not have a firm hypothesis explaining these results, but suggested they were possibly due to decreased financial security among those in private practice. We expected to find a similar trend, but we hypothesized that it would be associated with hours spent interacting with colleagues. Our rationale was that greater interaction with colleagues would facilitate peer consultation, provide continuing ethics education, and encourage awareness of institutional policies likely confluent with current revisions to professional ethics codes. Moreover, social influence has been shown to be a powerful motivator of attitudes and behaviors (for a review, see Cialdini, 2005). The results of our bootstrapped mediation model regression analysis offered preliminary confirmation of our hypothesis. Briefly, our results indicated that psychologists in private practice do spend less time interacting with colleagues, have more permissive attitudes towards generally unethical and discriminatory referrals (at the trend level), and this effect is significantly mediated by spending less time with colleagues. These results serve as reminders that psychologists, like many professionals, thrive when they have access to colleagues and a wide range of opinions. This is not to delegitimize private practice, a vital part of the profession, but only to suggest that clinicians working in private practice seek opportunities to consult with
colleagues and supervisors. Moreover, we must be careful with the exact interpretation of our analysis because we treated our mediator, an ordinal variable, as a continuous variable. Thus, while we can be confident of the effect, the units are unknown because 15 hour-per-month periods of interaction were collapsed into single units. While the data supports our theory that time spent with colleagues positively influences attitudes towards referrals, how much time is optimal could not accurately be assessed with our study design. Follow-up studies would do well to use more precise survey designs with greater granularity in the data.

Our fifth research question probed into the most important factors psychologists consider when making referrals. We sought qualitative responses from survey respondents using an open-formatted question and analyzed the data using thematic analysis. By and large, five broad themes emerged: scope of practice; goodness of fit; remuneration; ethics; and risk. Scope of practice was the most commonly embedded theme, touching upon issues of competence, areas of expertise, theoretical orientation, and adjunctive therapy. Interestingly, scope of practice, as a theme, roughly (but not completely) mapped onto the quantitative survey items designed to cohere with the guidelines of the Ethics Code, which were also generally the most highly endorsed reasons for referral. These results adhere to the admonishments of Wood and Wood (1990): “Clearly, the primary criterion [when referring] should be the level of professional competency (beyond that sufficient to meet the professional requirements of the certifying or licensing body of their respective disciplines) of the practitioner to whom the patient is referred” (p. 85).

Goodness of fit, which included questions of personality style, identity factors, availability, desire to work with a patient and a somewhat inarticulable feeling of harmony between patient and therapist, was another frequently emerging theme in the data. Wood and
Wood (1990) identify a similar issue as being one of two primary dynamic motivations when referring, although they write more of the fit between the referral source and the therapist receiving the referral, “That identification may be a composite of many elements—sex, ethnic or religious background, similar training and therapeutic experiences, similar personality characteristics, or personal history” (p. 86). Remuneration as a theme was mentioned by nearly a third of respondents, suggesting that psychologists often consider or make referrals when patients or third party payers have difficulty paying for services. Again, we saw this as an important consideration in both quantitative and qualitative sides of this study. Some respondents mentioned ethics, such as multiple relationships or the trustworthiness of the therapist to whom they were referring, as another important consideration. They indicated that they ponder the ethical nature of a referral before they make it. Nevertheless, it must be noted that these responses may have been primed by the salient topic and title of the survey. Last, risk was identified as a prominent theme in the data. This theme included responses indicating fear of being sued and discomfort with a heightened level of client safety. In all, the data suggested that the most important factors psychologists consider when referring relate to maximizing client’s treatment and well-being as well as protecting themselves from various forms of risk.

The sixth research question we posed was, what are psychologists’ primary concerns when making referrals and how do they address them? Again we identified scope of practice, goodness of fit, remuneration, and risk as prominent themes. But psychologists mentioned other critical issues, as well. Many respondents indicated that they are concerned with having a wide enough network of colleagues to whom to refer and actively try to enlarge it, and consider whether a referral would help strengthen their relationships with other professionals. Wood and Wood (1990) have suggested this motivation is inherently self-serving:
A second motivation for the referral choice is at least partially based on narcissistic gratification, a need to enhance one's own sense of self by referring to someone who will reciprocate in making referrals to us or to one of our professional group at some future date. Perhaps it is someone who has sent patients to us in the past and to whom we now want to extend an appreciative and seemingly altruistic professional favor. An aspect of this action is that one chooses someone who may be seen as an extension of oneself, and in that sense, preserves the fantasy of maintaining some investment in or control over that patient's treatment. It is also a way of establishing a special kind of bonding with the therapist to whom we have made the referral. (p. 86)

Client welfare was also explicitly mentioned as being a primary concern. Psychologists wrote that they are careful to give more than one referral option, assist clients with transitions, manage their feelings of abandonment, and communicate with them and future therapists as long as needed. A small but notable minority indicated they have no concerns about making referrals because they never make referrals or are completely confident in their decisions. Given the complex and rich data generally elicited from respondents, these responses were striking for their brevity and apparent lack of self-examination.

The final research question addressed whether the professional Ethics Code (APA, 2002) is sufficiently helpful to psychologists making referrals. Our hypothesis was that it is not, as it lack clear guidelines about referrals and include contradictory information. The question, which specifically asked if respondents felt there was an aspect of referrals not adequately covered by the Ethics Code (APA, 2002) and professional literature, was met with a variety of answers. Many responses described the Code as vague, unclear, or lacking in information. While some saw this as a detriment to their decision making, others viewed it as a purposeful tactic to give
psychologists the greatest range of freedom in their ability to refer. Another commonly evoked
response was that the Ethics Code was specifically inadequate in dealing with how to address
problems of fit between therapist and patient. Many of these responses focused on identity and
personality factors, transference, and feelings of safety, and lamented the lack of clarity in how
to ameliorate such situations. A number of respondents wrote of the need to build a network of
colleagues in order to have an adequate fund of therapists to whom to refer. They voiced the
difficulty of maintaining such a network and said that they wished the profession did more to
help clinicians with this issue. Remuneration continued to be a commonly voiced concern, and
respondents were particularly frustrated with the absence of information on how to navigate
issues of (non)-payment and managed care. Austad, Ariel, Hunter, and Morgan (1998) wrote
over a decade ago of this very problem, “The current code of ethics is not specific enough to
guide psychologists to make well-reasoned, relevant, and practical clinical decisions in these new
managed care settings” (p. 67).

Nearly a third of respondents wrote that the Ethics Code (APA, 2002) and professional
literature had adequate coverage of referrals. However, it must be noted that this response was
mostly given as “No,” which could also be explained by survey fatigue or annoyance. The other
two commonly given versions of this were “Not that I am aware of” and “Not that I can think
of,” which could just as easily be explained by lack of familiarity with the Code. Last, another
third of respondents stated they did not know if referrals were adequately covered, but again the
actual percentage is probably higher if we knew more about the adequate coverage responses. In
all, our hypothesis was partially supported by the data, particularly coming from responses
suggesting professional guidelines are vague about all or some aspect of referrals. But the
majority of responses indicated a lack of familiarity with the professional guidelines or their
coverage of this issue, similar to the argument put forth by Shiles (2009), suggesting that the hypothesis was not completely accurate and should be retested with greater precision and different methodology in the future. Finally, it must be noted that neither our hypothesis nor the data indicate that a way towards greater moral clarity in the profession is stricter ethics codes.

As the APA’s Committee on Scientific and Professional Responsibility wrote in 1964:

A code of ethics may prevent gross abuses, but also may imply the limits within which a practitioner may ‘get away with anything.’ Formalization of standards is a deliberate device for discouraging certain types of innovation, but the discouragement of innovation is scarcely always a desirable thing. (p. 171)

How do we make sense of these data, and particularly the relatively permissive attitudes of many psychologists? After all, the data indicate that the patients who are most likely to be harmed by these attitudes are precisely those made most vulnerable by years of overt and covert prejudice—the culturally diverse, including individuals of color, and various ethnic and religious backgrounds and sexual orientations (Sue & Sue, 2008). Furthermore, tolerant attitudes towards referring patients with annoying or difficult personalities puts patients with characterological problems or personality disorders at risk for abandonment. Taken together, our results suggest that a lack of clarity in the professional ethics codes could be playing a role in psychologists’ attitudes towards discriminatory referrals. However, an alternative, but not mutually exclusive, explanation is offered by Knapp and colleagues (2013), who suggest that there is a dark side of professional ethics. This dark side reflects the well of attitudes and behaviors that psychologists consciously believe to be ethical but would most certainly be deemed otherwise by their colleagues. Knapp and colleagues (2013) suggest that these permissive attitudes arise from either rigid adherence to laws and regulations without any appreciation of the nuances of context,
or solipsistic devotion to their own personal values and beliefs without integration of those espoused by professional guidelines. Indeed, the data we collected suggested that respondents with permissive attitudes were not rationalizing or dissembling, but rather assured that it was perfectly ethical to make referrals for almost any and all reasons they might have. Thus, these respondents were relying on their personal values and beliefs without consideration of those of the profession as a whole. Knapp and colleagues (2013), in their work on the Ethical Acculturation Model (EAM; Handelsman, Gottlieb, & Knapp, 2005), have proposed that differences in psychologists’ abilities to effectively integrate their personal beliefs with the ethics of the profession may be rooted in processes of acculturation and assimilation similar to those faced by immigrants. Thus, psychologists who assimilate become overly dogmatic in their reliance on professional rules; those that separate reject professional guidelines and rely exclusively on their prior personal beliefs; psychologists who denounce both their professional and personal values are said to be marginalized; finally, integration is said to occur when psychologists successfully fold professional ethics into their pre-existing personal ethical and moral viewpoints. If we apply this model to our data, we can view the permissive attitudes as being indicative of a separation strategy. Further research investigating the link between referral attitudes and the EAM could shed light on this connection.

Regardless of whether psychologists are holding permissive attitudes and occasionally engaging in unethical or ethically ambiguous behavior because of ignorance or a dark side of the profession, our results point to a need for increased training in ethical decision-making. At the graduate training level, this could mean further coursework or specialized modules in ethics education, and perhaps new approaches that target the integration of personal beliefs and professional ethics. In addition, more extensive training in multicultural issues could help reduce
bias in trainees. At the professional level, requiring continuing education credits that deal explicitly with ethical issues could help psychologists stay current and continue to evolve as ethical actors. Moreover, greater involvement and familiarity with professional ethics might instigate more pronounced calls for change when the Ethics Code fails to supply enough guidance. At the policy level, greater clarity on discriminatory referrals is certainly warranted. While more stringent codes may not solve the problem wholesale, it will go a long way towards resolving lingering questions about when it is appropriate to refer.

Another important implication from our study relates to psychologists’ struggles with issues of remuneration. By and large, our results suggest that psychologists take issue with, or are unaware of, the Ethics Code’s (2002) implicit prohibition against client abandonment when they are not being paid for their services. Although working in a helping profession, psychologists are themselves part of a capitalist society in which their personal welfare depends upon their ability to be make a living wage. In addition, their extensive training grants them the right to charge a rate commensurate with their years of study. Looking to a similar profession as a model, the medical field makes no such requirements of their members. Moreover, one can imagine the interpersonal issues that might ensue once a patient stops paying for services. It is difficult to imagine a psychologist not struggling with feelings of anger, guilt, and shame once he or she stops being paid but is expected to continue working with a patient. Furthermore, one could imagine psychologists working in areas that are economically depressed or have faced large-scale layoffs suffering with this issue more than others. Would it be fair for a practitioner to have more than one of their clients unable to pay them? Nevertheless, nuances to this argument are important because the social justice aspect of applied psychology would have us provide services to more than the just the wealthiest individuals. The fact that many clinicians
are out-of-network or refuse to work with insurance companies means payment can fall fully on the patient, something that only the most affluent members of society could afford on a regular basis. Does the occasional pro bono case mean we are doing enough for the community when so many individuals in need of mental healthcare go without resources? While a solution to this ethical and professional dilemma is beyond the scope of this paper, we suggest that the issue is investigated further at the highest levels of the APA and recommendations made for clarification, such as the exact meaning of “limitations to services” discussed in Standard 6.04, the length of time psychologists should be willing to see a patient who has stopped paying for services or guidelines for alternative courses of action. For example, sliding-scale fee arrangements and bartering are within the ethical guidelines of the profession and may preserve the dignity of both patient and clinician in a way that free services do not. Last, psychologists faced with this dilemma should seek counsel from colleagues and supervisors to determine the most ethical and responsible course of action, while also addressing their own conflicted feelings.

There are a number of limitations to this study that must be considered. Perhaps the most serious limitation is the low rate of return. At an overall response rate of 10.6%, this study had a significantly lower rate of return than many of the published studies on ethics in psychotherapy, which have tended to fall between 25% and 60% (Akamatsu, 1988; Gibson & Pope, 1993; Gartrell et al., 1986; Pope, Tabachnik & Keith-Spiegel, 1986, 1987, 1996). With such a low response rate, there are concerns of nonresponse bias. It is possible that respondents make up a self-selected group of individuals more interested in the topics of referrals, ethics, or professional development than the general population of psychologists. However, as Davern (2013) has written, “Response rates lack both validity and reliability as a proxy measure of nonresponse bias. Response rates lack validity in that there is not even a moderate correlation with
nonresponse bias (Groves, 2006)” (p. 905). Davern (2013) also points out that many studies have shown that higher response rates do not produce significantly different results than lower response rates for the same survey (Blumberg et al. 2005; Davern et al., 2010; Holle et al., 2006; Keeter et al., 2000, 2006; Triplett 2002). Nevertheless, the data contained herein must be taken only as preliminary findings and will hopefully lead to more comprehensive research on the topic.

There are a number of possible reasons for the low response rate. First, we did not distribute monetary or other forms of incentive to participate because of insufficient funding for this study. Incentives have been shown to significantly increase the rate of return in both web and mail based surveys (Hopkins, Hopkins, & Schon, 1988; Oden & Price, 1999). Second, initial notices and follow-up mailings, both of which have also been shown to improve response rate (Dillman, 2000; Oden & Price, 1999), were not used due to lack of adequate funding. Another possible contributing factor to the low return rate was the time of year in which we sent out the surveys, spring and early summer, when many professionals are on vacation and work fewer hours. In addition, the sensitive nature of the survey questions may have left some of the sample feeling insecure about divulging private information.

An important element in the low response rate is the differential between the mail (19.3%) and web (4.7%) versions of the survey. Both because of potential coverage error and because of difficulties obtaining email addresses, we used a multimodal administration. Previous research has shown that mail-based surveys produce a higher rate of return (Shin, Johnson, & Rao, 2012) but do not produce discernibly different data quality (Börkan, 2010). However, the 4.7% response rate for electronic surveys is somewhat misleading; a much lower number of respondents may have actually seen the request to participate. Of the 596 psychologists whose
email addresses were located and then sent an email request to participate, 338 did not open the email (this information is provided by the survey builder, Qualtrics). The reasons for this are unknown, but it would be reasonable to speculate that the email went directly into a spam or trash folder, or was disregarded because it came from an unknown source. The total number of potential respondents who opened the email was 258, bringing the response rate for electronic surveys to 10.9% of those who viewed the request to participate. This raises another important point, which is the relatively old age of the sample. It is possible that older psychologists responded to the mail surveys in greater numbers than their younger counterparts because of their familiarity and perhaps preference for postal rather than electronic mail.

Another key limitation with this study was the imprecision of some of the survey questions. The first question, which asked respondents how many times in the past five years they had made referrals for various reasons, could have been improved had rates (such as number of referrals per number of patients seen) rather than absolute numbers been elicited. Second, the survey did not differentiate between referrals made at time of consultation compared to those made mid-treatment, an important difference. Last, the qualitative question asking respondents if they felt there were aspects of the referral process not adequately reviewed in the Ethics Code (APA, 2002) could have benefitted from more precision. Many of the responses phrased as negatives were difficult to interpret as being endorsements of the Ethics Code or lack of familiarity with it. Overall, the construction of the survey should be taken as a preliminary step towards elucidation of this complex topic. Many of the issues it covered were complex and may have been better addressed with different types of questions and administration, such as live interviewing.
A further limitation of this study was the inability to establish validity and reliability of the SARE. Given the structure of the instrument, assessing for internal consistency in a classic sense, was problematic. Because it occupies an empty niche in the literature, there are no other instruments to utilize for comparison purposes. Future research on the ethicality of referrals may provide further information about the validity of this instrument. The generation of other tests designed to measure the same or similar principles will allow for more accurate validity assessment.

Similarly, more research into the SARE could provide greater understanding of this issue across multiple populations. For example, similar surveys could potentially be used to measure the beliefs and behaviors of counselors, licensed mental health workers, psychiatrists, and social workers on making referrals. Even within the population of psychologists, this study only looked at responses from those registered with the Massachusetts office of Consumer Affairs and Business Regulation. This obviously leaves out a large swathe of professional psychologists practicing today and eliminates the possibility of gleaning important information about geographic differences. These findings thus must not be considered a comprehensive review of the attitudes and behaviors of psychologists regarding referrals.
References


Mackinnon, A. (2010). The use and reporting of multiple imputation in medical research – a review. *Journal of Internal Medicine, 268*(6), 586-593.


Appendix A: Tables and Figures

Figure 1. Unstandardized regression coefficients for the relationship between work environment (private practice vs. other) and attitudes towards generally unethical and discriminatory referrals as mediated by hours spent interacting with colleagues.

*p<0.05
Figure 2. Themes (ovals) and subthemes (boxes) identified in responses to SARE Question 3: What are the most important factors you consider when you make a referral?
Figure 3. Themes (ovals) and subthemes (boxes) identified in responses to SARE Question 4: What concerns do you have when you make a referral? How do you address them?
Figure 4. Themes (ovals) and subthemes (boxes) identified in responses to SARE Question 5: Is there an aspect of the referral making process in psychotherapy that you feel is not adequately covered by professional literature and ethics codes?
Figure 5. Themes (ovals) and subthemes (boxes) identified in responses to SARE Question 6: Is there anything you feel it is important to know about making referrals that has not been addressed? If so, please provide whatever information you feel comfortable sharing.
Table 1
Demographics of sample (N=106)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Category</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Female</td>
<td>69</td>
<td>65.1</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>35</td>
<td>33.7</td>
</tr>
<tr>
<td>Age</td>
<td>18 to 30 years old</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td></td>
<td>31 to 44 years old</td>
<td>22</td>
<td>20.8</td>
</tr>
<tr>
<td></td>
<td>45 to 60 years old</td>
<td>33</td>
<td>31.1</td>
</tr>
<tr>
<td></td>
<td>61 to 75 years old</td>
<td>43</td>
<td>40.6</td>
</tr>
<tr>
<td></td>
<td>Over 75 years old</td>
<td>6</td>
<td>5.7</td>
</tr>
<tr>
<td>Years practicing</td>
<td>1 to 5 years</td>
<td>6</td>
<td>5.7</td>
</tr>
<tr>
<td></td>
<td>6 to 10 years</td>
<td>13</td>
<td>12.3</td>
</tr>
<tr>
<td></td>
<td>11 to 20 years</td>
<td>16</td>
<td>15.1</td>
</tr>
<tr>
<td></td>
<td>20 to 30 years</td>
<td>27</td>
<td>25.5</td>
</tr>
<tr>
<td></td>
<td>Over 30 years</td>
<td>42</td>
<td>39.6</td>
</tr>
<tr>
<td>Primary work setting</td>
<td>Private Practice</td>
<td>69</td>
<td>65.1</td>
</tr>
<tr>
<td></td>
<td>Hospital</td>
<td>12</td>
<td>11.3</td>
</tr>
<tr>
<td></td>
<td>Community Mental-Health Center</td>
<td>7</td>
<td>6.6</td>
</tr>
<tr>
<td></td>
<td>University or School-Counseling Center</td>
<td>6</td>
<td>5.7</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>11</td>
<td>10.4</td>
</tr>
<tr>
<td>Hours interacting</td>
<td>None</td>
<td>5</td>
<td>4.7</td>
</tr>
<tr>
<td></td>
<td>1 to 15 hours</td>
<td>73</td>
<td>68.9</td>
</tr>
<tr>
<td></td>
<td>16 to 30 hours</td>
<td>13</td>
<td>12.3</td>
</tr>
<tr>
<td></td>
<td>31 to 45 hours</td>
<td>9</td>
<td>8.5</td>
</tr>
<tr>
<td></td>
<td>More than 45 hours</td>
<td>5</td>
<td>4.7</td>
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<tr>
<td>Degree specialization</td>
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<td>40.6</td>
</tr>
<tr>
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<td>Clinical Psych. PsyD</td>
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<td>30.2</td>
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<tr>
<td></td>
<td>Counseling Psych-PhD</td>
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<td>9.4</td>
</tr>
<tr>
<td></td>
<td>Counseling Psych-EdD</td>
<td>12</td>
<td>11.3</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>7</td>
<td>6.6</td>
</tr>
</tbody>
</table>

Note: Responses to the items sum to less than 100% because of missing data.
Table 2
Percentage of Psychologists (N=106) Responding in Each Category to Question 1: How many times in the past five years have you made a referral for the following reasons?

<table>
<thead>
<tr>
<th>Item</th>
<th>Never</th>
<th>1 or 2</th>
<th>3 to 5</th>
<th>6 to 8</th>
<th>&gt;8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Because a client’s presenting problem falls outside of your area of expertise or competence</td>
<td>6.6</td>
<td>16.0</td>
<td>23.6</td>
<td>24.5</td>
<td>28.3</td>
</tr>
<tr>
<td>Because a client might get better care from another clinician</td>
<td>17.9</td>
<td>29.2</td>
<td>20.8</td>
<td>12.3</td>
<td>17.9</td>
</tr>
<tr>
<td>Because of a scheduling conflict</td>
<td>18.9</td>
<td>22.6</td>
<td>17.0</td>
<td>10.4</td>
<td>29.2</td>
</tr>
<tr>
<td>Because a client may stop being able to pay for services or has stopped paying for services</td>
<td>67.9</td>
<td>17.9</td>
<td>6.6</td>
<td>0.9</td>
<td>3.8</td>
</tr>
<tr>
<td>Because of a possible dual relationship with a client</td>
<td>45.3</td>
<td>28.3</td>
<td>17.9</td>
<td>2.8</td>
<td>4.7</td>
</tr>
<tr>
<td>Because a client has an annoying or difficult personality</td>
<td>58.5</td>
<td>28.3</td>
<td>8.5</td>
<td>0.0</td>
<td>1.9</td>
</tr>
<tr>
<td>Because of discomfort with a client’s religious or spiritual affiliation</td>
<td>96.2</td>
<td>2.8</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Because of discomfort with a client’s ethnicity or cultural background</td>
<td>97.2</td>
<td>1.9</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Because of discomfort with a client’s sexual orientation</td>
<td>96.2</td>
<td>0.9</td>
<td>0.0</td>
<td>0.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Because of sexual attraction to a client</td>
<td>98.1</td>
<td>0.9</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Because of past or ongoing sexual contact with a client</td>
<td>98.1</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Because of fear of being sued</td>
<td>81.1</td>
<td>12.3</td>
<td>3.8</td>
<td>0.9</td>
<td>0.9</td>
</tr>
</tbody>
</table>

*Note.* Responses to the items sum to less than 100% because of missing data.
Table 3

Percentage of Psychologists Responding in Each Category (N=106) to Question 2: Thinking about each of the same referral scenarios, to what extent do you consider them to be ethical?

<table>
<thead>
<tr>
<th>Item</th>
<th>Completely Unethical</th>
<th>Somewhat Unethical</th>
<th>Somewhat Ethical</th>
<th>Completely Ethical</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Because a client’s presenting problem falls outside of your area of expertise or competence</td>
<td>4.7</td>
<td>0.9</td>
<td>0.9</td>
<td>91.5</td>
<td>0.0</td>
</tr>
<tr>
<td>Because a client might get better care from another clinician</td>
<td>0.9</td>
<td>0.9</td>
<td>1.9</td>
<td>94.3</td>
<td>0.0</td>
</tr>
<tr>
<td>Because of a scheduling conflict</td>
<td>0.9</td>
<td>3.8</td>
<td>6.6</td>
<td>80.2</td>
<td>4.7</td>
</tr>
<tr>
<td>Because a client may stop being able to pay for services or has stopped paying for services</td>
<td>6.6</td>
<td>20.8</td>
<td>31.1</td>
<td>29.2</td>
<td>7.5</td>
</tr>
<tr>
<td>Because of a possible dual relationship with a client</td>
<td>3.8</td>
<td>2.8</td>
<td>3.8</td>
<td>84.9</td>
<td>0.9</td>
</tr>
<tr>
<td>Because a client has an annoying or difficult personality</td>
<td>16.0</td>
<td>30.2</td>
<td>25.5</td>
<td>21.7</td>
<td>3.8</td>
</tr>
<tr>
<td>Because of discomfort with a client’s religious or spiritual affiliation</td>
<td>25.5</td>
<td>21.7</td>
<td>19.8</td>
<td>22.6</td>
<td>4.7</td>
</tr>
<tr>
<td>Because of discomfort with a client’s ethnicity or cultural background</td>
<td>30.2</td>
<td>22.6</td>
<td>16.0</td>
<td>19.8</td>
<td>5.7</td>
</tr>
<tr>
<td>Because of discomfort with a client’s sexual orientation</td>
<td>31.1</td>
<td>24.5</td>
<td>17.0</td>
<td>18.9</td>
<td>2.8</td>
</tr>
<tr>
<td>Because of sexual attraction to a client</td>
<td>2.8</td>
<td>8.5</td>
<td>13.2</td>
<td>66.0</td>
<td>4.7</td>
</tr>
<tr>
<td>Because of past or ongoing sexual contact with a client</td>
<td>10.4</td>
<td>0.0</td>
<td>0.9</td>
<td>72.6</td>
<td>9.4</td>
</tr>
<tr>
<td>Because of fear of being sued</td>
<td>10.4</td>
<td>35.8</td>
<td>15.1</td>
<td>20.8</td>
<td>14.2</td>
</tr>
</tbody>
</table>

Note. Responses to the items sum to less than 100% because of missing data.
Table 4
*Spearman’s correlation coefficients between psychologists’ attitudes and behaviors (N=106).*

<table>
<thead>
<tr>
<th>Attitudes</th>
<th>Ethical</th>
<th>Unethical</th>
<th>Discr.</th>
<th>3</th>
<th>6</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Because a client’s presenting problem falls outside of your area of expertise or competence</td>
<td>0.137</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Because a client might get better care from another clinician</td>
<td>0.059</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Because of a scheduling conflict</td>
<td></td>
<td>0.153</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Because a client may stop being able to pay for services or has stopped paying for services</td>
<td></td>
<td></td>
<td>0.387*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Because of a possible dual relationship with a client</td>
<td></td>
<td></td>
<td>-0.122</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Because a client has an annoying or difficult personality</td>
<td></td>
<td></td>
<td></td>
<td>0.402*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Because of discomfort with a client’s religious or spiritual affiliation</td>
<td></td>
<td></td>
<td>0.079</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>8. Because of discomfort with a client’s ethnicity or cultural background</td>
<td></td>
<td></td>
<td>0.032</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Because of discomfort with a client’s sexual orientation</td>
<td></td>
<td></td>
<td>0.071</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Because of sexual attraction to a client</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>-0.002</td>
<td></td>
</tr>
<tr>
<td>11. Because of past or ongoing sexual contact with a client</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.</td>
</tr>
<tr>
<td>12. Because of fear of being sued</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.321*</td>
</tr>
</tbody>
</table>

† Ethical is composite of items 1, 2 and 5. Unethical is item 4. Discr. is composite of items 7, 8 and 9. Numbered items on horizontal axis correspond to numbered items on vertical axis.

*p<0.0042 (2-tailed)
Appendix B: Self-Assessment of Referral Ethics (SARE)

Self-Assessment of Referral Ethics

A survey conducted by Jonathan J Entis, PhD Candidate
Counseling and Applied Educational Psychology Department
Northeastern University

This survey is designed to assess the behaviors and beliefs of psychologists facing difficult decisions regarding making referrals. We are seeking input from professionals who can expand our current understanding of these situations. The survey is composed of multiple parts in both open and closed format questions. We are interested in whatever information you can provide based on your professional experience. Please respond only to the questions that you feel comfortable answering. This is a collaborative process and we value your knowledge and experience. Thank you.
Q1. How many times in the past five years have you made a referral for the following reasons? (Please circle your answer)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Never</th>
<th>1 or 2</th>
<th>3 to 5</th>
<th>6 to 8</th>
<th>&gt;8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Because a client’s presenting problem falls outside of your area of expertise or competence.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Because a client might get better care from another clinician</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Because of a scheduling conflict</td>
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</tr>
<tr>
<td>Because a client may stop being able to pay for services or has stopped paying for services</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Because of a possible dual relationship with a client</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Because a client has an annoying or difficult personality</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Because of discomfort with a client’s religious or spiritual affiliation</td>
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<td>Because of discomfort with a client’s sexual orientation</td>
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<td></td>
</tr>
<tr>
<td>Because of sexual attraction to a client</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Because of past or ongoing sexual contact with a client</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Because of fear of being sued

<table>
<thead>
<tr>
<th>How Ethical?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completely Unethical</td>
</tr>
<tr>
<td>Never</td>
</tr>
</tbody>
</table>

**Q2.** Thinking about each of the same referral scenarios, to what extent do you consider them to be ethical? (Please mark your answer by putting an X in the appropriate box)

- Because a client’s presenting problem falls outside of your area of expertise or competence.
- Because a client might get better care from another clinician.
- Because of a scheduling conflict.
- Because a client may stop being able to pay for services or has stopped paying for services.
- Because of a possible dual relationship with a client.
- Because a client has an annoying or difficult personality.
- Because of discomfort with a client’s religious or spiritual affiliation.
Because of discomfort with a client’s ethnicity or cultural background

Because of discomfort with a client’s sexual orientation

Because of sexual attraction to a client

Because of past or ongoing sexual contact with a client

Because of fear of being sued

Q3. **What are the most important factors that you consider when you make a referral?**

Q4. **What concerns do you have when you make a referral? How do you address them?**
Q5. Is there an aspect of the referral making process in psychotherapy that you feel is not adequately covered by professional literature and ethics codes?

Q6. Is there anything you feel it is important to know about making referrals that has not been addressed? If so, please provide whatever information you feel comfortable sharing.
Q7. Are you currently practicing in the state of Massachusetts?
A) Yes
B) No

Q8. What is your age?
A) 18-30
B) 31-44
C) 45-60
D) 61-75
E) Over 75

Q9. What gender do you identify as?
A) Female
B) Male
C) Transgender
D) Other _________________

Q10. How many years have you been practicing psychotherapy?
A) 1-5 years
B) 6-10 years
C) 11-20 years
D) 20-30 years
E) Over 30 years

Q11. What is your primary work setting?
A) Private practice
B) Hospital
D) Community mental health center
E) University or school counseling center
F) Other __________________________

Q12. How many hours per month do you spend interacting with colleagues, supervisors, or supervisees on a professional basis?
A) None
B) 1-15
C) 16-30
D) 31-45
E) More than 45

Q13. In what area of specialization did you receive your highest professional degree?
A) Clinical psychology, PhD
B) Clinical psychology, PsyD
C) Counseling psychology, PhD
D) Counseling psychology, EdD
E) Other____________________________________