PROFESSIONAL ISSUES

Ethical Responsibility and Professional Socialization

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Practitioners learn moral responsibility and are socialized on an individualized basis that begins in their family of origin and changes as they develop and participate in other groups, such as with other students going to school, athletic teams, music groups, church groups, and eventually professional groups. The professional socialization process and process for learning ethical responsibility often consist of one course on ethics in graduate training and thereafter are somewhat haphazard. As such, practitioners must make a discrete effort to increase their understanding of both professional and ethical responsibilities and for being socialized appropriately. Being active in professional associations such as the Association for Applied Psychophysiology and Biofeedback can be helpful in this process if the member develops support networks, seeks consultation, engages in continuing education activities (e.g., workshops, directed readings, etc.), and discusses topics of concern with others.

Introduction
Have you ever thought about how you learned moral and ethical responsibility or how you were and are being socialized professionally? May (1996) argued that a person’s moral responsibility and integrity are shaped by conscience, socialization, and moral support from the groups to which he or she belongs. For a biofeedback practitioner, the communities from which moral support could be available would include other biofeedback practitioners, such as members of the Association for Applied Psychophysiology and Biofeedback (AAPB), members of their professional discipline, and others working for the same employer.

However, the process of learning moral responsibility and being socialized begins much earlier and is an individualized process. It begins in a person’s family of origin and is influenced by the family’s interactions, moral and religious beliefs, ways of behaving, interactions with others, and other factors too numerous to mention. The process is also influenced by other groups with which the individual comes in contact and especially those with which the individual identifies. For example, other students and teachers in school, coaches, music teachers, church groups, community groups, and so forth.

Much of the process for learning moral and ethical responsibility and being socialized has changed over the years as technology such as television and the Internet have become more prominent, as the influence of religion has become less dominant in individual families, and as single-parent families have become more common. Think about how you and your own children learned or are learning moral responsibility and are being socialized. Is it a systematic planned process or is it being left to chance? What can you do to acquire the appropriate skills in the areas of moral and ethical responsibility and socialization, and how can you teach those things to others? Should something this important be left to chance?

Now think about the process whereby you acquired or are acquiring your skills in ethical responsibility as a biofeedback practitioner or professional and how the professional socialization process is occurring or has occurred for you. Was—or is—it a systematic process, or is it largely left to trial-and-error learning? I know that much of my early acquisition of professional skills in the areas of ethical responsibility and professional socialization was a process of trial and error. During my graduate psychology training, no courses in ethics were offered, and there was no discussion of guidelines and standards of practice. One learned by observing the faculty, supervisors, other professionals, and other students, often without any discussion of ethics, moral or professional responsibility, or even of what it means to be a professional. If the models available were ethical, one learned something about being ethical. If the models engaged in unethical behaviors and it was not obvious that the behavior was inappropriate, one could easily learn to identify such unethical behavior as acceptable. For example, it was not uncommon for university faculty to be sexually involved with some of the students they taught, and even ethics codes in those days did not mention such behaviors. Today, such behavior is considered unethical.

Things have changed somewhat by virtue of the development of official codes of ethics, practice guide-
lines and standards, practica, and courses and workshops designed to teach practitioners about these topics and about how to apply the content in daily practice. Yet there remains much work to be done and much for each of us to think about in the areas of ethical responsibility and professional socialization. A discussion of a few of these areas follows.

**Professional Organizations and Associations**
Members of professional organizations and associations such as AAPB can both receive and help teach others about ethical and professional responsibilities and about what it means to be a professional and the behaviors that are and are not ethically and professionally acceptable. The professional socialization process can and should also include attention to the practical issues encountered in a biofeedback practice.

AAPB has available a code of ethics (AAPB, 2003), a set of practice guidelines and standards (Striegel, 2004), and various other publications, including but not limited to the journal *Applied Psychophysiology and Biofeedback* and the magazine *Biofeedback*. In addition, AAPB offers training in the form of its annual conference and various workshops that include many opportunities for networking and thus for the development of professional relationships that can provide moral support and the opportunity to discuss and learn more about ethical and professional responsibilities and about professional socialization. When combined, these relationships and services provided by AAPB can help shape an appropriate professional and ethical conscience.

**Professional Socialization**
In simplistic terms, professional socialization includes the process and training whereby a person acquires the culture of a group, including but not limited to the values, beliefs, attitudes, and behaviors needed to interact and function in professional environments. A socialized professional adheres to the practical and ethical principles and standards of the discipline and/or associations to which he or she belongs or desires to belong. Professional socialization should not ignore consideration of the professional's personal well-being, his or her family, or the various communities to which he or she belongs (May, 1996). Finding a balance between professional responsibility and meeting one's own needs is a daily consideration. Not harming clients, not violating clients' rights, and not meeting one's own needs to the detriment of clients can be difficult skills to learn. When these skills are not learned appropriately, shortcomings in these areas can lead to the involvement of attorneys and to litigation against the practitioner. Greed or just meeting basic financial needs can tempt a practitioner to engage in unethical behavior, for example, not referring a client elsewhere when the client would be better served by such a referral or keeping a client in treatment when the client is no longer benefiting from the treatment.

Socialization and ethical responsibility are more a matter of being responsive to the needs of others than they are of just following rules (May, 1996). Professionals take on a responsibility for meeting the needs of clients and others whom they serve that goes beyond the responsibility owed to the general public (McDowell, 2000). By holding oneself out to the public as being a professional, the practitioner creates a legitimate expectation in the general public that he or she should behave at a higher level of moral, ethical, professional, and social responsiveness than members of the public per se. We are socialized as individuals by the groups to which we belong and with which we identify, and likewise, as professionals, we are socialized by the professional associations and individuals with whom we identify.

What is your level of professional integrity, and how well developed is your sense of role responsibilities? How did you develop integrity and role responsibilities, and how do you personally go about maintaining and improving them? Clearly, both are and were shaped, promoted, and inhibited by your interactions with other professionals, clients, and even your college education. Social pressure can encourage practitioners to behave in an ethical and professional manner or to behave in an unprofessional and unethical manner. For example, consider being told, “All your associates are doing it, so I will offer you the same deal. I will give you $20 for each client you refer to me rather than to someone else.” A kickback set up like this is unethical and in some states even illegal. Yet, over the years, numerous professionals have engaged in the practice. Was it due to a failure to be properly socialized as professionals, a lack of professional integrity, a lack of an ethical conscience, or all of these factors and more?

**Social and Other Pressures**
According to May (1996), a socially responsible professional is motivated largely by conscience. Ethical behavior must be trained and shaped within a context of social pressure. Social pressure often exists to support doing
what is convenient rather than what is ethically correct. An ethics code should not be designed for the comfort of its members if doing so encourages unethical behavior. Consider a common practice in medical waiting rooms where the full names of patients are often called out when it is their turn for service. From an aspirational ethical position, such behavior is a violation of confidentiality and exists in practice because it is convenient for the clinic staff and not because it is ethical. Should this practice continue? There are other options. See Striefel (2003) for more information on this topic.

When the Health Insurance Portability and Accountability Act (HIPAA) was first formulated, it required the signing of release-of-information forms before any protected health information (PHI) could be shared. However, the final guidelines enacted allow for PHI to be shared for various reasons without a signed release of information. Why the change? Simply, the physician lobbying groups argued that it would be inconvenient and time-consuming for physicians to have to get informed consent before sharing information. Was the trade-off of sacrificing patient confidentiality a reasonable one for making something comfortable and convenient for physicians and other practitioners? When, if ever, should a client’s rights be violated for the convenience of a practitioner? Remember that state law and ethics codes take precedence if they are stricter than the HIPAA requirements. What are the rules for your discipline and state regarding the sharing of PHI (confidential information)?

It seems very important for practitioners to have social support from their peers for doing what is right. Being in a practice where such support is provided in a reciprocal manner can greatly reduce stress and help practitioners maintain a high level of ethical behavior, integrity, and ethically responsible behavior. Ongoing participation in professional associations and consultative, supervisory, and collegial sharing in case staffings, or even via the Internet, can do the same thing if proper ethical guidelines are followed in the sharing of information.

A practical and prudent practitioner has no choice but to consider factors that go beyond his or her professional obligations when resolving ethical dilemmas. His or her own needs become part of the problem-solving approach regardless of whether or not they are given conscious attention. For example, a prudent practitioner will take proactive precautions to avoid angering his or her major referral sources. Have you ever had a physician call you to ask about a specific client he or she referred to you for treatment? “How is Mary Jones doing with her stress headaches?” asks Dr. Major Referral. The proactive practitioner finds out during the intake process who has made the referral and obtains a signed release of information from the client for sharing some level of information with the referral source. By getting that informed consent at the outset, he or she avoids having to say something like, “Gee Dr. Referral, I would really like to help you out, but confidentiality is a serious issue. If you could send me a release-of-information form signed by Mary Jones, I will check and see if I have a client by that name.” Good luck on getting further referrals from that physician. Being proactive and getting the signed release in advance also decreases the risk of the practitioner’s feeling pressured to share information without having a signed release-of-information form (the convenient way of giving in to pressure) and thus violating client confidentiality.

Remember that just because HIPAA allows the sharing of certain PHI without a signed release-of-information form in certain situations does not mean that it is ethical to do so within the context of state law or the codes of ethics for the various organizations to which you belong. What do the codes of ethics and laws of your state relevant to what you do have to say about this topic? You should be familiar with these documents.

There are probably no biofeedback practitioners who have not been pressured directly or indirectly by managed care requirements to behave in unethical ways; for example, practitioners are often pressured by managed care requirements via financial incentives to not inform patients about more expensive treatment options, even if such an option is the treatment of choice. Anticipating and being proactive in this era of managed care is an ongoing challenge, and slowly the rules are changing as practitioners and professional associations take legal action and advocate for laws that change the way managed care organizations operate. Professional socialization and collegial support are critical while this process of change unfolds if professionals are to behave in both a legal and ethical manner. See Striefel (1999, 2001) and Striefel, Whitehouse, and Schwartz (2003) for more information on managed care issues.

Employers often pressure employees to behave in unprofessional or unethical ways, for example, pressuring professional employees not to refer clients to practitioners outside of the home organization or pressuring them to use more serious diagnostic labels to ensure
payment for a greater number of treatment sessions. A number of unlicensed biofeedback practitioners have been hired by licensed health care practitioners or organizations and then are expected to maintain a full load of biofeedback clients without having access to a supervisor who knows anything about biofeedback. Frequently, such a supervisor does not know what kinds of problems are appropriate for biofeedback treatment and lacks the competence even to assess the skill level of the biofeedback practitioner. Over the years, I have had numerous calls from practitioners in such situations. Both the individual practitioner and the employer are at unnecessary risk if a client is injured because of the incompetence of the practitioner or if a violation of client rights or a violation of an ethical or legal expectation occurs. The best advice to practitioners in such situations can include encouragement: to find different employment, to arrange for appropriate supervision and/or consultation, to arrange for continuing education, or to meet with the employer to try to educate him or her regarding the risks and the relevant ethical and legal expectations. It can even include a recommendation to report the employer to the ethics committee for his or her professional discipline or to the state licensing board.

**Excuses**

McDowell (2000) pointed out that professionals provide excuses and/or unnecessary services because of pressures to compete and be financially successful. Can a professional compete and be a success financially while behaving in an ethical and professional manner? I certainly hope so because unethical behavior leads to harm to clients, damages the reputation of professional groups and individual practitioners, and leads to new laws, often overly restrictive, for governing the behavior of the professions (McDowell, 2000). It also leads to litigation for malpractice.

Most professionals today know what the ethical and practice standards for their profession are, but some fail to meet them and then offer excuses for their professional shortcomings (McDowell, 2000). Excuses are given as a means of evading acceptance of responsibility for what the practitioner did that he or she should not have done and/or for not doing what he or she should have done. Lawsuits often decide if the excuse has enough merit to mitigate responsibility for the behavior that falls below the accepted standards of practice. If courts repeatedly accept an excuse as valid, then perhaps the ethical standard needs to be modified or abandoned (McDowell, 2000). The American Psychological Association some years ago changed its ethical code and removed some restrictions on advertising that the courts had ruled were an infringement on professional rights to advertise.

Voluntary compliance with ethical codes and standards of practice is often insufficient for achieving compliance. Enforcement by the professional association that established the standards and codes is needed, along with involvement of members in helping to police and report violations. Otherwise litigation, new restrictive laws, and a deterioration in the public trust are likely solutions. The moral and ethical standards by which you evaluate your own behavior should be more demanding than that by which you judge the behavior of others (McDowell, 2000). Often, the reverse is the case. We excuse our own shortcomings but are intolerant of those of others.

McDowell (2000) discussed three potentially problematic traits about ethics. First, individuals have difficulty thinking in terms of probabilities. They want things to be right or wrong or true or false, that is, discrete rather than on a continuum. Yet the ethical dilemmas encountered by practitioners are seldom clearly right or wrong; otherwise, no dilemma would exist. Second, many individuals are indifferent concerning ethical issues and seldom discuss such issues with others. Yet seeking consultation, including an open discussion concerning ethical dilemmas, is often one of the best strategies for coming to a reasonable and professionally acceptable solution. Third, there is an almost universal tendency to make excuses when an individual performs improperly or inappropriately. One might assume that excuses are also likely when one's behavior falls short of adherence with ethical guidelines. Individuals seem to try to avoid taking responsibility for their failures, and they tend not to apologize (McDowell, 2000). Some practitioners have gone beyond these traits as they have gained experience in the professional world of health care. Others have not done so. In which group do you fall?

Practitioners have responsibilities to those they serve, including clients/patients, students, supervisors, employers, the public, their profession, and themselves. In all these responsibilities, they should strive to do no harm and to do good. Making excuses may well add to harm already done and is very unlikely to do any good for those served. Each of us in a problematic situation needs to decide how we will respond within a context of personal risk and legal and ethical expectations and potential consequences. Will we admit mistakes and accept our responsibilities, or will we make an excuse? Does making
an excuse began to erode our ethical thinking and behavior? Does it become easier to make an excuse the next time we make a mistake if we suffered no negative consequences the last time we made an excuse? Behavior analysis principles would argue that making excuses, if not followed by immediate negative consequences, can shape a person’s behavior so that he or she is more likely to make excuses in the future. In addition, one may well not learn how to avoid a mistake in the future if one makes an excuse rather than taking corrective action and thinking about and even seeking consultation about how to avoid a similar mistake in the future.

**Things to Think About**

There are a number of proactive steps that might be taken to improve the professional socialization process and the implementation of ethical responsibilities. All seem to start with practitioners thinking about the ethical responsibilities and discussing them with others. For example,

1. What would happen if AAPB had available a mentoring system to help new members become appropriately socialized as professionals? Would it increase membership or the number of people who volunteer to help carry out the various functions of the association?

2. How can the individual practitioner (you) arrange for appropriate and timely consultation and/or supervision when needed? The need exists, as demonstrated by the popularity of various chat groups. Are chat groups really sufficient, or should individual practitioners arrange for some other ongoing support?

3. What other training could be made available to practitioners to help them with practical, ethical, and professional socialization issues? How could one motivate practitioners to participate in such training when there are so many competing demands on their time and resources?

4. Do you realize that you are responsible for your own professional socialization and for behaving in a professional and ethical manner? What steps are you taking in these areas for improving your knowledge and skills? Additional reading is the minimal level of acceptable activity in this area.

**References**


