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A Model for Integrated Ethics Consultation

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Psychologists are socialized to seek consultation to improve patient welfare, deal more effectively with students and trainees, and maintain ethical standards in research. In this article we propose an integrated model for ethics consultation that augments traditional models of risk management and ethical decision making with more recent research on heuristics, biases, and the role of emotions in cognitive processes. Specifically, we offer a model in which consultation is often a multifaceted and multilevel process that occurs over time. We present the model along with examples in the hope that it will assist consultants and their consultees arrive at better decisions.

Keywords: ethical decision making, consultation, conflict of interest

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Psychologists frequently encounter ethical dilemmas as part of their daily work whether they are practitioners, teachers/trainers, or researchers. Seeking consultation regarding these problems is an integral part of professional responsibility for at least three reasons. First, ethical dilemmas can be complex, often raising a variety of competing ethical principles that can easily blur into one another, making clear choices elusive (Anderson, Wagoner, & Moore, 2006). Second, some dilemmas may require specific knowledge that psychologists may not possess. Third, dilemmas may engender distress that can interfere with cognitive processes and, therefore, optimal decision making. As a result, consultants may be required to face complex clinical, legal, and ethical issues as well as a consultee's highly fearful and/or emotional state (Thomas, 2005).

In many cases, psychologists are able to think through problems and arrive at a decision with little or no additional help. In others, a brief and informal consultation with a colleague may be all that is needed to reassure oneself of a correct course of action, and having such colleagues/consultants available in these instances is generally helpful in arriving at a good resolution (e.g., Koekkoek, van Meijel, & Hutschemackers, 2006). But matters are not always so simple. Sometimes ethical dilemmas arise unexpectedly through no fault of one's own. Others may arise because one has failed to attend to them earlier. Furthermore, some situations may involve very high stakes with the potential of treatment failure, patient complaints, or even the loss of life. Regardless of how they develop, such dilemmas may engender high levels of distress that can interfere with one's reasoning processes. The purpose of this article is to provide a model for psychologists who provide consultation on ethical matters when these circumstances arise in particular cases. Although our focus is on peer consultation, our model may be useful for consultants who volunteer to their state psychological associations and those who work for professional liability insurance carriers. We begin with several assumptions that underlie our work, outline the major facets and levels of consultation, and consider its limitations.

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An Integrated Model

We favor a collaborative model of case consultation in process as well as content (e.g., Kampwith, 2005). The process includes a consideration of how one acts in addition to what one thinks (e.g., Kampwith, 2005), mutual problem identification and decision making (e.g., Brown, Pryzwansky, & Schulte, 2006), and empowering the consultee. Our model recognizes the ability of consultees, based on an egalitarian relationship, to exercise their judgment to use or not use the advice provided as they see fit (S. Behnke, personal communication, September 15, 2005).

The last assumption recognizes that consultation differs from supervision. Supervisors play an evaluative role (Pope & Vasquez, 2007) and direct the treatment of (usually unlicensed) trainees who lack the authority to act independently (Knapp, Younggren, VandeCreek, Harris, & Martin, 2013; for further reading see, Falender & Shafranske, 2004.). On the other hand, in consultation psychol-

ogists provide their expertise to other professionals who are their legal equals. Therefore, consultees have the capacity to accept or reject the information they are given as they see fit because they retain control and ultimate decision-making authority (Knapp & VandeCreek, 2013). Finally, it is important for consultants to remember that consultees have more information regarding the situation, and they are the ones who will live with the consequences of their decisions (Gottlieb, 2006). Therefore, consultants must defer regarding the facts of a case, and it is ultimately up to the consultee to determine if the consultation is helpful.

More specifically, we propose that ethics consultation, at least in more complex cases, may become a multifaceted and multilevel process that takes place over time. Viewing consultation in this way may be especially helpful and perhaps necessary to the extent that consultees experience internal conflicts of interest (Gottlieb, 2012), that is, those conflicts that originate internal to the professional relationship and that advance interests that practitioners enjoy only because they occupy a professional role (Stark, 2005).

Facets of Consultation

We refer to our model of consultation as integrative because it includes the critical analysis of legal/ethical issues, clinical concerns, and contemporary decision-making research. More specifically it: (a) assumes integral relationships among legal, clinical, and ethical issues; (b) strives for optimal outcomes; (c) encourages consultants to establish a structure for the relationship; (d) accepts that all humans may have faulty reasoning processes that need to be challenged; and (e) encourages clarity in defining the reasons for the consultation and the processes used in providing it. We consider each of these facets in more detail below.

The False Trichotomy

We have heard claims that good clinical care, sound ethical decision making, and effective risk management can somehow conflict with each other in certain circumstances. Those who argue this position often trichotomize these matters, placing one in opposition to another. We acknowledge that there are times when emphasizing one issue over others may be appropriate, such as when a question is purely legal in nature. But, when we examine such assertions more closely, we find that these conflicts generally disappear (e.g., Knapp, Gottlieb, Berman, & Handelsman, 2007; Younggren & Gottlieb, 2004). For example, Knapp Younggren, VandeCreek, Harris, and Martin (2013) identified "false risk management strategies," such as not keeping detailed records in an emergency, as those that neither reduced risk nor were justified on the basis of any ethical principle or good clinical practice. Therefore, we assume that there is rarely a conflict between these issues (Gottlieb, 2006) and that consultants should explore all three of these factors in every case (Younggren & Gottlieb, 2004).

Positive Ethics

We do not support consultation as a *pro forma* exercise, so a consultee can write brief notes in a patient's chart memorializing that she or he received consultation regarding a particular issue. Rather, we assume that we can do more than help consultees only meet minimum legal requirements or to achieve a "just good enough" solution. We are guided by aspirational or *positive ethics* (Handelsman, Knapp, & Gottlieb, 2009) and contend that consultants should help consultees achieve the best possible solution whenever possible. This approach is intended not only to help consultees with the particular dilemma at hand, but to achieve additional goals, such as: (a) assisting consultees to find the best solution within an overarching ethical theory, (b) developing skills that will help consultees prevent future problems, and (c) facilitating consultees' personal and professional growth. In other words, our model is designed to help consultees flourish; when we do so, we "invite a broader array of possibilities into our personal and professional lives" (Wise, Hersh, & Gibson, 2012, p. 488).

Structuring the Relationship

Prior to initiating a consulting relationship, the consultant is well advised to consider the following matters before agreeing to proceed:

Competence. Should consultants always accept an assignment? We believe the answer is no because the duty to refer is just as incumbent on consultants as it is on practitioners. Prospective consultants may not have the requisite expertise (Gottlieb, 2006), such as in diversity issues, or they may not feel personally confident in the consulting role. In such cases, prospective consultants should disclose their limitations and offer referral to someone they consider more able to assist.

Also, consultants may recommend additional consultation when a question falls outside their boundaries of competence. These situations may arise, for example, when there is a legal question that the consultee should first discuss with legal counsel before proceeding with ethics consultation.

Boundaries. Issues of boundaries and multiple relationships are also relevant considerations for prospective consultants. For example, in more complex cases (below we refer to them as Level 3 or Level 4 consultations), consultants should consider declining the offer to assist someone whom they know very well simply because the existing personal relationship may raise potential conflicts of interest (Gottlieb, 2006). In fact, to emphasize the point one of us (MMH) has said in jest that psychologists should "hire a consultant they hate." This joke is intended as a caution against those who may blur boundaries due to conflicts of interest.

Confidentiality. Consultees may presume that any consultation they seek would be retained in confidence, but this is not necessarily the case. Although consultants have an obligation to keep information confidential, they should also advise consultees that in the event of a malpractice suit or licensing board complaint, disclosure of the consultation may be compelled. Consultations between psychologists are not protected from disclosure on the same basis as those for example between lawyers and their clients.

A second problem arises in those states that impose reporting obligations on psychologists regarding the unethical behavior of their peers such as Colorado and Oregon. When consultants agree to accept assignments in such a state, they are well advised to inform consultees of their legal obligations.

Fees. Many organizations such as liability insurance carriers, and a number of state psychological associations, offer free ethics consultation to policy holders and members, respectively. The extent of these consultations may vary, but in our experience such assistance is usually designed for answering more clear cut and

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straightforward questions because these organizations are not typically equipped to provide more extensive consultation services. Therefore, consultees may wish to directly retain expert consultation for a fee in more complex situations. In such cases, consultants have the obligation to disclose fully their fees and reasonable estimates regarding expected cost.

Recordkeeping. We recommend that consultees make notes for a number of reasons. First, as a matter of good risk management, it is in consultees' interest to make a record of consultations. Second, it indicates that the consultees are following best practices and acting in behalf of their patients/clients. Third, especially in more complex situations, the notes will serve as guidelines for consultees to follow. This will be especially helpful in those cases where consultees are distressed and may not remember everything that was discussed during the consultation.

Some states, such as Missouri and Florida, have specific rules or regulations that may mandate making notes of consultations, but even if there is no specific requirement in one's jurisdiction it may a good idea in more complex cases. At times consultants may wish to make notes that record relevant facts, alternatives discussed, and recommended actions. Notes may also be useful for follow-up, stimulating greater thought and clarity, and improving the thought process. Finally, if consultees become subjects of law suits or state regulatory board complaints, consultants' records may serve as supporting documentation.

Some Inherent Limitations on Ethical Decision Making

Technical knowledge per se may be insufficient for effective consultation because consultants also may have to deal with how consultees are thinking and feeling, as well as their situational demands. In recent years much has been learned about how heuristics and cognitive biases can adversely affect decision making (e.g., Kahneman, 2003.). For example, Dual Process Theory (Sloman, 2002) and Kahneman's (2011) notion of System 1 (fast, intuitive, automatic) and System 2 (slow, deliberate) thinking neatly encapsulate the obstacles that one may encounter when faced with ethical dilemmas.

Kahneman (2011) noted that humans are more vulnerable to "thinking fast" errors when they are distressed. At such times, they are inclined to oversimplify problems and act too quickly using only immediately available data (Rogerson, Gottlieb, Handelsman, Knapp, & Younggren, 2011). Furthermore, because stress disrupts cognitive processes (e.g., Youssef et al., 2012), it can cause people to focus more on their potential losses than on gains (Pronin, Puccio, & Ross, 2002) and lead them to overrely on avoiding further distress (Slovic, Finucane, Peters, & MacGregor, 2002). For example, when psychologists find themselves intimidated by a patient or a lawyer, they may agree to actions they know to be wrong simply to avoid the distress of a confrontation and/or the need to set limits.

The combined impact of thinking fast and emotional distress has the unfortunate effect of increasing the chances that decision makers will act based primarily on their perceived self-interest and in doing so lose a broader perspective. When this situation arises, inherent conflicts may arise. Chugh and colleagues have referred to this as *bounded ethicality, which* refers to "the limits on the quality of decision making with ethical import [that] . . . places a critical constraint on the quality of decision making . . . in systematic ways that unconsciously favor this particular vision of the self in our judgments" (Chugh, Bazerman, & Banaji, 2005, p. 75; Kern & Chugh, 2009).

Also, everyday work demands can cause ethical issues to diminish in importance. Bazerman and Tenbrunsel (2011) have used the term *ethical fading* which refers to the process by which ethical dimensions are eliminated from a decision and blinds decision makers to the implications of their decisions. In a similar vein, other scholars have examined the effects of conflict of interest from the standpoint of *moral credentialing* or "the act of establishing oneself as a virtuous or moral person . . . that . . . can actually facilitate selfish or ethically questionable behavior" (Brown et al., 2011, p. 1) and others have examined the role that personality characteristics may play in this process (Cooper & Pullig, 2011).

The findings reported above reflect processes internal to the individual decision maker. Consistent with systems theory, we begin consultation assuming that ethical dilemmas occur within a social context. That is, the internal factors we have reviewed affect, and are affected by, the context in which they arise. The Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association (APA Code, 2010) notes that "the application of a standard may vary depending on the context" (p. 1061), and Rogerson, Gottlieb, Handelsman, Knapp, and Younggren (2011) noted that ethical decision making is contextual and interpersonal. Pomerantz (2012) captured some of these dimensions when he encouraged psychologists to ask, "Would I make the same decision if the persons(s) toward whom the decision is directed had different characteristics?" (p. 324). Therefore, ethical decisions will vary based upon the interpersonal context in which a dilemma is situated.

Clarity in Ethics Consultation

What are the reasons for a particular consultation? Is it to gather information, validate previous decisions, or think through and resolve a dilemma? In an initial conversation, consultants should try to assess the consultees' level of clinical and ethical/legal knowledge, the clarity of their thinking, and their level of distress because such an evaluation can offer important guidance regarding planning a course of action. One way or another, the orientation employed should depend on the needs of the consultee. For example, if there is risk of harm to consultees or others, risk management and self-protective strategies may be appropriate. If consultants see that a situation has no perfect answer and it is impossible to uphold one moral value without compromising another, various ethical decision-making models may be appropriate (e.g., Cottone, 2012). If consultants perceive that consultees are not balancing professional obligations and personal morality, they may choose to focus on positive or aspirational ethics (Handelsman et al., 2009) and the extent to which consultees have incorporated our professional values as their own (Handelsman, Gottlieb, & Knapp, 2005).

In all of these approaches, consultants can pay attention not only to the case under discussion but to more general aspirational issues and skills to help consultees generalize and derive long-term benefits from the consultation experience.

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Transparency. Consultation should be transparent. By this we mean that consultants share their thoughts with consultees at every step in the process by thinking out loud and saying things such as, "Let's think through this together." In this way, consultants reveal their reasoning process for consultees and model the thought processes that are involved in various ethical decision-making models (e.g., Cottone, 2012; Haas & Malouf, 2005). By doing so, consultees may see additional options and/or appreciate multiple perspectives; thus, consultation also can become an effective teaching mechanism.

Self-care. Good self-care can prevent many ethical dilemmas. The nature of our work can be stressful, and this is especially the case when one must deal with a difficult student, trainee, or patient at the same time one is coping with significant personal distress. In such situations, it is easy to minimize or exaggerate a clinical or ethical dilemma, dismissing it as unimportant or viewing it as more dire than it actually is. Or, one may not see the relationships among, and relative importance of, various clinical, legal, and ethical components. When psychologists practice good self-care, they may be better able to explore these reactions for themselves (Crowley & Gottlieb, 2012; Wise, Hersh, & Gibson, 2012).

It is usually safe to assume that some consultees who request assistance are distressed (Thomas, 2005), their decision-making capabilities may be temporarily impaired (Rogerson et al., 2011), and their perceptions of ethical dilemmas exacerbated or skewed by conflicts of interest (Gottlieb, 2012). This will certainly not always be the case, but out of an abundance of caution it is our default assumption simply because all of these phenomena are integral to who we are; we cannot escape them. Therefore, a consultant's skill set should include technical knowledge, awareness of the role nonrational processes play in decision making, appreciation of the social context, and a willingness to spend the time needed to address the conflicts of interest of which consultees may be unaware.

Levels of Intervention

Consultations will vary depending on the amount of time, skill, knowledge, and resources the problem will require. This is because dilemmas range from straightforward to highly complex, and as complexity increases the demands on consultants will increase correspondingly. We have found it useful to think of consultations in terms of four levels of complexity ranging from simple factual questions with unambiguous answers to highly complex dilemmas where consultees are highly distressed and exhibit poor self-awareness. We created the categories below as illustrations, but in reality they fall along a continuum of complexity and are not intended as discrete categories with sharp divisions between them. Finally, we assume that during a consultation, the level of complexity may change as new information is obtained.

Level 1

The least complex and time-consuming consultations are those that contain unambiguous questions that have clear and sufficient answers. This is the only level at which we recommend an expert model. Consider the following:

> Dr. Jones called her consultant about a child patient who made a credible report of maltreatment. Dr. Jones knew she had to report what she heard to the child protection authorities, but she was unsure regarding to whom she should make the report and how soon the report had to be made. The consultant provided her with the answers to her questions and the conversation ended.

In this straightforward example, the consultant was asked for specific information and provided it. Had the consultant felt there was a reason to do so, she might have raised additional issues with the consultee including: (a) how clinical management of the case might change now that the mistreatment had been revealed, and/or (b) how Dr. Jones was feeling and whether her feelings might alter her subsequent treatment.

Level 2

Sometimes consultees call with questions that appear simple and straightforward to them but in fact entail greater complexity. This often occurs because consultees may be unaware of certain information, such as legal issues, that could affect their decision.

> A mother called Dr. Nakasone asking to have her child seen for anxiety due to the excessive conflict she was experiencing from her divorcing parents. Feeling sympathetic for a child "caught in the middle," he made an appointment to see her the next day. After hanging up, he had the vague feeling that he had missed something and called for consultation.

In this case, Dr. Nakasone might not have appreciated the risks he was taking. For example, he knew the parents were divorcing, and he had good reason to believe that this was not a "good divorce." But, he had not considered whether the mother may have been bringing the child to see him primarily for strategic purposes rather than the child's benefit. He also did not consider the possibility that the mother might not have had the legal authority to bring the child for treatment in the first place.

When the consultant shared these questions with Dr. Nakasone, he quickly realized his error. Without much further discussion, he understood that he needed to call the mother back and have her lawyer send him a copy of the controlling legal documents giving her the authority to bring the child to see him. Also, had the consultant felt the need to do so, she might have asked him whether or not this was a situation in which he wished to be involved, and if so, what he might do to not have the legal context affect his prospective clinical work with the child, such as insisting on the involvement of both parents.

Level 3

Issues at this level may or may not be any more ethically or legally complex than those at Level 2, but they become more difficult and time-consuming when consultees are distressed and/or may not be thinking clearly.

> Dr. Gonzalez's patient was not reaching her therapeutic goals or adhering to treatment recommendations, yet when she raised the question of termination and referral, the patient became highly resistant. Dr. Gonzalez did not pursue the matter further and allowed the situation to continue, but she soon became increasingly frustrated. By the time she sought consultation, Dr. Gonzalez realized that she had developed very ill-feelings toward her patient, and she was having difficulty controlling them.

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At this level, the consultant's first step is to address the consultee's level of distress in order to discuss its potential impact on the consultee's thinking and decision making. One strategy in this example would be to de-escalate and slow down the process to help Dr. Gonzalez avoid acting hastily and to reduce her own level of discomfort. For example, further discussion might reveal that Dr. Gonzalez was inordinately distressed because she was paying excessive attention to the potential of a state licensing board complaint if she terminated the relationship and too little to the clinical picture and what was best for her patient.

The practical implication of intervention at this level is that it will take far more of the consultant's time than dilemmas at lower levels because she must first take on a quasi-therapeutic role. That is, she must address how Dr. Gonzalez was feeling and help her gain control of those feelings before she was able to address the clinical, ethical, and/or legal issues involved. At this level we assume that this process may take more time but that the goal of helping the consultee gain a better understanding of the situation, and her own role in it, was realistic.

Level 4

The hallmark of this level is that consultees may not recognize that they need help and/or are resistant to accepting it due to their own distress, conflicts of interest, inadequate socialization into the profession, and/or lack of understanding of their fiduciary obligations.

Consider the following example:

> Dr. Harris, an early career psychologist who was hoping to improve his skills, was receiving ongoing consultation from a senior psychologist, Dr. Jackson. At one point, Dr. Jackson inquired about his new patient Suzie, about whom she was especially concerned because she had presented with rather serious symptoms. Dr. Harris promptly replied that he had terminated her treatment. Dr. Jackson was rather surprised to hear this and asked why he had done so. His response was that Suzie had expressed sexual feelings for him; as a result he immediately ended the professional relationship to avoid acting on his feelings and risk hurting her.

Dr. Jackson now faces a multitude of issues. For example, had Dr. Harris become aware of his feelings for Suzie and acted impulsively to reduce his own discomfort? Did he lose sight of his fiduciary obligations to her as a result of temporary impairment? Or was Dr. Harris poorly trained and/or inadequately socialized into the profession?

Dr. Jackson must have found herself asking these, and probably many more, questions within the first minutes of her conversation with Dr. Harris. As a result, she was quickly faced with the question of whether to try and help him or not. At a minimum, she had to decide if she has the expertise to help Dr. Harris manage what may become a highly complicated and emotional situation that could be rather time-consuming and perhaps quite demanding of her personal resources.

The Element of Time

Consultations are often approached with, "I've got a quick ethics question for you." One of us (MCG) often responds, "You may have a quick question, but I won't promise a quick answer." There are times when questions are relatively straightforward and answers can be easily provided as we noted in our Level 1 example. At other times, the opening question will present obvious complexities such as in our examples at Level 3 and Level 4. A third possibility is that an initially straightforward question can lead to others that may make the situation more complex than either the consultant or consultee had first imagined. Therefore, we include time as an element in the consultation model because some situations will demand more from the consultant than others, and it is seldom possible to know which ones will and will not require it at the outset.

At the most basic level, it may be necessary for consultants and/or consultees to do some research. For example, consultees may call with questions they presumed were ethical in nature but are in fact primarily legal matters. In this case, they will need to contact a knowledgeable attorney to learn the law before discussing how to proceed.

Consultation may also take more time when consultees receive information they did not anticipate. For example, a consultee called with what he presumed was an unambiguous question. When the consultant explained that the situation was actually more complex than he had realized, he became more distressed than he was before he called. It was almost as if he was saying, "I called you with problem X, and now you've told me I also have problems Y and Z! I didn't need you to do that." In other words, consultants must be prepared to take additional time when they find that their efforts uncovered more complex problems and/or produced more distressed consultees as a result of the information provided.

Even when a consultation is fairly straightforward, an integral part of our model is follow-up. We recommend doing this for a number of reasons. First, it may be helpful to determine if the dilemma was resolved. If it has not been, further consultation may be indicated.

Second, follow up may provide the consultee with the opportunity to debrief and obtain closure. Third, it can serve the purpose of obtaining feedback for consultants about the effectiveness of their services. Finally, and perhaps most importantly, follow-up can serve the goals of positive ethics by helping to solidify what consultees learned that might be helpful in the future. One way or another, consultation services end when consultees feel they are no longer needed or when consultants feel there is nothing more they can do. By emphasizing time as an element in consultation, we do not mean to suggest that consultation is endless. Instead, we wish to emphasize that when consultants agree to assist colleagues, they accept the responsibility of remaining in their role as long as their services are needed.

Limitations

In this article we gathered research from various areas to create an integrated model for ethics consultation. In doing so, we have tried to show that helping consultees make good ethical decisions can be a time-consuming and complex process. Yet, our model has its limitations; we note some of the more salient ones below.

We acknowledge that not all ethical decisions will require the time or level of attention we have described here. For example, some consultees may be unwilling to participate in the process we have proposed, others may lack the ability to take advantage of it, and some may refuse to accept what they are told. Hence, we recognize that our model will not necessarily be best for everyone

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or every situation, but when consultees do not seem to understand the purpose of our model, we begin to worry that the consultee's condition may be compromised and/or that she or he may not be sufficiently sensitive to professional standards. For example, if a consultant is presented with a consultee who does not seem to be able to think very clearly, it may be time to slow down the process even more than we suggested above.

Experience has taught us that good decisions do not necessarily feel good. We all hope for outcomes that will be good for everyone, and this is a worthwhile goal, but it is not always realistic. Final decisions are often more gray than black or white, and even when the best alternative has been chosen, it may still not feel quite right and leave consultees with mixed feelings. Therefore, even when the consultee knows that a certain decision is the appropriate one, it does not necessarily mean that they will automatically feel better.

We often act as consultants to colleagues who bring us problems with no clear answers.

Frequently we find ourselves saying that a proposed action does not violate a specific ethical principle or rule yet does not feel very good. In other words, just because a contemplated action is not unethical per se does not mean that acting on it is a good idea. When this type of dilemma arises, it is time for consultants to encourage consultee to slow down and try to think ahead about their personal values and the potential unintended consequences before proceeding.

We assume that the consultation process is collaborative and that in general consultees should make their own decisions. In part, this is so because many ethical decisions are inherently dilemmatic and have no clear answers. But sometimes answers are relatively clear cut. What happens then if a consultee disagrees with the consultant's recommendation? How forceful should one be? We work very hard to avoid such situations, but there may be times when being clear and unequivocal about one's recommendations is indicated. If a consultee refuses to accept the recommended course of action, it is probably time for the consultant to withdraw.

A final limitation is that consultants are subject to the same biases and stresses as consultees. Thus, they need to pay attention to their own choices regarding consultation. For example, consultants may be too quick to find a simple answer because of their own time pressures, or take too much time to increase their income. In other words, our specialized training does not make us immune to our own biases and blind spots (Pronin & Kugler, 2007; West, Meserve, & Stanovich, in press).

Conclusion

The purpose of this article was to provide a model that we hope will improve the case consultation process. We did this by expanding the notion of ethics consultation, conceiving of it as a collaborative process that emphasizes positive ethics. More specifically, it strives to integrate the standards for best clinical practices, good ethical decision making, and sound risk management while integrating current science regarding decision making. Finally, in more complex situations we propose that it can be a multifaceted and multilevel process that may take place over time.

The model is designed for daily use by practitioners but we also hope it will be seen from a broader perspective that might facilitate positive ethics in several ways. First, the model might be expanded to include ongoing and preventive consultations that are not necessarily focused on particular cases or dilemmas. Second, good consultation is not just about helping others solve problems; it can also be about helping our colleagues practice positive ethics. Third, the model may help consultees lean to think about ethical decision making in new ways. Fourth, using the model may help consultants to practice positive ethics themselves. By doing so they "leverage the professional community to collaboratively present problems of competence and to aspire to excellence" (Johnson, Barnett, Elman, Forrest, & Kaslow, 2012, p. 558). Consistent with the recommendations of Johnson, Barnett, Elman, Forrest, and Kaslow (2012), such consultation might shift the culture of psychology toward more caring for our colleagues.

The Greek word *akrasia* refers to acting against one's better judgment or lacking command over oneself. The research we have reviewed leads us to conclude that the Greeks were right; we do not always have the control over our own thinking, feelings, and behavior that we might prefer. Hence, there are times when we must rely on the help of others to keep us from acting against our own interests as well as those of the clients/patients to whom we are responsible. When these situations arise, we hope colleagues will, as the risk mangers teach us, "never worry alone." Instead we hope they will reach out for assistance from a knowledgeable colleague from whom they can obtain the most objective information and widest exploration possible. When they do so, we hope our model will improve the process and lead to better outcomes.

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