The Competent Community

Toward a Vital Reformulation of Professional Ethics

W. Brad Johnson — *United States Naval Academy*
Jeffrey E. Barnett — *Loyola University Maryland*
Nancy S. Elman — *University of Pittsburgh*
Linda Forrest — *University of Oregon*
Nadine J. Kaslow — *Emory University*

Psychologists are ethically obligated to ensure their own competence. When problems of professional competence occur, psychologists must take appropriate steps to regain competence while protecting those they serve. Yet conceptualizations of the competence obligation are thoroughly intertwined with Western ideals of individualism and a model of the person as self-contained, self-controlled, and perpetually rational. Research in health care, education, and multicultural and social psychology raise serious doubts about psychologists' capacity for consistently accurate self-assessments of competence. To address this problem, the authors advocate that education, training, professional ethics standards, and credentialing criteria be infused with a robust communitarian ethos and a culturally pervasive ethic of care. The authors propose a shift in discourse about competence to incorporate both competent individuals and competent communities.

Keywords: ethics, competence, communitarian, self-assessment, care

A person is a person through other persons.
—Zulu idiom

We are bound up in a delicate network of interdependence.
—Desmond Tutu

Developing and assessing competence increasingly are the sine qua non of training and credentialing efforts in professional psychology (DeMers, 2009; Elman, Illfelder, & Robiner, 2005; Kaslow, 2004; Kaslow et al., 2004; Rodolfa et al., 2005; Vasquez, 1992). Professional psychologists—those who deliver services requiring licensure—have an ethical obligation to establish and maintain competence in those areas in which they practice. Like other health care professions in Western cultures (e.g., American Dental Association, 2011; American Medical Association, 2001, 2004), the American Psychological Association's (APA's) "Ethical Principles of Psychologists and Code of Conduct" (referred to here as the Ethics Code; APA, 2010) holds the individual psychologist exclusively responsible for ensuring competence to practice. Notions of self-contained identity, preeminence of personal control, and presumed accuracy of self-assessment drive professional standards that make ongoing evaluations of competence a largely private affair at the level of the individual psychologist. This is the case despite the fact that human beings are conspicuously inaccurate in their self-assessments of any characteristic or competency (Dunning, Heath, & Suls, 2004). Furthermore, increasingly diverse demographics require greater multicultural competence to practice ethically, yet evidence exists that self-reported multicultural competence is only somewhat correlated with objective measures of cultural competence (Cartwright, Daniels, & Zhang, 2008; Constantine & Ladany, 2000; Worthington, Mobley, Franks, & Tan, 2000). Unfortunately, psychologists and other health care professionals suffer occasional problems of professional competence (Elman & Forrest, 2007; Kaslow et al., 2007; Tarkan, 2011). When personal distress, illness, or cognitive decline—not to mention the natural degradation in the currency of one's education—place psychologists' competence at risk, it may be both unreasonable and illogical to expect psychologists to accurately predict adverse effects of these events, or to fully recognize decrements in functioning, let alone to formulate a cogent and ethical response.

In this article, we propose a fundamental shift in conceptualizations of the ethical obligation to maintain professional competence. We advocate that individual notions of accountability must be augmented with interdependent, collectivistic, or communitarian perspectives on ethics, which balance individual responsibilities with community obligations (Etzioni, 1998; Markus & Kitayama, 1991; Pedersen, 1997). When communities of psychologists accept responsibility for supporting the functioning and professional competence of colleagues, problems of professional competence will be less frequent

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W. Brad Johnson, Department of Leadership, Ethics, and Law, United States Naval Academy; Jeffrey E. Barnett, Department of Psychology, Loyola University Maryland; Nancy S. Elman, Department of Psychology in Education, University of Pittsburgh; Linda Forrest, Department of Counseling Psychology and Human Services, University of Oregon; Nadine J. Kaslow, Department of Psychiatry and Behavioral Sciences, Emory University.

Correspondence concerning this article should be addressed to W. Brad Johnson, Department of Leadership, Ethics, and Law, United States Naval Academy, Luce Hall, Stop 7B, Annapolis, MD 21402. E-mail: johnsonb@usna.edu

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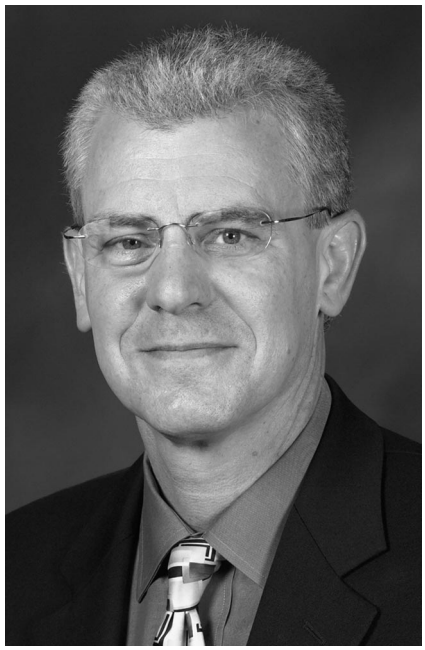

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and less likely to harm consumers, the profession, and psychologists themselves. We conclude with recommendations for the profession, including a shift from a predominantly individual and deontological ethics code toward one that incorporates a robust communitarian ethic of care.

The Burgeoning Culture of Competence in Psychology

For nearly three decades, professional psychology has moved toward competency-based education, training, and credentialing (Bourg, 1990; Rodolfa et al., 2005). Leaders have fostered a "culture shift" that emphasizes acquisition of competence during training and ongoing assessment of competence over the course of one's career (Kaslow, 2004; Kaslow et al., 2004, 2009; Lichtenberg et al., 2007; Roberts, Borden, Christiansen, & Lopez, 2005). This culture shift recognizes that it is imperative that the profession articulate the unique competencies that define a professional psychologist. Such clarity enables the profession to communicate with its members and with the public about the services psychologists provide (Kaslow, 2004). Kaslow et al. (2009) asserted that "competence in health-care providers is demanded by consumers, expected and certified by regulators, and lauded by policymakers" (p. 528).

Competence in professional psychology refers to developmentally appropriate levels of knowledge, skills, and attitudes and their integration in various foundational domains of functioning. The most durable and frequently referenced definition of competence was offered by Epstein and Hundert (2002): "Professional competence is the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community served" (p. 226). Although definitions of competence center around a psychologist's ability to carry out certain tasks appropriately and effectively (Johnson et al., 2008; Kaslow, 2004), educators and supervisors remain keenly aware of the complexity of competence and the difficulties inherent in capturing its nuanced cognitive, affective, and relational dimensions (Kaslow et al., 2009; Pope & Vasquez, 2007). Although *competence* refers to an overall or integrated macro facility as a psychologist, *competencies* describe elements of knowledge, skills, and specific attitudes/values, or the essential micro components of competence (Bourg, 1990; Kaslow et al., 2004).

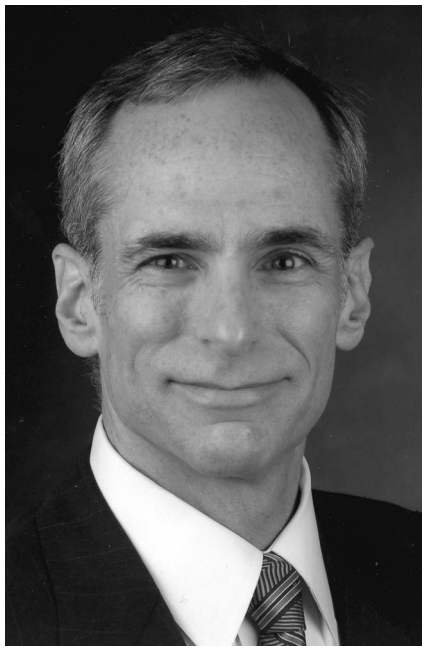
Professional Competence as an Ethical Obligation

Once a professional psychologist achieves licensure by exhibiting entry-level competence, he or she is free of the scrutinizing gaze of supervisors and generally not required to ever again demonstrate competence or undergo peer review. The one exception to this is the decision to secure board certification in a specialty area, which entails a peer review process for competency assessment (Nezu, Finch, & Simon, 2009). However, only 2.5% to 3.0% of psychologists hold board certification (D. Cox, personal communication, October 28, 2011).

Systemic features of the profession's current credentialing and regulatory procedures exacerbate inattention to competence among licensed psychologists. First, at present, maintaining licensure is contingent merely upon documenting sufficient continuing education hours, and many jurisdictions have no such requirements. It is indicative of a systemic problem that psychologists often speak of maintaining licensure, not maintaining competence. One notable jurisdictional exception is Ontario, Canada, where psychologists complete a comprehensive self-assessment protocol to document continued competence and develop a plan for the enhancement of their competence (College of Psychologists of Ontario, 2011).

Second, the regulatory culture is largely complaint driven. A psychologist conceivably may provide care below minimum thresholds of competence for an entire career without coming to the attention of a local community of psychologists, an ethics committee, or a regulatory board. Ethics committees and regulatory boards take action only after potentially unethical behavior is brought to their attention (Bennett et al., 2006; DeMers & Schaffer, 2011). Unfortunately, not all substandard conduct is brought to ethics committees' and regulatory boards' attention (Van Horne, 2004). This complaint-driven approach unduly focuses on addressing ethical and legal transgressions and fails to leverage the professional community to collaboratively prevent problems of competence and to aspire to excellence.

Postlicensure, psychologists must individually accept that their status as professionals invokes ethical and legal obligations; each professional must individually embrace an ethic of continual self-assessment of professional competence across the life span (Roberts et al., 2005). Principle A of APA's Ethics Code underscores this obligation in



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aspirational terms: "Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work" (APA, 2010, p. 3). More important, in Standard 2.06, Personal Problems and Conflicts, the Ethics Code details the individual psychologist's enforceable duty to continuously self-evaluate competence and to take steps to protect consumers when personal problems or conflicts threaten to reduce competence:

> (a) Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.
>
> (b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties. (APA, 2010, p. 5)

Because no ethical standard enjoins psychologists to maintain close collegial or consultative relationships or intervene and assist when a colleague's competence begins to ebb, assessing competence and taking appropriate measures to maintain competence remain an exclusively personal obligation. Although scholars concur that an ethical psychologist should engage in continuous self-assessment and remain acutely self-aware when it comes to level of performance (Barnett, Baker, Elman, & Schoener, 2007; Kaslow, 2004; Pope & Vasquez, 2007; Vasquez, 1992), many psychologists never avail themselves of personal psychotherapy (Guy, Stark, & Poelstra, 1988; Norcross, 2005) or ongoing consultation (Guy et al., 1988; Norcross, 2005).

The Problem(s) With Assessing Professional Competence

Although psychology's shift to a culture of competence, which emphasizes formative and summative assessments of trainees, has enhanced training rigor and efficacy, maintaining competence beyond initial credentialing continues to mean that psychologists rely on self-assessment and voluntary consultation with colleagues if problems arise (Roberts et al., 2005). Self-assessment of competence is fraught with several disadvantages including the inherent fallibility of human self-assessment and the fact that competence is context driven and vulnerable to decrements in the context of distress (Dunning, Johnson, Ehrlinger, & Kruger, 2003). To make matters worse, psychologists are reluctant to address problems of competence in colleagues, even when they detect clear evidence of such problems (Barnett, 2008; Barnett & Hillard, 2001; Bernard, Murphy, & Little, 1987; Good, Thoreson, & Shaughnessy, 1995).

Human Beings Fail to Recognize Their Own Problems With Competence

Across hundreds of studies in social psychology, human self-assessments of skill and character traits are flawed in substantive and systematic ways (Dunning et al., 2004); "people tend to be blissfully unaware of their own incompetence" (Dunning et al., 2003, p. 83). On tests of humor, grammar, logic, clinical skill, and desirable character virtues, people overestimate their test performance and ability. Ironically, this effect is most pronounced for the least competent performers, who subsequently make unfortunate, possibly unethical, personal and professional choices (Kruger & Dunning, 1999). Those whose competence is most compromised may be least able to effectively detect problems with competence and respond appropriately. "Poor performers are doubly cursed: their lack of skill deprives them not only of the ability to produce correct responses, but also of the expertise necessary to surmise that they are not producing them" (Dunning et al., 2003, p. 83).

To complicate matters further, psychologists, like other human beings, are self-serving and prone to attribute poor performance to bad luck or uncontrollable circumstances (Campbell & Sedikides, 1999). Vulnerability to the *self-serving bias* persists across cultures and increases the probability that a psychologist suffering problems of professional competence will ignore performance problems or attribute them to fleeting circumstances (Mezulis, Abramson, Hyde, & Hankin, 2004; Myers, 2009). Self-serving bias, and a related perceptual predisposition, *illusory optimism*—the belief that one is immune to misfortune—may undermine a healthy appreciation for one's vulnerability to decreased competence and may prevent psychologists from taking appropriate precautions (e.g., self-care, collegial consultation, peer review, or limiting or closing one's practice).

What about self-assessment efficacy among health care professionals? Psychology, medicine, nursing, and other health care professions increasingly are rooted in

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self-directed, lifelong learning that is contingent on self-assessment of competence and ongoing professional development activities. Unfortunately, medical providers often fail to accurately assess their own competence levels (Davis et al., 2006). Statistical correlations between physicians' self-rated performance and external assessments are weak to nonexistent (Barnsley et al., 2004; Risucci, Torolani, & Ward, 1989). Professionals who function in the lowest quartile of competence are least able to accurately self-assess or to use benchmark exemplars to improve their performance (Hodges, Regehr, & Martin, 2001).

Some proportion of health care professionals have difficulty recognizing the limits of their own competence; as a rule of thumb, "people's capacity to evaluate themselves and predict their behavior is usually quite modest and often much more meager than common intuition would lead one to believe" (Dunning et al., 2004, p. 70). If we extrapolate from medicine to psychology, these findings raise concerns about psychology's adherence to a tradition of self-directed learning and self-assessment and maintenance of competence. Yet ethics codes and continuing education policies in medicine, psychology, and other health care disciplines presume that individual practitioners are capable of recognizing and resolving their own competence deficiencies (Eva, Cunnington, Reiter, Keane, & Norman, 2004).

Professional Competence Is Impermanent and Context Specific

The current system of training, credentialing, and regulation implicitly assumes that competence, once achieved, is relatively permanent and impervious to contextual effects of the psychologist's environment and/or wellness (Johnson et al., 2008; Schulte & Daly, 2009). Epstein and Hundert (2002) reminded us that competence is "a statement of the relationship between an ability (in the person), a task (in the world), and the ecology of the health systems and clinical contexts in which these tasks occur" (p. 228). Competence demonstrated in one context—such as a state hospital internship—may not effectively transfer to an academic health sciences center, a college counseling clinic, or private practice with children.

Similarly, multicultural scholarship confirms the importance of cultural context in professional competence (Knapp & VandeCreek, 2007; Vasquez, 2010). For instance, culture often shapes help-seeking behavior, identification of prejudice and discrimination, diagnostic assessment and intervention decisions, and the therapeutic alliance and its outcomes (Arredondo et al., 1996; Pedersen, 1997).

In addition, competence is not always steady when psychologists are faced with professional stress and personal distress. Several authors have cogently articulated the "hazards" of psychotherapy practice for the psychologist (Barnett et al., 2007; Barnett & Hillard, 2001; O'Connor, 2001; Smith & Moss, 2009), with one reflecting that "psychotherapy is often a grueling and demanding calling" (Norcross, 2000, p. 710). Sources of distress in professional practice may include isolation from other professionals, vicarious traumatization, or shame regarding one's feelings about clients who are persistently fragile, suicidal, or unresponsive to intervention. Distress often forecasts emotional exhaustion and burnout (Sherman & Thelen, 1998; Smith & Moss, 2009). Professional distress occurs when—in response to ongoing stressors, challenges, conflicts, or demands—a psychologist's emotional state is characterized by depression, anxiety, and fatigue (Barnett et al., 2007; Norcross, 2000). Although distress does not always lead to problems of professional competence (i.e., failure to meet expected performance benchmarks in one or more competency domains; Elman & Forrest, 2007), it increases the risk of diminished competence (i.e., lowered levels of performance in one or more competency domains, even if the reduced level of performance remains at or above minimal competency standards).

How frequent are problems of professional competence? A significant proportion of practicing psychologists experience episodes of considerable distress but often fail to assess or take measures to address declining competence (Advisory Committee on Colleague Assistance, 2006; Barnett & Hillard, 2001; Sherman & Thelen, 1998). Surveys of practicing psychotherapists indicate that between one third and one half have experienced at least one serious episode of depression, half have reported episodes of emotional exhaustion, and nearly a quarter have had suicidal feelings (Mahoney, 1997; Pope & Tabachnick, 1994). Although emotional distress—even episodes of serious psychopathology—need not pose an ethical concern if psychologists accurately self-assess and effectively address their own problems of professional competence, they often fail to do so. Large surveys revealed that 59% of practicing psychologists continued to see clients when too distressed to be effective (Pope, Tabachnick, & Keith-Spiegel, 1987),

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whereas 30% admitted that their personal problems decreased the quality of the care they provided (Guy, Poelstra, & Stark, 1989; Sherman & Thelen, 1998).

And what of declining competence that is due to the effects of aging and diminished cognitive acuity? Many of us will experience a "terminal drop" in cognitive functioning in the years prior to death (Suedfeld & Piedrahita, 1984). As physicians age, they perform less effectively on complicated surgical procedures (Tarkan, 2011); those with mild cognitive deficits may not be aware that their performance is flagging. As psychologists age, one can expect similar problems of professional competence related to advancing cognitive decline. Yet a significant proportion of psychologists plan to practice well beyond the typical retirement age, and nearly 13% in one survey planned to practice until death (Guy, Stark, Poelstra, & Souder, 1987); this proportion is likely to increase given the current negative economic environment. Although airline pilots must submit to twice-yearly physical and psychological exams after the age of 40 and accept mandatory retirement at age 65 (Tarkan, 2011), health care providers face no such scrutiny unless a complaint triggers a regulatory investigation. Noting the crux of the problem as it pertains to assessment of competence, Guy et al. (1987) wrote,

> The problem of greatest concern is that it is the psychotherapist alone who must make ongoing assessments regarding the impact of advancing age on his or her clinical competency . . . obtaining licensure or registration in most states [or provinces] permits the clinician to practice without further supervision or evaluation until death. (p. 817)

There are good reasons to question whether a newly minted psychologist will have either the capacity or the will to effectively self-assess his or her competence across a lifetime of ever-changing job demands, varied life stressors, bouts of intense personal distress, and ultimately, physical and cognitive decline.

Reluctance to Address Problems of Professional Competence in Colleagues

If psychologists are not always accurate in their self-assessments, and if they are likely to experience distress and episodic problems with professional competence, can they count on colleagues to step in and help? Unfortunately, psychologists admit that they might not directly approach a colleague who appears to be functioning below thresholds for competence or otherwise behaving unethically, even when they believe that they are ethically obligated to do so (Barnett, 2008; Bernard et al., 1987; Wilkins, McGuire, Abbott, & Blau, 1990; Wood, Klein, Cross, Lammers, & Elliott, 1985). This is not a problem limited to psychology (Kruger & Dunning, 1999). When a psychologist exhibits problems of professional competence, colleagues—if they notice the problem—may avoid initiating a difficult discussion and assisting the psychologist for several reasons: (a) lack of certainty regarding their ethical duty to intervene, (b) fear that there is insufficient evidence to intervene, (c) concern about causing negative professional outcomes for a colleague to whom they feel some loyalty, (d) worry about harsh or unpredictable responses by regulatory boards and ethics committees, (e) concern that if they address or report a colleague's behavior they will be ostracized by the community of psychologists, and (f) lack of an established relationship with the psychologist sufficient to warrant collegial intervention (Barnett & Hillard, 2001; Biaggio, Duffy, & Staffelbach, 1998; O'Connor, 2001; Smith & Moss, 2009). Additional multicultural factors may affect psychologists' decisions to intervene with colleagues, and these include (a) uncertainty about whether prejudice, discrimination, or bias has occurred and if so whether it was intentional or unconscious; (b) doubts about their own multicultural competence; and (c) inexperience and lack of skill at addressing multicultural issues (Toporek & Williams, 2006).

Clues as to why psychologists might be reluctant to address problems with colleagues are evident in the current APA Ethics Code (APA, 2010). The only ethical standard bearing on responsibility for monitoring colleagues is Standard 1.04, which enjoins APA members to seek informal resolutions to confirmed or suspected ethical violations on the part of other psychologists. Therefore, concerns about competence need not trigger any intervention until the colleague's behavior rises to the level of a perceived ethical transgression. To complicate matters further, failure to intervene and support a colleague who exhibits questionable competence may be fueled in part by the *fundamental attribution error* (Ross, 1977). That is, when explaining another psychologist's behavior, each of us is inclined to *over*estimate the extent to which problems of competence reflect that individual's traits or attitudes while *under*estimating the impact of the situation on that individual's practice (e.g., relationship turmoil, financial difficulties, physical illness, difficult client events). Our susceptibility

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to the fundamental attribution error helps to explain why it might be it easy to blame a colleague for problems of competence, thus electing avoidance or ostracism rather than engagement and assistance.

Although formal Colleague Assistance Programs (CAPs) might offer one avenue for outreach, assessment, and peer support when a psychologist's competence appears to falter (Barnett & Hillard, 2001), many struggling professionals avoid these programs because they fear their involvement might trigger regulatory board action, and psychologists do not often recommend peers to CAPs for fear of adversely affecting their peers' ability to practice (Schoener, 2005). Further, most state, provincial, and territorial psychological associations do not offer formal CAPs because of a lack of utilization (Advisory Committee on Colleague Assistance, 2006; Barnett & Hillard, 2001).

Communitarianism and the Ethics of Care

Western cultures often promote independent models of the self that celebrate personal control and the preeminence of individual rights and responsibilities. Moral philosophies and ethical theories emerging from this individualistic context tend to be deontological or rule based (James & Foster, 2006). Beginning with Plato, moral agents are construed as continuously rational, healthy, and untroubled when deliberating the correct course of moral behavior (Macintyre, 1999; Markus & Kitayama, 1991). But traditional individualistic ethical theories have been criticized for erroneous assumptions of impartiality and universality in ethical decision making and an implied preference for emotional detachment in the process of ethical reasoning (Beauchamp & Childress, 2008; Meara, Schmidt, & Day, 1996).

In reaction to individualistic models of moral philosophy, communitarian, feminist, and multicultural scholars emphasize the salience of mutual interdependence and emotional responsiveness in leading a moral life. Communitarians emphasize the interdependent self. From this perspective, professionals who acknowledge their embedded position in a web of social connections, their human frailty, and their genuine dependence on others will be better equipped to effectively make ethical decisions (Macintyre, 1999; Markus & Kitayama, 1991).

Communitarianism

A communitarian perspective on a moral life recognizes both individual dignity and the social dimension of human existence (Etzioni, 1998). It is not only the individual who owns ethical responsibilities; communities too have obligations, including the duty to be responsive to members. At the core of communitarian notions of social justice is the idea of reciprocity; each member owes something to all the rest. "If communities are to function well, most members, most of the time, must discharge their responsibilities because they are committed to do so" (Etzioni, 1998, p. xxxvi), not because they fear lawsuits or licensing board complaints. Modern communitarian ethics draws upon the African philosophy of Ubuntu embodied in the Zulu idiom *I am what I am because of who we all are*, which stresses the importance of connections and allegiances with others in defining one's identity (Ramose, 2003). Desmond Tutu (1999) reflected that "a person operating from an Ubuntu perspective is open and available to others and affirming of others, aware that he or she belongs to a greater whole and is diminished when others are humiliated or diminished" (p. 35).

Moral philosopher Alasdair Macintyre (1999) spoke to the salience of communitarian ethics for imperfect and fallible human beings. He noted that in spite of our insistence that we are independent, untroubled, and always lucid moral agents, we are in fact highly "dependent rational animals" (Macintyre, 1999, p. 2) who can only be understood in terms of our vulnerability and ultimate dependence on others. As human beings and professional psychologists, each of us is vulnerable to affliction, and most of us will experience a serious illness or incapacity. "How we cope is only in small part up to us. It is most often to others that we owe our survival, let alone our flourishing" (Macintyre, 1999, p. 1). Communitarians accept that some measure of caring, sharing, and being our brother's or sister's keeper is essential for the preservation of dignity, happiness, and healthy functioning (Etzioni, 1998). As though speaking directly to the issue of competence among professionals, Macintyre (1999) addressed the value of interdependence in moments of personal distress and need: "I must be able to trust you and rely on you, not only in the routine transactions of everyday life, but also and especially when I am something of a burden and a nuisance, by reason of my disabilities" (p. 110). Far from eschewing personal responsibility, communitarian philosophy acknowledges that to flourish, we need to refine virtues that allow us to function as accountable moral agents and acknowledge the

extent of our dependence on others (Macintyre, 1999; Markus & Kitayama, 1991). If psychologists and other professionals resist notions of the virtuous community for fear that such interdependence limits personal freedom and opens the door to criticism and even punitive responses, communitarians would remind us of the paradox that "freedom comes only by participation in a truthful polity capable of forming virtuous people" (Hauerwas, 1981, p. 3). Psychologists functioning with a communitarian perspective would feel some sense of accountability for the competence and well-functioning of their colleagues; show less reticence and suffer less shame about exposing imperfections, emotional distress, and need for assistance with colleagues; and share a concern for the common good that would include all those served by their professional community, not just their own individual clients/patients or students/supervisees.

The Ethics of Care

Communitarian moral philosophy is allied with the ethics of care, a strand of virtue ethics that is critical of utilitarianism and Kantian deontological ethics emphasizing rules, duties, impartiality, and universality. Borrowing from Thomas Aquinas's virtue of *misericordia*—a sense of empathy or just generosity that allows one to understand another's distress as one's own—an ethics of care emphasizes interdependence and communal relationships that engage us emotionally and require a response of care to neighbors in need (Held, 2005; Macintyre, 1999). The modern ethics of care movement is linked most prominently to Carol Gilligan (1982) and Nel Noddings (1984) and their work in moral psychology and relational ethics. Challenging justice-based models of moral reasoning, Gilligan proposed that in contrast to an ethics of individual rights and neutral principles, women tended to affirm an ethic of care centering on empathic responsiveness within an interconnected network of relationships (Beauchamp & Childress, 2008; Gilligan, 1982). Following Gilligan, Noddings (1984) proposed that the virtue of care involves an orientation to relatedness and responsiveness to others' needs. Relational ethics assumes that individual ethical reasoning is important but not enough and that emotion and relationship-based virtues (e.g., care, friendship, mercy, benevolence, sensitivity) and interdependence are essential when engaging in moral reasoning and ethical decision making. From the perspective of an ethic of care, psychologists who become aware of a colleague's distress or diminished competence might ask first, "Who shall we be in relation to our colleague?" (Jordan & Meara, 1990) and only later ask, "What shall we do?"

The Contributions of Multicultural, Feminist, and Social Justice Psychology

Communitarian and ethic-of-care frameworks for understanding ethical practice in psychology share common ground with feminist, multicultural, and social justice psychology. Feminist and multicultural ethics scholars provide strong critiques of psychology's ethics as too immersed in Western concepts of individuality and autonomy and as ignoring values such as the salience of emotions, connection to others, and communal responsibilities (Brabeck, 2000; Brown, 2004; Houser, Wilczenski, & Ham, 2006; Pedersen, 1997; Ridley, Liddle, Hill, & Li, 2001; Vasquez, 2010).

Ethical stances arising from collectivist cultures provide a window into how deeply individualistic perspectives are embedded in the current APA Ethics Code. According to multicultural ethicists, Western ideals of individualism give short shrift to worldviews that focus on family and community responsibilities. For many clients and psychologists of color, individual rights and needs are best understood within a larger cultural frame. From a collectivist perspective, the moral ethnocentrism of the APA Ethics Code neglects this communal context. Psychologists practicing from dominant-culture perspectives may be less able to accurately assess their competence to provide ethical service to clients from collectivist cultural backgrounds.

Psychologists cannot meet their commitments to multicultural competence without incorporating a commitment to social justice work that includes advocacy, prevention, outreach to communities, and political action (Vera & Speight, 2003). This commitment cannot be met without an expansion of professional activities to include "advocacy and intervention at the community and policy levels" (Goodman et al., 2004, p. 794). From a social justice perspective, competent ethical practice includes committing to serving clients and communities who have the least power and are the most disenfranchised; seeking to ameliorate the power imbalances in society and in therapeutic relationships; working collaboratively with indigenous support systems; advocating and acting to reduce conditions of domination and oppression; and promoting values of compassion, care, and collaboration with clients and their communities (Goodman et al., 2004; Toporek & Williams, 2006; Vera & Speight, 2003.)

Toward a Communitarian Reformulation of the Competence Obligation: Maybe Competence Takes a Village

In this final portion of the article, we encourage a bold reconceptualization of the competence obligation in professional psychology and an accompanying culture shift in training, regulation, and life in the community of psychologists. In 1997, Prilleltensky recommended that psychology adopt a communitarian approach that fosters a balance among values such as caring and compassion, collaboration, democratic participation, and distributive justice. We hope to nudge psychology toward a similar community perspective vis-à-vis professional competence that is rooted in an interdependent view of the self. Communitarian principles challenge us to transform the culture of psychology (Prilleltensky, 1997). If the community of psychology views competence not only as an individual obligation but also as a collective moral duty, we can think in terms of

both competent psychologists and competent communities. A psychologist's competence must be consistently affirmed and validated by competent colleagues.

Care as an Ethical Principle, Character Virtue, and Community Norm

A genuinely communitarian psychology will be centered in a commitment to care as an undergirding ethical principle, a character virtue, and an abiding community custom. As a matter of aspirational ethics, acting responsibly and compassionately toward others should be a foundational pillar of moral thought and action. Although general ethical principles do not represent obligations, as in the case of enforceable standards, they do guide and inspire psychologists toward the highest ethical ideals (APA, 2010). It is difficult to fathom the relevance of existing principles (e.g., beneficence, fidelity, integrity, justice, respect) without a firm commitment to the principles of care and compassion (Prilleltensky, 1997).

If care is a salient ethical principle, it is an equally prominent professional character virtue. Indeed, concern for others is one of the essential components of the professionalism competency within professional psychology (Elman et al., 2005; Fouad et al., 2009; Kaslow et al., 2009). Virtue ethics call upon psychologists to aspire toward ideals and develop traits of character that enable them to achieve those ideals (Jordan & Meara, 1990; Meara et al., 1996). Many scholars agree that care and compassion for others are vital for the character of health professionals (Beauchamp & Childress, 2008; Kitchener, 2000; Prilleltensky, 1997; Stern, 2005). As character virtues, care and compassion indicate deep concern and empathy for another's welfare. Kitchener (2000) reflected that "to act out of care is not to respond in terms of fixed rules or principles but out of affection and regard for another who is in a particular circumstance" (p. 51). Genuine caring is difficult work; the one caring should always act to bring about a favorable outcome for the one cared for (Noddings, 1984).

Finally, care is a vital community norm. Communitarian writers emphasize the importance of interdependent self-concepts among members of high-functioning and caring communities (Held, 2005; Markus & Kitayama, 1991). When community members recognize their dependence upon each other and respond with gratitude and reciprocal care and concern, the community and its members are likely to flourish (Macintyre, 1999). When care is a custom within psychologist communities, psychologists will feel a powerful sense of accountability for the personal well-being and professional competence of their colleagues. When care is a guiding ethical principle for a psychologist as well as a matter of character, responding with compassionate engagement to a colleague with diminished competence will be an automatic reaction.

A Communitarian Recasting of the "Ethical Principles of Psychologists and Code of Conduct"

Ethics codes in the health professions provide rules and guidelines regarding appropriate behavior for professionals (Meara et al., 1996). Generally prescriptive and normative, they are intended to protect the public by specifying what professionals ought and ought not do. Like codes in other mental health professions, the current APA Ethics Code (APA, 2010) offers little guidance regarding obligations to the community of psychologists and rests on the presumption that individual psychologists are consistently capable of recognizing and resolving their own competence deficiencies (Eva et al., 2004).

The General Principles—aspirational moral ideals—of the APA Ethics Code include several principles relevant to communitarian concern for colleagues: Principle A, Beneficence and Nonmaleficence; Principle D, Justice; and Principle E, Respect for People's Rights and Dignity. It is striking that the APA Ethics Code neither includes Care and Compassion as a guiding general principle nor conveys a clear obligation to the community of psychologists. Although Beneficence (Principle A) comes close in some respects with attention directed toward safeguarding the rights and interests of clients, it does not explicitly encompass care for our colleagues.

We encourage the profession to modify and amplify the principle of beneficence to incorporate a clearer focus on care and compassion, not only for those who psychologists serve but also for members of the professional community. Alternatively, Care and Compassion could become a distinct general ethical principle, differentiated from Beneficence and Nonmaleficence.

Moving from aspirational principles to ethical obligations, we maintain that Standard 2, Competence, in the current APA Ethics Code (APA, 2010) requires attention. In this article we have elucidated the problems inherent in placing ethical responsibility for competence exclusively on the shoulders of individual psychologists—particularly when problems of competence occur. At present, psychologists must determine the contours of their own competence (Standard 2.01), maintain their competence (Standard 2.03), and limit or discontinue their professional work when personal problems interfere with their competence (Standard 2.06). Although the Ethics Code enjoins psychologists to seek appropriate consultation when deciding whether to continue professional work (Standard 2.06), such consultation is to be initiated by the individual and is framed as a discrete event isolated from the whole of the psychologist's professional life. Further, Standard 2 currently creates no obligation for psychologists to look after colleagues' competence as a way of caring for them in addition to safeguarding clients and the profession. We share the view of Stern (2005) and others that, although missing from our current ethics code, a humanistic concern for others is a foundational component of professionalism. We contend that concern for colleagues warrants direct attention in our ethics code.

As examples of how a communitarian ethic might be infused in the APA Ethics Code, we offer illustrations of revised standards that reflect communitarian ideals and an ethic of care and that respond to concerns raised by feminist, multicultural, and social justice psychology. Although it is beyond the scope of this article to propose a compre-

hensive reformulation of the APA Ethics Code, we hope that these examples pique psychologists' interest in recasting the profession's Ethics Code. Words in italics are our additions to current standards:

Standard 2.03, Maintaining Competence: Psychologists undertake ongoing efforts to develop and maintain their competence. *Psychologists maintain regular engagement with colleagues, consultation groups, and professional organizations and routinely solicit feedback from these sources regarding their competence for work in specific roles and with specific populations.*

Standard 2.06, Personal Problems and Conflicts: *(c) When psychologists become aware that a psychologist colleague is experiencing problems that may lead to interference with professional competence, they offer care and support, and collaborate with that colleague in assessing competence and determining the need to limit, suspend, or terminate their work-related duties.*

Other parts of the Ethics Code, including the Preamble, the General Principles, and other Ethical Standards, might be augmented in similar ways to reflect communitarian ideals.

On Creating Competent Communities: Recommendations for the Profession

Moving forward, we urge psychologists to infuse communitarian assumptions and values into their notions of competence across the life span of their careers, beginning with graduate education. To address competence issues during education and training, Forrest, Elman, and Shen-Miller (2008) recommended using an ecological model (see Bronfenbrenner, 1979) that emphasizes nested, interacting levels of the training system (individual trainee, peers, faculty, supervisors, administrators, institutions, community, and the broader culture). An ecological perspective initiates a conceptual shift from a focus on individual trainees to a systemic, interactive perspective for understanding and intervening with competence problems (Elman, Forrest, Vacha-Haase, & Gizara, 1999; Forrest et al., 2008). This perspective values reciprocal involvement in both prevention and intervention, an approach compatible with the communitarian approach we advocate here.

Reconceptualizing education and training from a communitarian perspective requires training faculty and supervisors both to teach communitarian concepts and to model the framework in transparent actions. Current educational practices that prioritize privacy and confidentiality for students with competence problems appear to be grounded in models more related to psychotherapy than training (Forrest & Elman, 2005; Kaslow et al., 2007) and may need to shift toward more transparency within the training communities so that students can learn about how to address competence concerns they have with others. Results of recent studies show that students are uncertain about (a) whether faculty know about their peers' unethical and incompetent behaviors, (b) whether faculty are addressing competence problems students observe in their peers, and (c) their responsibilities as students when they observe peers not meeting professional standards (Oliver, Bernstein, Anderson, Blashfield, & Roberts, 2004; Rosenberg, Getzelman, Arcinue, & Oren, 2005; Shen-Miller et al., 2011). Teaching and modeling a communitarian approach to addressing competence problems within the training community of psychologists would alleviate many of these student concerns.

Curricular components that address competence standards, professionalism, self-reflection and self-assessment (Forrest et al., 2008), as well as how to engage in conversations with colleagues about competence concerns or problems (Jacobs et al., 2011) are building blocks for developing the values and skills necessary to act later as licensed psychologists to seek help from colleagues or to assist colleagues struggling to maintain competence. With regard to their own vulnerability to diminished competence, trainees should be assisted in developing "defensive pessimism" so that they might anticipate occasional problems of competence and remain motivated to respond preventatively and proactively to such problems in both themselves and their colleagues (Norem, 2000).

Because self-assessments of multicultural competence are influenced by social desirablity and are not highly correlated with more objective measures of multicultural competence, special attention must be paid to diversity issues in training. Yet many faculty are confused, uncertain, uncomfortable, and often in conflict with each other about how to address the intersection of diversity and problems of competence, especially when racial differences are present (Shen-Miller, Forrest, & Elman, 2009). Faculty groups in which multicultural realities are viewed as competence issues (e.g., the lived experiences of faculty of color, faculty whose programmatic research focuses on diversity questions) do better than faculty groups that use "color-blind" approaches that avoid or ignore the presence of racial and ethnic differences in training environments (Shen-Miller, Forrest, & Burt, in press). Training opportunities focused on the intersection of competence and diversity will build a stronger community of psychologists who are ready to address multicultural competence as a key component of professional competence.

Perhaps most important, trainees must be explicitly prepared for the role of colleague in competence consultations (Johnson et al., 2008). New psychologists should demonstrate competence in providing peer review; in constructively engaging troubled colleagues in what may be difficult conversations about their competence; and in demonstrating care for colleagues, those they serve, and the profession (Biaggio et al., 1998; Forrest et al., 2008; Jacobs et al., 2011; O'Connor, 2001). Graduating psychologists with these values and skills will help create the shift to a communitarian approach to competence.

We encourage APA's Office of Program Consultation and Accreditation to reexamine the "Guidelines and Principles for Accreditation of Programs in Professional Psychology" (APA, 2009) in light of these recommendations. At present, trainees are required to demonstrate "attitudes essential for lifelong learning, scholarly inquiry, and professional problem-solving" (APA, 2009, p. 7), but there is no mention of competence related to collegial consultation or community-centric competence assessments. The inclusion of such a communitarian focus on the active support of

colleagues and on the prevention of problems of professional competence would be an important addition.

We also recommend a shift in the profession's approach to ongoing credentialing (licensure). In light of the fluidity and context specificity of competence, not to mention its vulnerability in the face of personal distress and the limitations of self-assessment, we encourage consideration of requirements for ongoing peer consultation and occasional multisource assessments of competence, such as periodic 360-degree evaluations, case presentation reviews, consumer surveys, live or recorded performance ratings, and perhaps simulated role plays (Kaslow et al., 2009; Lockyer, 2003; Roberts et al., 2005). Periodic recertification of competence should become a requirement of licensure renewal. We further encourage the Association of State and Provincial Psychology Boards (ASPPB) and APA to collaborate in creating language for model licensure legislation that incorporates responsibilities to colleagues.

Finally, we introduce the notion of *competence constellations*, which are based on the construct of mentoring constellations (Higgins & Thomas, 2001; Johnson, 2007). A competence constellation is a psychologist's network or consortium of individual colleagues, consultation groups, supervisors, and professional association involvements that is deliberately constructed to ensure ongoing multisource enhancement and assessment of competence. Both the composition and quality of a constellation are important. We hypothesize that the quality of a psychologist's competence constellation will be determined by the quality of both career and psychosocial support provided by the constellation members (Higgins & Thomas, 2001). Career assistance such as information, consultation, and competence appraisals can broaden and affirm competence. Psychosocial assistance, such as emotional support and concern during life's tribulations, can bolster well-being and self-confidence (Johnson & Barnett, 2011). A psychologist's competence constellation might ideally include a personal psychotherapist (Norcross, 2005). APA's Advisory Committee on Colleague Assistance (2006) can bolster formation of competence constellations by enhancing the viability of colleague assistance programs and peer-assistance networks. Of course, training program faculty and supervisors must model their own engagement in a community of colleagues, and regulatory and credentialing bodies need to require continued evidence of a psychologist's participation in a constellation of competence-minded colleagues.

Conclusion

Transitioning to a communitarian approach to professional competence will not be without challenges. There may be several perils along the way. First and foremost, the culture of individualism criticized in this article runs deep, both within the broader culture and specifically within psychology (Prilleltensky, 1997). Strands of cross-cultural research confirm that those of us from Western cultures are less likely than those from interdependent cultures to take others' perspectives when interpreting their behavior (Wu & Keysar, 2007); to the degree that psychologists value self-determinism, they will be inclined to believe that professionals should behave autonomously (Prilleltensky, 1997). Against the grain of Western values and professional norms, psychologists must work against fears that communitarian engagement with colleagues may be perceived as an effort to constrain personal freedom and intrude on individual privacy.

Second, systemic change often generates resistance, even when the existing system conflicts with the self-interests of participants. Research on self-justification theory (Jost & Hunyady, 2005) reveals that human beings will legitimize and support ideologies that allow them to believe in a just and rational world. This theory predicts that psychologists may adhere to individualistic systems of ethics in spite of the problems created by such an approach.

Finally, communitarian practice requires considerable moral maturity, trust in one's colleagues, and sufficient education and preparation for one's role in a community. Not only must psychology trainees receive early experience with collegial engagement, they must observe trainers who are transparent, willing to be vulnerable, and connected to colleagues. Last, psychology must take an honest look at the ways in which our litigious society creates disincentives for professional vulnerability and honesty.

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