Some of the Most Controversial Issues in Psychology

Clinical Update
By Zur Institute

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Following is a short discussion of some of the most controversial issues in psychology in general, and psychotherapy, social work, and counseling in particular.

Obviously, this is not a complete list. We would like to hear from you via e-mail on what you may consider additional issues that are not included in this piece.

1. Can psychotherapists routinely waive insurance co-pays?

As a therapist, you must carefully read your insurance contract and make sure you understand what it says about waiving co-pays. If you then decide to waive insurance co-pays, make sure you do not do it routinely with all clients, and document your reasons in the clinical records. Consult with experts on difficult cases.

More info on Fees: Free Article, Online Course, Consultation

2. Is it ethical to terminate treatment when a client can no longer pay?

While we have no obligation to see clients who cannot pay, we should not abandon them either. Terminations must be handled thoughtfully and with care. Delay termination if the client is in crisis. Give notice and reasonable time for termination to take place. Give referrals if necessary. If appropriate, assist with the transition to a new therapist. Make sure to document well.

More info on Termination: Guidelines, Online Course

3. Is it ethical to have clients as Facebook friends?

While many digital immigrants (i.e., older therapists) recoil at the thought of having clients as Facebook friends and too readily call it "unethical," the answer to this question and similar ones is the proverbial, "It depends." It depends on what is on the therapist's profile, the personality, age, presenting issues and background of the client, the nature of the therapist-client relationship and much

more.

More on Social Networking: Free Article, Online Course

4. Is f2f superior to phone or online therapy?

One of the many myths in our field is the superiority of in-person or face-to-face communication when compared to phone, e-mail or online communications. There is an extensive amount of conclusive research that supports the efficacy of telehealth and phone or online communication. Just because most therapists feel more comfortable with f2f communication does not make it superior or "ethical." Many clients prefer non-f2f, as it frees them up to be less self-conscious and more revealing due to what Dr. Suler labeled the "dis-inhibition effect" of digital communications.

More info: Online Course: Telehealth & Psychology of the Web

5. Can I provide telepsychology (tele-mental-health) services across state lines?

Treating clients who reside in different states is one of the hottest topics in tele-medicine in general, as well as in tele-mental-health. Where the client resides is one of the main factors that therapists must pay attention to. It may be illegal to treat a client in a different state. Make sure to check if that state mandates that treating-therapists must be licensed in-state. States' laws vary. Some states have temporary licensing provisions, others require licensure in their state, and many states haven't addressed this issue so there are no governing laws or regulations. Depending on where your potential clients live, the rules will be different. Be well informed and well trained before you practice across states lines.

More info on Telehealth: Ethics Codes **and** Online Course

6. Are therapists at high-risk for lawsuits?

We have been indoctrinated to fear lawsuits and our licensing boards. The fact that psychotherapists pay malpractice insurance in the range of $400 to $1,300 a year in comparison to some physicians (i.e., obstetricians and neurosurgeons) who may pay up to $100,000 per year illustrates that we, therapists, are a very low risk group. The percent of complaints to licensing boards is not as high as many attorneys and "ethicists" lead us to believe. Even when charges are brought, most complaints are dropped without any charges being filed. [Note: Make sure that you have paid the extra $40-$50 so your malpractice insurance also covers licensing board complaints.

More info on Ethical Risk Management: Free Article, Online Course

7. Do minor boundary crossings gradually lead to boundary violations, exploitation and harm?

The baseless and paranoid idea of the "slippery slope" has been with us for too long and, when followed, results in substandard care. It is idiotic to assert that non-sexual touch is likely to lead to sexual touch, that simple gift-giving results in social relationships, or that bartering inevitably ends in exploitation.

More info on Boundaries: Free Articles, Online Courses, Book

8. Is using Skype Kosher?

As Skype is so convenient, popular, free, and easy to use, many therapists have been using it to conduct online therapy and supervision. The main questions that surround the use of Skype concern privacy, confidentiality and HIPAA compliance. While many established telemedicine companies and providers have been using Skype for quite some time, others are advocating the avoidance of Skype in favor of platforms that claim to be HIPAA compliant. Some suggest that clear informed consent can mitigate the concerns. This debate is likely to be continued for the foreseeable future.

More info on Skype: Resources, 33 CE TeleMental Health & Digital Ethics Certificate

9. Is the Harm Reduction treatment model (such as controlled drinking) a valid alternative to abstinence?

Many clinicians have uncritically subscribed to the AA notion of, "once an alcoholic, always an alcoholic." The fact is that the Harm Reduction model has extensive scientific support and is widely and successfully applied in Europe. It is important for all clinicians to remember that one approach does not fit all. (If the only tool that you have is a hammer, everything looks like a nail.)

More info on Harm Reduction: Online Course

10. Are "victims" always completely innocent, or do some bear responsibility for their misfortunes?

Psychotherapists and attorneys are in the forefront of those who fuel the "Victim Industry" in the U.S. "Don't blame the victim," has become a moratorium on exploring situations where victims bear responsibility. As a result, we have become a nation of victims. In reality, some victims are 100% innocent (i.e., abused children) and others are willing and relentless participants in their own victimization (i.e., women who knowingly continue to date and marry abusive men). As the saying goes, "Fool me once, shame on you. Fool me twice, shame on me."

More info on Victimhood: Free Resources, Online Course

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11. Must therapists always give referrals when a client terminates prematurely?

There is a myth, or erroneous belief, that therapists must always give referrals to clients who terminate against their advice or when therapists initiate the termination. While sometimes it is necessary to give referrals, other times clients may not want, need, or require them (your policies in this area should be spelled out in your Informed Consent Forms). Sometimes, when a client terminates 'against medical advice,' it may be inappropriate to follow up with a letter of referral or request to come back for a termination. Other times, it may be appropriate to simply let the client travel the path they think is best without interfering. The right course of action depends on the client, the setting, the nature of termination, and other contextual factors. As always, seek consultation in complex cases and document your reasoning, actions, and non-actions.

More info on Termination: Guidelines, Online Course, Consultation

12. Is it a good idea for therapists to text with clients?

An increasing number of clients (primarily young ones, aka, digital natives) ask and expect to be able to text us. The question arises: Should we give out our cell phone numbers to exchange texts with clients? The answer depends on several factors. First, we must consider that texting tends to be one of the better ways to reach adolescents and young adults, many of whom prefer texting to e-mail and phone calls. Sometimes, texting is the only way to reach these clients. While texting with 'at risk' adolescents may be highly advisable and effective (and can save lives), texting with intrusive, entitled, or demanding clients of any age may not be clinically advisable. Many older or "reluctant digital immigrant" therapists recoil at the idea of texting with clients altogether and ignorantly call doing so "unethical." Therapists must go through a rational, ethical decision-making process and evaluate not only the risks and benefits of texting with clients but also the risks and benefits of not texting with clients. This process should be articulated to clients in Office Policies and/or in person.

More info: Office Policies, Online Course on Digital Ethics

13. Do therapists need to respond to clients' e-mails and texts instantly?

An increasing number of clients expect us to respond to their texts and e-mails instantly. With the proliferation of iPhones, iPads and other mobile devices, these expectations become the norm with a wide section of the population. Except in unique or special situations (i.e., acute crisis, or being on call) therapists do not have a mandate to be instantly available 24/7. What is important is to inform our clients in person and via our Office Policies about our availability, backups, alternative resources and our general policies regarding e-mails and texts. We must be clear about our attitudes around technology, discuss this with our clients and be sure the Office Policies include information about digital contact.

More info: E-mail in Therapy Article, Telehealth Online Course

14. Can therapists accept payment from clients who earn money illegally?

Can therapists be paid for therapy by clients who make their living by selling illegal drugs, illegal prostitution, or other illegal activities? Legally and ethically speaking, unless the situation includes a danger to the client, others, children, or elders (i.e., situations that include a duty to report), therapists must maintain confidentiality and can accept money that was acquired illegally. Clinically speaking, therapists may wish to explore with their clients the motivation, meaning, risks & benefits, and reasons for the illegal ways of making money. Therapists can decide that for personal-moral-ethical reasons, they cannot work with such clients. If this is the case, they may discuss the matter with the clients but must appropriately terminate and refer, if necessary. Record-keeping in regard to illegal activity must be done with caution. As always, consult in difficult situations.

More info: Online courses on Confidentiality, Ethical Decision-Making, Consultation

15. Do we always need to use a DSM diagnosis in our initial assessment report of treatment plan?

While insurance companies and Medicare may require a DSM diagnosis, therapists are not required to include it in their initial assessment or treatment plan. Therapists can use non-DSM terminology to identify the presenting problem and focus of treatment. They can rely on the Psychodynamic Diagnostic Manual (PDM) for diagnosis, and can also use developmentally (i.e., "Couple are preparing for their empty nest era"), existentially (i.e., "Patient is seeking more meaning in his life"), or familiarly-based (i.e., "This is an enmeshed and undifferentiated family") diagnosis.

More info: Online courses on Treatment Plan, PDM

16. Are women always the victims, or are they also the perpetrators of domestic violence?

Domestic violence perpetrated by women is rarely-discussed, and is generally considered to be a politically incorrect topic to discuss. The majority of research in this area over the last forty years has focused on male violence against women. In recent years, research has begun to identify a growing trend of violence by women in their relationships that is nearly equal in frequency to that perpetrated by men in years past. The lower statistics for males as victims of domestic violence are partly due to the fact that men are often reluctant to identify themselves as victims, and less likely to call the police or reach out to their community for help. The general belief, as presented in the movie "The Burning Bed," is that women will strike men only as a last resort and in self-defense. While true in many situations, this does not seem to be the entire picture. Women's rights advocates' efforts to push for arrests of men in domestic violence calls has, paradoxically, also resulted in a higher number of female arrests.

More info: Online course on Female Batterers - Male Victims

17. Must all treatments be empirically supported to be considered ethical?

The debate around Evidence-Based Therapy (EBT) or Empirically Supported Treatment (EST) protocols has been raging among psychologists for many years. As with many researchers, academicians and CBTs, psychopharmacological-oriented therapists have lobbied for the exclusive inclusion of EBT (and the general medical model) due it its "scientific support." Many humanistically and psychodynamically oriented therapists (among others) claim that simple double blind experimental designs and lab research do not tap into the complexity and depth of therapeutic exchange and psychological healing. Insurance companies support the idea for simple economic reasons, as EBT tends to be short term (easy to quantify and research). Unlike many academicians and researchers, many practitioners view psychotherapy as art as much as science.

More info: Online course on Ethical Decision-Making

18. Is the DSM a scientific, valid, and reliable document?

Unlike what we were told in most graduate schools and assessment workshops, the DSM is a politically and economically driven document more than a scientific one. Decisions regarding inclusion or exclusion of disorders are made by majority vote rather than by the review and acceptance of indisputable scientific data. One telling example: Homosexuality was listed as a mental disorder in the DSM until 1974, when gay activists demonstrated in front of the American Psychiatric Association Convention. The APA's 1974 vote showed 5,854 members supporting and 3,810 opposing the disorder's removal from the manual. Ever since, homosexuality has not been regarded as a mental illness. Voting on what constitutes mental illness is truly bizarre and, needless to say, unscientific. In recent years, the DSM has been primarily driven by the psychopharmacological industry, which reaps huge profits from each new diagnosis that can be treated with medication.

More info: Article, Online Course on DSM-5: Diagnosing for Status and Money

19. Is it ethical to treat more than one member of a couple, concurrently, in individual therapy?

Over the last few decades, some dogmatic family and couple therapists have insisted that it is never Kosher to see members of the couple individually while they are also in couple therapy. The inflexible, one-size-fits-all approach is obviously inconsistent with (back to the proverbial) "It Depends." Whether a therapist sees family members individually or not, must depend on the personalities and attitudes of the clients, whether they have trusting relationships between themselves and with their therapists, and whether therapists can handle the multiple relationships with the different sub-systems. Once again, what may be appropriate with one couple may not be with another. Ethical, effective, and competent therapists know the difference. Informed consent and discussion regarding secrets and good record-keeping are important.

More info on Family Therapy: Online Course, Clinical Forms

20. Is it ever ethical for a therapist to be seen naked by a client?

Most, if not all, therapists, understandably, are likely to respond with a "Hell no!" as they probably connote this situation with a sexual encounter. Obviously, sex with clients is ALWAYS unethical, counter-clinical, and illegal in most states, but then imagine a situation in which a therapist is stepping out of the shower stall in the local gym when, to his or her great surprise, a client (equally naked) steps out of the next stall. This is called an "incidental contact," "chance occurrence," or what I call an "out-of-office experience" that takes place in the community, outside of the treatment room. Such nude encounters have been reported to have taken place between men and women at nudist beaches or at the hot-tubs in Esalen. This vignette is an example of how therapists and ethicists must first understand and comprehend the specific context of each and every situation BEFORE they cast uninformed, 'instinctive' judgment

More info on Experiences Outside the Office: Article, Online Course

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21. Is an affair always a "symptom" of problems within a marriage?

Sometimes extramarital affairs occur alongside or within the context of a loving, committed marriage. They do not always indicate a problem with the marital relationship. The commission of infidelity is often likely to engender strong emotional responses, dogmatic thinking, emotional defensiveness and moral rigidity in clients as well as their therapists. However, contrary to what is commonly believed by the public and assumed by many therapists, extramarital affairs are neither rare, exclusively men's doing, nor must they signal the end of a marriage. In fact, the discovery that one or both partners have moved outside the boundaries of their marital vows seeking to have needs met, or growth expanded, may open a window of opportunity. It may bring each partner toward greater intimacy and deeper insight into themselves as well as their spouse. Partners in more than a third of all marriages (inclusive of many cultures, male or female initiators, gay or straight, youthful or geriatric) are being challenged to confront and deal with the complexities of extramarital affairs. Indeed, infidelity has become an equal opportunity affair. Internet or online affairs have become extremely prevalent. There is also a recent and growing acceptance, especially among the younger generation, of non-traditional relationships including polyamory, and open marriage.

More info on Infidelity: Types of Affairs, Online Course

22. Is PTSD really increasing, or are therapists confused about diagnostic criteria?

Diagnosis of PTSD has proliferated in recent times causing statistics of the disorder to be inflated. Faulty adherence to DSM criteria is diluting the important notion of PTSD. It is generally agreed that individuals have higher or lower thresholds for developing symptoms of PTSD: what may be truly traumatizing to one may not cause another to become symptomatic. However, in order to meet the criteria for the diagnosis, the DSM requires that "the person has experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others". For example, those who survived the burning towers on 9/11 in NYC may qualify for the diagnosis of PTSD, while those who developed some of the symptoms of PTSD from witnessing it on TV, would not. Therapists who do not differentiate appropriately between stress and trauma and inaccurately diagnose PTSD feed the PTSD epidemic. Psychiatrists, psychotherapists, counselors and social workers have erred when using the diagnosis simply because a client was fired from a job, harassed on the job, or discovered that their spouse had an affair or, in other situations when people became angry, disappointed or witnessed horrors on TV or the Web.

More info on PTSD: Free New Audio, Online Course (20 CE)

23. Should we keep records of e-mails and texts?

Therapists are noticing that an increasing number of clients choose to communicate with them through e-mail and texts and wonder whether they need to keep records of these communications. In principle, e-mails and texts are no different than traditional voice mail messages. Important and clinically significant communications should be incorporated into the clinical records. Simple requests for appointment changes, or communications regarding minor business issues may not be very significant. E-mails can easily be filed by simply storing them on one's e-mail system. There are several programs which transcribe voice mail messages. With the right software or expert help, texts can be printed and/or stored online. Confidentiality and privacy considerations must be carefully evaluated for of all of these storage, transcribing and recording methods. Therapists may want to include a statement in their office policies and/or discuss and be clear with their clients that voice mail, texts and e-mails are part of the clinical records. This allows clients to make informed decisions about how they communicate with their therapists.

More info on Record Keeping: Article, & Online Course & Consultation

24. How can therapists counter negative posting on them on Yelp and other sites?

There is a myth that psychotherapists are helpless when clients make negative, defaming, or inflammatory postings regarding

therapists on web sites that are designed for customer feedback, such as www.Yelp.com. Therapists should not respond emotionally and impulsively by writing to clients or to Yelp. Instead, they should take the time to weigh the options and get informed first. While therapists cannot ethically solicit clients' testimonials, they can solicit testimonies from colleagues, supervisors, graduate school professors and such. These positive evaluations may overshadow the negative ones. If the posting is more than just an opinion or other statement protected by free speech, but constitutes defamation, slander or libel, one may be able to contact Yelp and have them take it off. In such cases, one can even resort to legal action. Therapists are advised to be careful not to inflame the situation by protesting too loudly to the person who posted the negative evaluation. Do not respond impulsively and consult with experts before you take action.>

More info on Negative Postings: Article, Online Course, Consultation

25. Is there such a thing as pediatric bipolar disorder?

There must be something seriously wrong with the idea of diagnosing a preschooler with a bipolar disorder. Increasingly it seems the pharmacological industry's greed has no limits. The complicity of some medicating psychiatrists, who benefit from prescribing medications to children, has no bounds either. In recent years, spirited or introverted, quiet pre-schoolers have been prescribed anti-psychotic and anti-manic medication in increasing numbers. Reports about the long-term damages of such 'treatments' are beginning to surface. Between 1994 and 2003, the percent of mental office visits for bi-polar disorder in youth increased from 0.4% to 6.7% and between 1996 and 2004, the percent of youth leaving psychiatric hospitals with a diagnosis of bi-polar disorder went up 400%. In my opinion, this is probably one of the saddest and most outrageous exploitations in the field of mental health.

More info on DSM: Free Article, Online Course

26. Are psychotherapists always more powerful than their clients?

From the first day in graduate school in psychology, we psychotherapists-in-training have been instructed to pay great attention to the "inherent power differential" in psychotherapy. We were taught to be aware of the imbalance of power between therapists and clients, and repeatedly warned against inadvertently abusing or exploiting our vulnerable and dependent clients. The idea of power, as an attribute possessed exclusively by the therapist in the client- therapist relationship, has been largely left unchallenged. Our professional newsletters and advice columns on ethics and risk management present a similar unified message about therapists' unilateral power and clients' inherent vulnerability. Many psychotherapy or counseling clients are, indeed, very vulnerable. They may be distressed, young, impaired, traumatized, psychotic, anxious, and/or depressed. However, there are also clients who function highly, emotionally and psychologically, and are powerful and effective in these and many other ways. They may be wealthy investors, powerful CEOs, established artists, or simply very centered, solid human beings who seek therapy to find meaning, seek their highest potential in a certain arena, or perhaps find a closer relationship to God. They are neither depressed, nor traumatized, nor vulnerable. As therapists we must know the difference: we must remember that not all clients are created equal

More info on Power: Free Article, Online Course

27. Why is psychiatric testing mandated for only two surgeries: Transsexual and Bariatric?

Out of countless medical procedures, only two require the psychiatric testing pre-surgical stamp of approval: Bariatric and Transsexual. Interestingly, cosmetic surgery and elective lumbar surgery do not. Posit that for each of these surgeries, it is important for the patient to be clear about their reasons and expectations, as each is considered to be irreversible, or difficult to reverse, and require significant lifelong, potentially irreversible changes. Add to this equation that these evaluations are expensive, time-consuming, have little predictive utility or criterion validity and are usually sources of confirmation bias. Finally, evidence suggests that many surgeons make their own judgments regardless of the supposed psychopathology of the patient. The goal of testing is to develop relevant answers to specific questions. Bariatric surgery, for example, is the only procedure which results in sustained and substantial weight loss (and is becoming the treatment of choice for diabetes). However, in most cases it is not the science, but most major health insurers who require psychiatric testing. So we administer the testing for the "integrated health team" and for the patient who might otherwise be denied treatment or insurance payment for their surgery.

More info: Bariatric Surgery Online Course

28. Is it ever ethical for a male therapist to say, "I love you," while stroking the hair of a young female client as she is lying on a bed?

Most therapist would have a rapid, internal, negative response to this question and would instantly think this would definitely be unethical and, probably, due to its sexual nature, illegal too. Now, imagine that this exchange takes place in a hospital room, where a young, terminal cancer patient has invited her long time therapist to spend one last visit with her before she dies. This is an extreme example but one that may help clear our cognitive map in order to deeply consider the context of therapy. Indeed, it is the context of therapy which ultimately determines what is ethical and what is not. What is appropriate in a remote village in Alaska may not be within the standard of care in a psychodynamic clinic in downtown NYC. Similarly, what is clinically appropriate in home visits may not be appropriate in mental hospitals or home offices. When exploring the context of therapy, consider 1. Client factors (gender,

presenting problem, age, sexual orientation, culture, etc); 2. Setting of therapy (inpatient, military base, traditional office, etc.); 3. Orientation of the therapist; 4. Therapist-client relationships; and 5. Therapist factors (gender, background, culture, etc). **In summary: context matters.**

More info: Context in Therapy, Course on Standard of Care

29. Are risk management and ethics the same?

One of the biggest misperceptions in our field is the confusion between what constitutes ethics and what constitutes risk management. Many risk management and ethics workshop instructors and graduate school ethics professors fail to differentiate between the terms. Risk management generally refers to ways that therapists may conduct themselves in order to reduce the risk of licensing board sanctions and to prevent lawsuits. The most common advice of risk management advocates is, "Don't touch your client beyond a handshake or a quick A-frame hug," "Don't except gifts!" or "Never engage in dual relationships." In contrast ethical behavior is focused on what is the highest level of care, integrity, loyalty, and fidelity to clients and with relevancy to the clients' family and community. At times, the ethical way may include a soothing touch, graciously accepting a gift and appropriately engaging in non-exploitative dual relationships. In recent years we have seen a development in which the term "ethical risk management" has been used to describe a way to be ethical and aware of legal issues at the same time. In summary, I believe that an ethical therapist can provide the highest level of care while staying well within legal bounds

More info on Risk Management: Free Article, Online Course, Consultation

30. Is the standard of care fixed, constant and static over time?

There is a myth and faulty belief among therapists and other experts that the standard of care is static, fixed, and permanent. The standard of care is a very important legal construct as it is the standard against which we are judged in malpractice suits and licensing board hearings. Most broadly, the standard of care is defined as the usual and customary professional standard practice in the community. It describes the qualities and conditions which prevail, or should prevail, in a particular mental health service, and that a reasonable, average and prudent practitioner follows. Generally, as more therapists practice in a new way, this new way gradually becomes part of the standard of care. For example, telehealth or therapy via phone, text, e-mail, or video-conferencing is becoming part of the standard of care as technology rapidly accelerates providing new modes of communication. The standard of care is derived from statutes, case law, licensing board regulations, consensus of the professionals and community, and Ethics Codes. The standard of care is not a standard of perfection, black and white, determined by outcome, permanent or fixed. It does not follow any particular theoretical orientation, nor is it guided by risk management principles.

More info on Standard of Care: Free Article, Online Course, Consultation

31. Is it ever permissible for a therapist to be physical or violent with a patient, such as slapping, striking or even shooting the patient?

The answer to this unusual question is that it depends on the situation. If a client is physically threatening or physically assaulting, punching or hurting the practitioner or other people, the clinician has the right to protect himself or others from the assaulting patient. This was the PA case in July 2014 when a psychiatrist shot a violent gun-wielding patient who was shooting at people in the psychiatrist's office.

I was asked if it was ever permissible for a mental health practitioner to be physical or violent with a patient, such as pushing, slapping, or striking the patient. My answer was an unequivocal "yes." I wrote that violence sometimes rears its ugly head in a variety of circumstances, sometimes unexpectedly or unpredictably, and mental health practitioners have a right to protect themselves. I proposed the unlikely circumstance of an angry patient attempting to stab his therapist, and the therapist's right to punch or otherwise strike the patient – or more. A recent news story (July 24, 2014) from Pennsylvania, where a psychiatrist shot a violent/threatening patient in an exchange of gunfire in the psychiatrist's office, illustrates well that violence against a patient is not just a theoretical question.

More info on responding to dangerous patients: Psychiatrist Shoots Patient **by Richard Leslie, J.D. in *CPH Bulletin***

More on controversial topics:
Controversial and Contemporary 'Hot' Issues & Myths in Psychology

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