1

Agenda

- Introduction
- Problem 1: Risk Management (RM) and Vulnerabilities
- Yours: Patient Characteristics and Situations
- Mine: Bias in Decision-Making: What Behavioral Economics Teaches Us about Vulnerabilities in Ethical and RM Choices

Break

- Mine: Bias in Decision-Making, continued
- Ours: Combined Vulnerabilities and Risk
- Addressing Vulnerabilities and Managing Risk

Lunch

- Problem 2: Remote Services and the Impact of the Pandemic
- Problem 3: Where to Draw the Line? Advocacy, Competence, and Roles

Break

- Problem 3: Advocacy, continued
- Problem 4: Clinician Self-Care: Why Should We Care?
- Conclusion

2

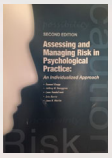
Learning Objectives

1. Describe basic principles of risk management, as applied to several specific clinical situations that frequently arise in professional practice
2. Identify core heuristics and biasing processes that can interfere with appropriate risk management and ethical decision-making
3. List three strategies to ameliorate decision-making challenges
4. Describe three preliminary considerations prior to engaging in interjurisdictional practice
5. Define boundary issues in advocacy for patients and clients
6. Identify three strategies for promoting self-care for professionals

3

The Trust Risk Management Program

- www.trustinsurance.com
  - Sample documents and templates
  - Education Center: Resources and articles
- *Assessing and Managing Risk in Psychological Practice*
- Workshops and webinars
- Advocate 800 Consultation Service
  - (800) 477-1200
- Policy enhancements
  - Deposition representation
  - Regulatory coverage (e.g., HHS, Medicare investigations)



4

The Trust Risk Management Team


Leisl Bryant, PhD, ABPP


Julie Jacobs, JD, PsyD


Marc Martinez, PhD, ABPP


Joe Scroppo, PhD, JD


David Shapiro, PhD, ABPP


Dan Taube, JD, PhD

Emeritus: Eric Harris, EdD, JD; Jeffrey Younggren, PhD, ABPP

5

Why Discuss Vulnerability in a Risk Management Workshop?

Paraphrasing T. Roosevelt 1910 famous quote:

- "It is not the critic who counts," not the person who points out how someone stumbles or where someone else could have done it better
- The credit belongs to the person in the arena, "whose face is marred by dust and sweat and blood; who strives valiantly; who errs, who comes short again and again…"
- It is this person "who knows great enthusiasms, the great devotions; who spends himself in a worthy cause; who at the best knows in the end the triumph of high achievement, and who at the worst, if [s/he] fails, at least fails while daring greatly."

6

Why Discuss Vulnerability in a Risk Management Workshop?

- Brené Brown, DSW (2012) theorized that:
  - Vulnerability is the core, the heart, the center of meaningful human experiences
  - Vulnerability is necessary for human connection, emotional health, and creativity
  - Vulnerability is not weakness… it is emotional risk, uncertainty, and exposure
  - Shame about vulnerability undermines emotional health in many ways, including being related to addiction, depression, aggression, and other psychological and social ills
  - Shame—and dysfunction—grow in the context of secrecy

7

Why Vulnerability in a Risk Management Workshop?

- We are framing our conversation today about risk management today in the context of vulnerability to highlight the importance of recognizing, reflecting upon, and discussing our vulnerabilities
- Without doing so, as professionals we heighten the risk of negative outcomes for ourselves professionally as well as for our patients
- Some of our suggestions also will echo what Brown - and earlier, and in a different context, Kohut, suggest around addressing the vulnerabilities that each one of us has

8

Vulnerabilities and Risk: Yours, Mine, and Ours

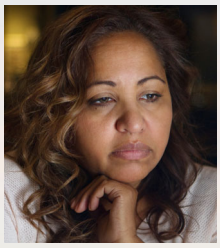
- There are vulnerabilities and attendant risks to engaging in professional relationships:
  - "**Yours**" = ***patient's/client's*** vulnerabilities
  - "**Mine**" = vulnerabilities of the **clinician**
  - "**Ours**" = the **interplay** of vulnerabilities in the **professional relationship**

9

"Yours"
Patient/Client Vulnerabilities

10

Vignette 1



Marta

Dr. Change

11

Vignette 2

Dennis

Dr. Caring

12

Patient/Client Vulnerabilities

- The often fraught decision to seek out psychological services presents inherent vulnerabilities for a patient
- In essence, patients are choosing to make themselves vulnerable in some manner in order to overcome challenges, gain information, or perhaps get access to resources (e.g., obtaining a disability assessment)
- And in what manner does this professional relationship create vulnerability?

13

Patient/Client Vulnerabilities

- In professional relationships, there are power differentials emerging from:
  - "Duties of station": Veatch, 1980; role related status differentials and attendant power ("Dr." and "Patient")
  - Potential to control resources (e.g., diagnosis gives access to insurance coverage; an assessment could result in financial support during a time of disability, etc.)
  - "Structural asymmetries" (Aron, 1990; Celenza, 2007)

14

Patient/Client Vulnerabilities

- Celenza (2007) described three aspects of asymmetry:
  1. The structured manner in which attention is focused almost completely on client
  2. The disclosure asymmetry in terms of personal information revealed by each. This patient-role-related demand is to disclose very personal information, failings and shortcomings and events and symptoms that are often shame-filled. Consider what patients disclose in psychological assessments
  3. Differential mutuality; the above happens in a relationship that requires that both people be very involved and invested—but in different ways
- These asymmetries can be found in all kinds of psychological services

15

Patient/Client Vulnerabilities

- Patient Characteristics:
  - Traumas, past and present (PTSD, childhood maltreatment, domestically violent relationships, assaults, sex trafficking, DID, recovered memories)
  - Substance dependence
  - Suicidal ideation and attempts
  - Potential violence toward others
  - Cluster B personality disorders (people with borderline, narcissistic, or antisocial characteristics)

16

Patient/Client Vulnerabilities

- Patient circumstances
  - Child custody conflicts
  - Requesting third-party evaluations from treating clinicians (e.g., disability evaluations, fitness of duty, emotional support animal letter requests, etc.)
  - Patient involvement in unrelated lawsuits

17

"Mine" Psychologist Vulnerabilities

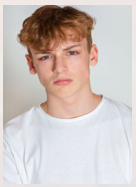
18

Vignette 1

Dr. Screen

Dr. Festina

Run



19

Vignette 2

Dr. Lente

20

Self Assessment

- Our traditional risk management approach has included the recommendation that clinicians conduct routine, conservative evaluations of our **competence:**
  - Intellectual
  - Technical
  - Emotional
  - Cultural
- But…how accurate are we when engaging in such self-evaluations?

21

Impact of Bias

- Superiority bias (Hoorens, 1993)
- McCormick et al. (1986)
  - 189 drivers surveyed and asked to rate their comparative driving skills
  - 80% said they were above average

- But this does not apply to highly trained clinicians, does it?

22

Superiority Bias continued…

- Walfish et al. (2012)
  - Surveyed 129 mental health professionals
  - No participants rated their skills as below average
  - 75th percentile was modal rating
  - 25% rated their skills at the 90th percentile or above
- We likely tend to overestimate our skills and competencies, like everyone else

23

Superiority Bias continued…

- Sheldon et al. (2014) assessed the superiority bias regarding emotional intelligence (EI) among graduate students
  - Findings support the superiority bias
  - "… we found that the least skilled had limited insight into deficits in their performance…
  - …when given concrete feedback, low performers disparaged either the accuracy or the relevance of that feedback, depending on how expediently they could do so…
  - …Paradoxically, it was top performers who indicated a stronger desire to improve their EI following feedback" (p. 125).

24

Cognitive Shortcuts

- In addition, clinicians are not immune from the cognitive and affective vulnerabilities that impact all human beings
- Decades of behavioral economics research have identified numerous shortcuts and built-in cognitive biases in our judgements and decision-making processes

25

Judgements/Decision making

- Kahneman (2011) has long argued for a "two system" thinking analogy, which he popularized in his book…

"Thinking, Fast and Slow"

26

Judgements/Decision making

- System 1
  - Fast
  - Intuitive
  - Emotionally reactive
  - Evolutionarily essential
- But…System 1 does not handle
  - Novel situations well
  - Complexity well

  (though with practice and accurate, timely feedback, expertise and accuracy can develop)

27

Heuristics

- Kahneman, Tversky and others have identified myriad System 1 heuristics (thinking shortcuts), such as:
  - **Availability** (we're often biased by information that is easier to recall, and in our experience, occurred together)
  - **Anchoring** (basing decisions more heavily on initial estimates, even if far off or irrelevant, without sufficient adjustments for new/other information)
  - **Representativeness** (relying on how similar a new event is to an old group of events—often without considering base rates or sample sizes)
  - **Confirmation bias** (the tendency to seek evidence to confirm preconceptions, and to under emphasize information that contradicts them)

28

Affect Heuristic

- Idea that emotions bring with them related, evolutionarily beneficial "action tendencies" (Fridja, 1987)
- These tendencies are "states of readiness to execute a given [kind] of action, [which] is defined by its end result aimed at or achieved." (p. 70)

29

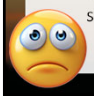
Affect Heuristic

- The theory was that emotionally-related action tendencies (e.g., toward approach, avoidance) would influence decisions
  - Not because the emotion was negative, per se;
  - Rather, because of its particular quality and ability to enhance adaptation to the specific context and social environment

30

Emotions Impact Decision Making

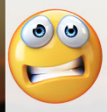
- Bodenhausen et al. (1994):
  - found that **anger** resulted in significantly more decisions based on ethnic and academic stereotypes than did sadness or neutral feelings
- Small and Lerner (2008): two studies about the impact of anger vs. sadness on judgements regarding welfare and social policy
  - found that "…incidental anger decreased the amount of welfare assistance participants recommended…, whereas sadness increased the amount recommended…"(p. 145)



31

Emotions Impact Decision Making

- Kouchaki and Desai (2015): Series of 6 studies looking at whether anxiety impacted ethical decision-making
  - Across all 6 studies, they found (among other things) that: Participants in the anxiety condition *LIED MORE FREQUENTLY*
- They suggested that this is because:



Defensive Responding

32

Psychologist Vulnerabilities: Shame

- In their study on **shame**, **de Hooge et al**. (2010) found that **participants had conflicting action tendencies—depending on the situation**. "After a shame experience…, people want to protect themselves from further possible damage. Hence, ***they revert to withdraw strategies when actions to repair the self are either not possible or too risky***" (p. 122)
- **Tangney et al.** (2011) have shown that ***shame*** can decrease recidivism, but ***when coupled with externalizing/blaming defense associated with it, it was strongly related to recidivism among released inmates***. (Note that guilt was associated with less recidivism)

33

Psychologist Vulnerabilities: Shame

- Though shame surely can be pro-social under certain conditions, when associated with externalizing blame, it can promote poor decision-making and judgements (like anger and anxiety)
- In her TED talks on vulnerability, Brené Brown (e.g. 2010) described a similar idea—that it's common in our society for us to "numb ourselves to those painful things [including shame]…[and] we **revert to blame to discharge pain and discomfort**."

34

But wait….

- …it turns out that **feelings are NOT the enemy**!

- In fact, a number of studies have suggested that without the "System 1" responses we spoke about earlier, and affect, in particular, our decision-making goes off the rails

35

Importance of Emotions

- Damasio (1994): damage to ventromedial prefrontal cortices (VMPC) led to an inability to feel, with fully retained cognitive functioning → BUT, there were profound negative effects on rational decision-making ability
- Koenigs et al. (2007): individuals with impaired VMPC
  - "the present findings are consistent with a model in which a combination of intuitive/affective and conscious/rational mechanisms operate to produce moral judgements" (p. 910)
- Damasio and other's view these "**somatic markers**" (also called "**embodied cognition**") to represent:
  - gut feelings
  - decisions based on quick, emotionally-laden assessments that are often tied to emotions from past (good/bad) experiences and outcomes

36

Importance of Emotions

- "Affect may serve as a cue for many important judgments." (Slovic et al., 2002)
- AFFECT = INFORMATION
- As Thrift (2004) put it, emotions are "a different type of intelligence about the world" (p. 60).

How do you know that something is wrong, or potentially questionable or unethical?

37

Back to Kahneman…

- System 2:
  - Effortful
  - Slow
  - Deliberative
  - Logical
  - Self-aware
  - Comes into play when situations are more complex
  - "Supervises" System 1 intuitions (Kahneman & Frederick, 2002)

38

What Does this Have to Do with Ethics and RM?

- Ethical conflicts and situations that involve risk often are inherently uncertain
  - Increases likelihood of System 1's biases influencing judgment
- These decisions also tend to trigger a variety of emotions:
  - e.g., anxiety, annoyance, guilt, shame
- These emotions and intuitive responses can…
  - offer direction, action tendency, embodied knowledge and awareness of ethical issues
  - lead to significant errors in judgment

39

So what do we do?

- How do we reap the benefits of…
  - intuitive judgments
  - feelings
  - action tendencies
  - And System 2 strengths
- …but not fall prey to their systematic biases?

- A difficult task
  - requires attention and effort
  - being distracted or "cognitively busy" can reduce our ability to use the data we already have

40

Additional Factors Hindering Good Decision-Making

- Simonovic et al. (2017):
  - "**stress…reduced…performance by impeding reflective thinking**…It was concluded that more reflective participants appear to learn from the outcomes of their decisions even when stressed" (p. 258)
- Persson et al. (2018):
  - **time pressure ("fast" vs. "slow") increased the use of the affective system, as opposed to a more cognitive one** (they used skin conductance to evaluate decision making under time pressure).

41

Psychologist Vulnerabilities

- To make matters more challenging, there are also ***circumstances*** that create more risk to **clinicians**:
  - Act as primary ***supervisors***
  - Become or are ***isolated***
  - Are ***personally vulnerable*** because of losses, health compromises, personal challenges, personality traits (e.g., the greater narcissism)
  - Experience ***excessive positive or negative counter-transference***
  - Work with ***attractive*** or ***wealthy patients***

42

"Ours"
The Interplay of Patient and Clinician Vulnerabilities

43

The Interplay

- When the vulnerabilities of the patient (e.g., trauma history, hopelessness, etc.) intersect with therapist vulnerabilities (e.g., biases, anxiety, depletion of cognitive resources, personal losses, etc.) the risks to both patients and clinicians amplify
- Put another way, it's the interaction of both sets of vulnerabilities that substantially increase risk

44

Ours: Example One

- Dr. Cal's new patient Sarah is enraged at her boss and says she will shoot him (she has no history of violence, but has been using methamphetamines with increasing frequency) — Ambiguity/uncertainty
- In Dr. Cal's outpatient private psychotherapy practice, this has never happened before — Novelty
- Dr. has had the usual training in his state regarding duty to protect law, but like many clinicians, has had little experience in assessing and reporting threats of violence — Technical competence

45

Ours: Example One

- The risk is compounded by Dr. Cal's understandably heightened anxiety — Affect heuristic-anxiety
- And the situational demand is that he must respond quickly — Time pressure
- Dr. Cal calls Sarah's boss to warn her, and also warns and asks Sarah's partner her to monitor Sarah--but Sarah has not given permission for disclosures to her partner or family members
- Dr. Cal is uncomfortable calling the police, so refrains from doing so — Competence, affect?
- Sarah get's fired from her job, and her partner leaves her. She lodges a compliant against Dr. Cal for breaching her confidentiality

46

Ours: Example Two

- Dr. Excell is an experienced clinician. Though he worked in a large organization for many years, and was considered a "star" at his prior job, he left and went into private practice about three years ago
- He finds it a very lonely professional life — Isolation & perhaps more than usual superiority bias?
- Dr. Excell has a patient with some significant borderline features he sees twice a week. The patient struggles with addiction, and often doesn't follow Dr. Excell's recommendations — Three patient higher-risk characteristics

47

Ours: Example Two

- The patient is involved in a lawsuit against a pharmaceutical company for injuries related to his use of a prescribed headache medication — Unrelated lawsuit
- Immediately following a difficult session, the patient texted Dr. Excell saying he forgot that his attorney needs his records immediately for the lawsuit — Time pressure
- Dr. Excell was somewhat annoyed — Affect heuristic-anger
- At the same time Dr. Excell was at the end of his day, tired, and had not eaten in about seven hours — Cognitive depletion
- He sent the records via e-mail, but got a response from a different patient saying she thought he had sent material that she should not have received

48

Ours

- In risk management terms, when there's a threat and a vulnerability, that creates risks of adverse outcomes
- At times, the combination of patient and clinician vulnerabilities can threaten the professional relationship
- The threats to the patient are that they could be harmed (e.g., via significant boundary violations, confidentiality breaches, sudden termination, etc.)

49

Ours

For professionals, risks include:

- Licensing board complaints (high incidence, high consequence)
- Malpractice suits (low incidence, high consequence)
- Ethics complaints (no insurance coverage, public expulsion, reports to licensing boards)
- Negative online reviews
- Insurance audits

50

Managing Risks and Vulnerabilities

51

Managing Risk and Vulnerability

- These vulnerabilities and potential problems can appear overwhelming and intractable
- Indeed, it is very challenging to actually be able to address our biases, time pressure, and the risks that patients bring with them
- But there are positive steps to manage and address vulnerabilities that are very useful

52

Managing Our Vulnerability

- How do we promote the engagement of **System 2,** particularly amid the cacophonous press of daily demands?
- Navy Seals:
  - **"SLOW IS SMOOTH, AND SMOOTH IS FAST"**
- Put another way, we have to find ways to **slow down** our responses to challenging situations

53

Managing Our Vulnerability

- Slowing down allows System 2 engagement
- A slower, reflective turn of mind also permits access to our emotional experience **AND** intelligence
- Akin to ideas of mindfulness and reflection

54

How to Shift Into Reflective Mode

- Using frequently occurring practice activities as "speed bumps"

55

Shifting into Reflective Mode

- What happens when we don't heed a speed bump…

56

Speedbumps

- These speed bumps (tools for slowing down) involve four practices:
  1. *Engaging in a thorough **informed consent process***
  2. *Having a "low threshold" for seeking and using routine **consultation***
  3. *Employing **documentation** as a reflective tool*
  4. *Making use of a **structured decision-making** process*

57

Slow Down → *1. Informed Consent*

- Informed consent **process** is a platform for **setting the frame for the relationship**
- It helps to demonstrate that the clinician is forthcoming and has integrity
- It helps to **reduce surprises and uncertainty**


58

Slow Down → *Informed Consent*

- Of course, though a signature is important, the informed consent process is **not** handing out the form and saying "here, sign this"
- That approach contradicts the spirit of a consent process
- It also undermines its potential to help establish a stronger alliance at the outset of treatment
- There is some evidence that a well-conducted consent process can improve a collaborative approach

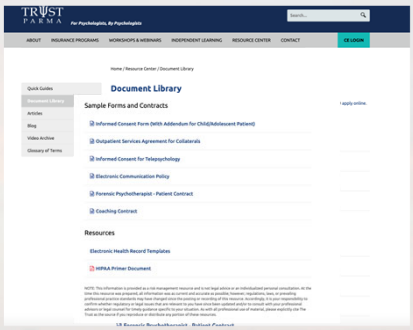
59

Slow Down → *Informed Consent*

- Reviewing the structure of treatment helps set more realistic expectations
- It raises questions that patients may not have considered (e.g., the limits on privacy, financial issues)
- It allows the clinician to identify potential problem areas and engage in clarification
- It slows the process down at a point where the patients or parents may feel a significant amount of intensity (e.g., when a couple comes into their first session in the midst of an argument; or the parent has intense concern over their teen's self-cutting)

60

Slow Down → *Informed Consent*



https://parma.trustinsurance.com/Resource-Center/Document-Library

61

Slow Down → *Informed Consent*

- Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and wi wi co ev rig otl he

Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

62

Managing Our Vulnerability

- The **second** set of **speed bumps** relates to the oft-repeated advice that we all engage in routine **consultation** with colleagues and, when needed, with experts

63

Slow Down → *2. Consultation*

Benefits include:

- Requires us to describe the situation which can slow us down enough to identify concerns
  - Helps "cool" hotter emotions
  - Provides opportunity to reflect on our feelings and action tendencies – and their possible (good/bad) consequences
  - Allows for an increase in the deliberate integration of ethical principles and standards of care
  - AND, we get to borrow other people's pre-frontal cortex for a bit

64

Slow Down → *Consultation*

- Consultation also can be a forum for ongoing skill development
- But there are challenges: it's difficult for clinicians to get accurate, timely feedback on effectiveness
- Even if we do get feedback:
  - it does not necessarily translate into improvements (Tracey et al., 2014)
  - there's some evidence that we may LOSE some effectiveness over time (Goldberg et al., 2016)
- ***But…all is not lost…***

65

Slow Down → *Consultation*

- Goldberg et al (2016)
  - 7-year case study at a clinic evaluating whether clinicians can improve their skills and get better outcomes over time
  - They found that clinicians COULD get better over time if:
    - we get regular **feedback**
    - **AND routine consultation** about **challenging cases**, with a **focus on** fostering the ***alliance***, **client engagement, and client goals**,
    - **AND** engage in **rehearsal/practice** of relevant approaches

66

Slow Down → *Consultation*

- Notice, once again, the importance of the ***alliance***
  - It's a protective factor against complaints/lawsuits
- **Education, communication, and engagement with patients around negative outcomes reduce the risk of malpractice claims** (note that this ties into a good informed consent process, as well)
  - e.g., Hickson et al., 1992; Kachalia et al., 2018; Levinson et al., 1997; Kohn, Corrigan, & Donaldson, 2000
- So, consultation about relationship quality, communication, and taking patient complaints seriously can yield multiple benefits

67

Slow Down → *3. Documentation*

- **Record-keeping is a third way to slow down and engage System 2**
- **Of course, it's a critically important risk management strategy**

- **AND, it requires at least some reflection on:**
  - **Evaluations and assessments we have completed**
  - **Actions we have or have not taken**
  - **Actions we are considering**

68

Slow Down → *Documentation*

What would the typical session note content include?

- Identifying information
- Date
- Start/stop times of session
- Content of session
- Mental status components (if necessary)
- Intervention
- Plan

 69

69

Slow Down → *Documentation*

Session Note Content:

- Risk assessment (if necessary), and how clinician addressed any apparent risks
- Professional consultations* (if conducted)
- Notes should be able to demonstrate to knowledgeable observer that appropriate, competent psychotherapy occurred
- Should be legible!!
- Length, comprehensiveness determined by length of treatment, risks, use of third party payors, likelihood of utilization review, etc.

70

70

Slow Down → *Documentation*

Session Note Content:

- Must be specific to this patient/client
- Needs to be related to treatment goals
- Should be expressed in terms of changes in patient's functioning
- Must include reasonable explanation for limited progress
- Should be drafted with understanding that they will be seen by others

 71

71

Slow Down → *Documentation*

Session Note Content:

- It is in part a business decision: how much time spent in order to protect oneself?
- It is also a continuity of care decision; what is needed to assure good care?
- How would patient respond to reading the content?
- When challenged, unwritten recollections appear self-serving
- Never alter a record!
- If you need to make changes or additions, they should clearly be marked as such

 72

72

Slow Down → *Documentation*

Record Keeping in High Risk Situations:

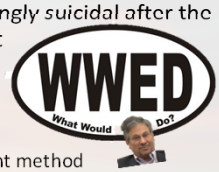
- These situations require "ninth grade algebra" (explain how the outcome of your evaluation is *logically linked* to your chosen intervention)
  - *What you did and why you did it*
  - Strategies you rejected and reasons for rejecting
  - How you resolved conflicts between potential benefits and potential risks
  - Ethical and legal principles which were involved in your decision making
  - Consultations and reasons that you rejected recommendations, if any

73

73

Slow Down → *Documentation*

- High-risk example: a patient with chronic suicidal ideation becomes increasingly suicidal after the disruption of an important relationship



- Eric Harris RM Note:
  - Use a structured assessment method
  - Document questions and responses about risk and protective factors
  - Provide a rationale for how the assessment/data support the chosen course of action

74

Slow Down → *4. Decision-Making Model*

- Structuring the decision-making process can also help us slow down
- There are numerous ethical decision-making models, such as:
  - Hill et al. (1995)
  - Kitchener (1984)
  - Knapp & VandeCreek (2012)
  - Koocher and Keith-Spiegel (2016)
  - Pope & Vasquez (2016)

75

Slow Down → *Decision-Making Model*

- Knapp, Gottlieb, & Handelsman (2015) - **Five Step Model**:
  1. Identify or scrutinize the problem
     - e.g., is it a conflict between values?
  2. Develop alternatives or hypothesize solutions
     - including **getting input,** involving patients, reflection, **consideration of non-rational factors**, as detailed earlier
  3. Analyze and evaluate alternatives
     - consider which principles may take precedence, and try to reduce harm caused by possibly violating other principles
  4. Implement the decision
     - "act or perform;" engaging in an effective course of action
  5. Evaluate the outcome
     - "look back"

76

Slow Down → *Decision-Making Model*

"Life can only be understood backwards; but it must be lived forwards."
-Soren Kierkegaard

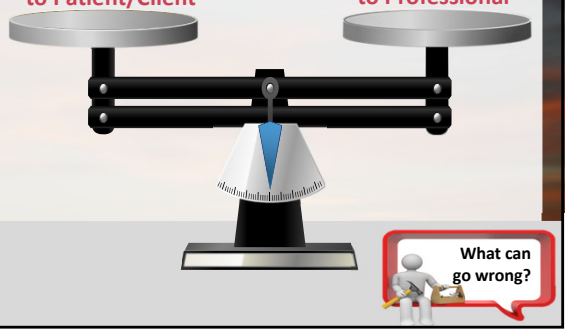
The prospective assessment of retrospective evaluation

77

Slow Down → *Decision-Making Model*

Risks and Benefits to Patient/Client

Risks and Benefits to Professional



78

Managing Our Vulnerability

To summarize:

- **"Slow is smooth and smooth is fast"**
- Use available professional activities to promote a reflective approach:
  - a collaborative *informed consent* process
  - routine *consultation* and feedback
  - careful *documentation*
  - Engaging in *structured decision-making* procedures grounded in ethical and risk management principles

79

Questions?

80

Remote Services and the Impact of the Pandemic

81

Recall the Earlier Example of Dr. Lente

- A clinician who had to shift to remote services as a result of COVID-19
- He shifted to doing phone sessions
- At least in his state, the relevant insurance company would not pay for telephone only**, resulting in upset and a complaint

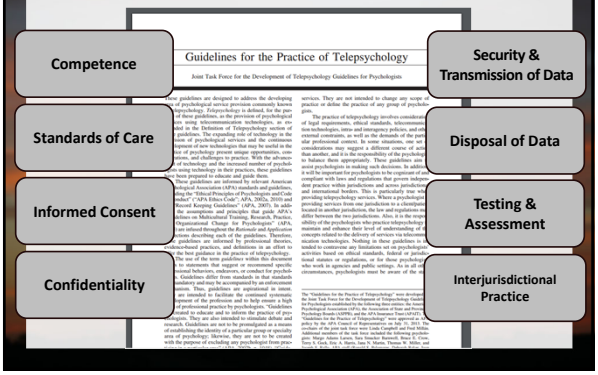
82

Remote Psychological Services

- Many private health insurance companies—and even Medicare-- temporarily loosened its rules by the beginning of May 2020 about the use of phones**
- Almost wholesale move to remote care as a result of COVID-19
- APA guidelines for Telepsychological practice

83

APA Telepsychology Guidelines (2013)



84

APA Ethics Code Relevant Standards

- **EC 4.01:** A primary obligation to take reasonable precautions to protect confidentiality in any medium
- **EC 6.01:** Create and handle records to facilitate care, allow replication of research, ensure fiscal accuracy, and meet institutional/legal mandates
- **EC 6.02 (a):** Maintaining confidentiality; We maintain confidentiality in all aspects of record development, access, transfer, storage and in any medium

85

HIPAA Regulations

Three general rules were imposed by HIPAA on "covered entities:"

- **"Final" Privacy Rule** (2013)
  - related to whom and in what circumstances providers can disclose protected health information about an identifiable patient
- **Security Rule** (2005; updated 2013)
  - related to steps a psychologist must take to protect ELECTRONIC confidential information (PHI) from unintended disclosure, destruction
- **Breach Notification Rule** (2009)
  - what CEs are required to do if PHI is accessed, used, or disclosed in violation of HIPAA

86

HIPAA Security Rule

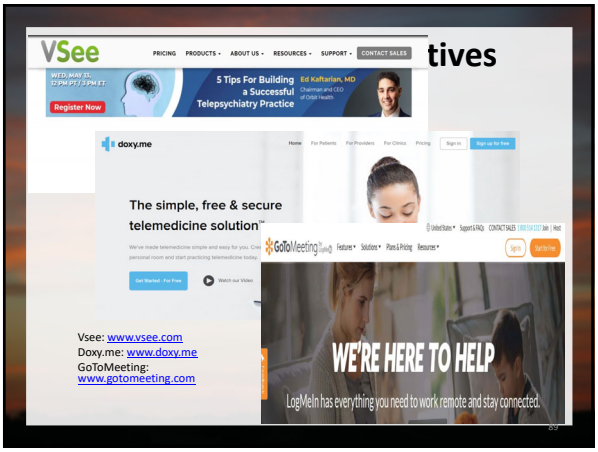
- Focuses **only** on electronically transmitted or stored PHI
  - Distinguished from **Privacy Rule,** which applies to **all PHI**
- Electronic transmission includes:
  - Internet, extranets, dial-up lines (not phone calls), computer-generated faxes (not traditional paper-to-paper faxes), private networks, and ePHI that is physically moved from one location to another

87

Must I use "HIPAA Compliant" Video Chat?

- As a result of COVID-19, the Office for Civil Rights, DHHS (March 20, 2020) said it was not going to impose penalties for the good-faith use of non-HIPAA compliant remote platforms for telehealth, as long as they were not "public-facing"
- The relaxation of this rule will end when DHHS decides
- But is it a good idea?
  - Insurance companies and licensing boards
  - Confidentiality risks
  - Informed consent

88



89

What Makes One Platform more Secure than Another?

- There are technical differences (e.g., end-to-end encryption)
- But also, the companies that offer more security will sign a business associates agreement (a BAA)
  - It is a contract between a HIPAA covered provider or organization and another business in order to protect private healthcare information
- Once BAA is signed, the business associate becomes subject to laws and penalties for breach, just like psychologists
- If not using a secure platform:
  - Make it the exception and document rationale
  - Include notification of such in your informed consent process/document

90

HIPAA's Third Rule: Breach Notification

- Can involve digital, hard copy, or oral information breaches for covered entities
- Does not need to disclose much
  - Identifying information (e.g., client name) that is related to health care (e.g., email re: therapy appointment time) would trigger the requirement
- "Secured" vs "Unsecured" PHI
  - **Secured**: encrypted or adequately destroyed
  - **Unsecured**: impermissible use/access/disclosure triggers Lee breach notification rule

91

BNR Considerations

- There is **no breach if the PHI is secured (e.g., using encryption methods approved by DHHS**)
- Safe Harbor Provision
  - We can claim "safe harbor" (no need to notify clients) if *we can demonstrate* there is no "**significant risk of harm**."

92

BNR Considerations

https://www.trustinsurance.com/Resources/Articles/ID/10/Choosing-Encryption-Software

93

Consent and Remote Care Policies

- There are, of course, other issues not related to privacy and security in providing remote care
- The APA Ethics Code (2017) and Telepsychology Guidelines (2013) require a clear consent process for engaging in tele-psychology
- It is also a prudent risk management approach
- Similarly having a policy regarding one's online presence is also helpful from a practical perspective, as well as for risk management purposes

94

Boundaries and Remote Care

- A potential vulnerability for client and therapist alike
- Novel boundary issues
- Possible risk that the flexibility of remote care may lead to more frequent and/or more casual interactions
- Misconception that the 'remote' nature of the service lessens the likelihood of boundary crossings and violations

95

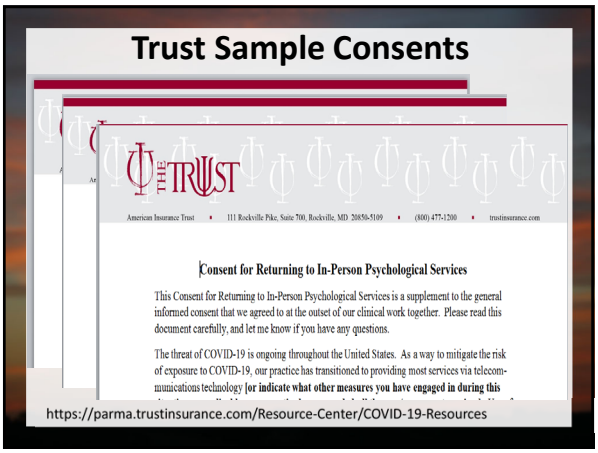
Boundaries and Remote Care

(Drum & Littleton, 2014)

- Maintain professional hours and respect timing of sessions
- Ensure timely and consistent feedback and manage excessive communications
- Ensure a private, consistent, professional, and culturally sensitive setting
- Ensure privacy of non-clients and prevent unintentional self-disclosures
- Ensure telecommunication technologies used convey professionalism
- Model appropriate self-boundaries
- Ensure privacy of the therapist's work

96

Trust Sample Consents



97

Consideration regarding In-Person Care

- Slow down and use the four methods of managing risk (consultation, structured decision making, careful informed consent, documentation)
- Have a well-reasoned justification for the determination that in-person services or continued remote care are actually the best way to provide care
- Develop and post/disseminate a set of office policies and practices to minimize health risks
- Frequently monitor government and professional guidance and standards: for example, the CDC standards for outpatient services are likely to change (or have changed) soon as vaccinations progress

98

Consideration regarding In-Person Care

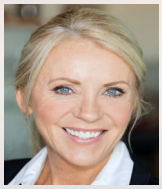
- Take into account the risk categories of patients, their families, staff and yourself
- Track local/state infection and fatality curves; is there a surge or spike?
- Carefully track where your state is in phasing back to business as usual; whether critical/essential worker status has changed, and possible immunities for providing care are in place
- Of course, rapid change has been the rule

99

Crossing Jurisdictional Boundaries

University

Global requests



Dr. Collage

100

Interjurisdictional Practice

- So far, we've talked about privacy, security, consent, and boundary issues in remote care
- We assumed that the services are happening within the jurisdiction where the professional is licensed
- What happens when patients/clients are located out of the jurisdiction in which the professional is licensed? That is, in other states or other countries?

101

Who Regulates Practice?

- In the U.S., the regulation of professions is assigned to states, including:
  - Education and training
  - Privacy and confidentiality
  - Disciplinary procedures and perspectives
  - State may have specific requirements for intra-state Telepsychology (e.g., CA)
- But when one's patient/client is in another state, the question becomes, where does a transaction take place? For example, the client is in Florida, the provider is in Montana, and they are using an Internet-based video chat program?
  - Where client resides?
  - Where clinician resides?
  - In cyberspace?

102

Who Regulates Practice?

Many states have taken the position that the transaction takes place in the **forum state—that is, where the client is located**

- But, state licensing boards will have difficulty with enforcement against clinicians not licensed by that board
- All states have temporary practice provisions of some kind (**though much variability)
- With COVID-19, some temporarily loosened their restrictions, even where they may not have permitted temporary practice before (e.g., CT)**

103

103

Who Regulates Practice?

Federal perspective

- Although the federal government has recognized the importance of use of electronic technology and provision of telehealth services
- And federal courts have ruled at times that states where the professional is NOT licensed do not have jurisdiction over the professional
- It has not taken any consistent steps to resolve the issue, so it has been left to the states to address

104

104

Who Regulates Practice?

- One solution is to create voluntary contracts (called “compacts”) between states that would allow cross-jurisdictional practice
- These kinds of compacts have a long history
- Nurses have been successful—having some 27 states that have signed on
- Physicians have made some headway, as well, having 12 states
- What about psychologists?

105

Interjurisdictional Practice

- ASPPB has spearheaded a move toward Psychology Compacts
- They have proposed essentially three components in their model legislations
  - PSYPACT
  - Interjurisdictional Practice Certificate
  - E-Passport

106

106

Interjurisdictional Practice

Psychology Interjurisdictional Compact (**PSYPACT**)

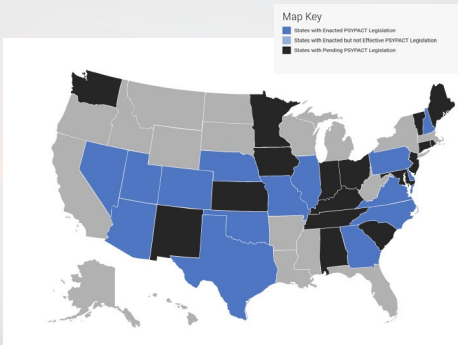
- Interstate compact → enforceable contracts between states
- Goal is to develop agreements between states that allow the remote practice of psychology
  - Also permits temporary face-to-face practice in states that join the compact (30 days in a calendar year)
- It required a minimum of 7 states to agree before it could become enforceable
- As of June 2021, there will be at least 17 member states: It has been operational for over a year
- ASPPB began issuing ePassports to member-state licensees in July 1, 2020

107

Interjurisdictional Practice

108

PSYPACT Status (as of March, 2021)



109

A Note About "Home State" and PSYPACT

- PSYPACT requires that for practitioners who possess an ePassport to work remotely in a PSYPACT member state
- They must be physically located in the state wherein they have their original license when practicing remotely—their home state
- That means that ePassport holders would NOT be permitted to engage in remote care in PSYPACT member states if they were in a state different from where they hold their full license to practice

110

Legal Issues

Tentative conclusions (for non-PSYPACT practitioners):

- Even if a psychologist actively promotes services in an interstate manner, forum state licensing boards may be unable to gain jurisdiction unless a PSYPACT member state (though arguably, a court in that state could)
- Psychologists who actively market non-therapeutic services such as coaching, with appropriate disclaimers, appropriate case selection, and appropriate referrals when issues require therapy will also be safer, provided that their language describes what they actually do
- Psychologists who provide services across state lines will be subject to review by ***their own*** state licensing boards

111

Managing Risk of Interjurisdictional Practice

1. It's lower risk if the **client initiates the services,** and it's not as the result of the psychologist's attempt to advertise services interjurisdictionally or the psychologist's participation in a commercial enterprise that provides interjurisdictional services
2. There is a clear **rationale** that providing services using telepsychology would be at least equal, if not superior, to those services which the client could receive through an in-person referral to a provider in the client's jurisdiction (e.g., continuity of care during a time-limited return home due to COVID-19)

112

Managing Risk of Interjurisdictional Practice

3. The psychologist takes reasonable steps to ensure the **competence** of his or her work and to **protect clients and others from harm**. This means psychologists, at a minimum, are conversant and compliant with all of the [APA] telepsychology guidelines
4. The psychologist has conducted a conservative **assessment** of the client's diagnosis, history, and risk level and determined that these factors do not contraindicate providing services via telepsychology

113

Managing Risk of Interjurisdictional Practice

Additional considerations:

- Client suitability/clinical appropriateness is key
  - Clinical benefits v. risk
  - Efficacy
- Training/competence in the area
  - Technological competence
  - Clinical competence
- Informed Consent (see The Trust examples, above)
- Confidentiality
- Preparation for emergencies
  - Safety concerns
  - Local resources available
- Service reimbursement

114

Managing Risk of Interjurisdictional Practice

- Practitioners should be ***familiar with the laws in the forum state and abide by them to the extent possible***.
- Consider clinical, ethical, legal, and risk dimensions of this work
- The Trust Coverage Policy
  --Coverage for interstate psychological services for malpractice (if properly licensed) and licensing board complaints
  --Coverage for coaching
- BUT…
  --NO coverage for criminal prosecutions for unlicensed practice
  --And malpractice coverage is possibly more complex if one is sued for international practice

115

Is It any Different for International Practice?

- The considerations are very similar to the above
  - Many nations do not regulate the practice of psychology (e.g., Singapore, France, Thailand, India)
  - Among those that do regulate practice (Canada, China, Mexico), there may be little objection to following patients, as long as one does not "hang out a shingle"—either online or with a physical presence in the forum country
  - Temporary practice provisions may exist in some countries
  - Patient/client suitability is still a critical issue
  - The nature of the services--temporary, a transitional period, or permanent (the latter carrying more risk with less suitable patients/clients) will also be relevant
  - It is unlikely that with a short term, suitable patient, that most countries will create an international incident over a few video chat sessions

116

How COVID-19 Impacted such Practices?

- Many states (e.g., FL, NC, NJ, SC) significantly loosened their restrictions regarding the provision of remote services by validly licensed practitioners in other U.S. jurisdictions at the onset of COVID-19
- BUT—this relaxation of the rules does not typically extend beyond the emergency period
- For example, New Jersey has extended these rules to June 21, 2021, after which laws about interjurisdictional practice will return to where they were prior to COVID-19 (if the PHE is not extended)

117

How Has/Will COVID-19 Impact such Practices

- Medicare coverage—for telehealth and even phone-only, was also extended beyond the usual geographic restrictions
- But state laws still apply
- And whether, and how long Medicare's relaxation of the rules will endure, remains to be seen

118

How Has/Will COVID-19 Impact such Practices

- Though it's hard to predict, there's an increased likelihood that PSYPACT will spread more widely and quickly
- It's possible that Medicare will have fewer restrictions on telehealth, though there are already concerns about fraud and abuse
- The relaxing of HIPAA enforcement is probably going to end, but…

119

Questions?

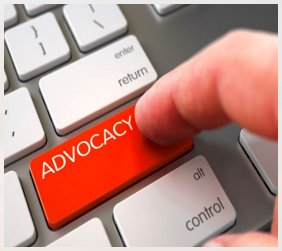
120

Professional Advocacy: What Are the Limits?

121

Definitions

- **Advocacy** = umbrella term for a range of activities designed to change society by appealing to individuals, organizations or systems, or government
- **Lobbying** = a set of activities designed to influence legislation



122

Social Ecological Model of Advocacy

https://www.cdc.gov/cancer/crccp/pdf/colorectalactionguide.pdf

123

Advocacy Roles for Psychologists

Heinowitz et al., 2012

124

Scientist-Practitioner-Advocate Training Model

"Comprehensive graduate training must prepare students to intervene at both individual and systemic levels to effectively serve clients." (p. 304)

Mallinckrodt, Miles, & Levy, 2014

125

APA Ethics Code (2017)

Preamble:

- Psychologists are committed to increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society.
- Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching, and publication. They strive to help the public in developing informed judgments and choices concerning human behavior. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness.

126

APA Ethics Code (2017)

- **Principle A: Beneficence and Nonmaleficence**
  - *Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research.*

127

APA Ethics Code (2017)

- **Principle D: Justice**
  - *Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists.*
- **Principle E: Respect for People's Rights and Dignity**
  - *Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making…do not knowingly participate in or condone activities of others based upon [such] prejudices.*

128

Why we DON'T advocate…

- Lack of interest in advocacy issues
- Lack of awareness about current, relevant public policy concerns
- Lack of training or education about potential advocacy issues
- Focus on individual issues, rather than systemic issues that contribute to pathology
- Poor political representation at the local, state, and national levels
- Low financial contributions for advocacy efforts
- Perceived personal sacrifices required
- Perceived incongruence with their professional agenda
- More comfortable with individual advocacy (i.e., on behalf of a client) than advocacy on larger platforms

Cohen, Lee, & McIlwraith, 2012

129

Why we SHOULD advocate…

Cohen, Lee, & McIlwraith (2012, p. 156):

- We are a relatively small, well-connected profession
- We have a important contributions to make
  - Our interventions are rigorously science-based and demonstrably effective
  - The integration of research with practice is our strength
- The interests of psychologists are largely the same as the interests of the public
  - We are offering them what they want
- Psychology has a good reputation and enjoys the trust of the public

The future of the field and the people we serve depends on advocacy efforts!

130

Psychology Advocacy Outcomes

- Funding for psychological research
- Advancing psychology as a STEM discipline
- Prescriptive authority for psychologists
- Mental health and substance abuse parity
- Addressing minority health disparities
- Interstate compact agreement (PSYPACT) to advance telepsychology
- Critical changes in law and policy based on psychological research
  - *Brown v. Board of Education*
  - *Roper v. Simmons*

Garrison, DeLeon, & Smedley, 2017

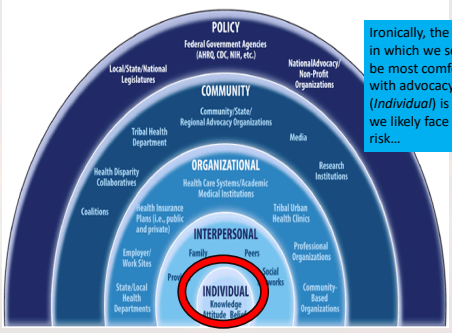
131

Ways to Engage in Advocacy

- Knowledge transfer
- Knowledge translation
- Demonstrating the value of our work
- Influencing local and state-level policies
- Advocacy within one's organization or workplace
- Financial support of political action committees or psychology lobbying groups
- Individual client advocacy

132

Social Ecological Model of Advocacy

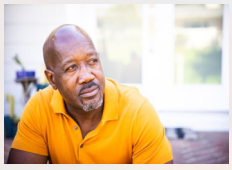


Ironically, the one level in which we seem to be most comfortable with advocacy (*Individual*) is where we likely face the most risk…

https://www.cdc.gov/cancer/crccp/pdf/colorectalactionguide.pdf

133

Case Example



Dr. Helpful

Jenna's Mother

Jenna

134

Potential Areas of Concern

- Clinical issues
- Ethical issues
- Legal issues
- Risk management issues

135

Frequently Requested Advocacy Letters

Non-Litigation Purposes
- Educational safety/Threat assessment
- Fitness for duty
- Fitness for weapon license/permit
- Emotional support animal (under Fair Housing laws)
- Educational accommodations
- Disability
- Surgical readiness (e.g., bariatric surgery, gender transition)

Litigation Purposes
- Child welfare/parenting Capacity
- Child custody
- Personal injury
- Worker's compensation
- Sexual harassment

136

Clients request letters to be sent to 3rd parties

Third party entities can include:
a) the client's family members or friends
b) the client's current or potential future employer
c) insurance companies (health; disability; life)
d) government agencies (e.g., Social Security)
e) law enforcement entities
f) courts or administrative bodies
g) attorneys representing the client or a third party
h) other mental health professionals

137

Issues to Consider

- Am I **competent** to offer any relevant information on the requested topic?
- Am I engaging in an impairing **multiple role** if I do respond to the request for information/opinion?
- What are the **potential consequences of giving** information/opinion to the third party?
- What are the **potential consequences of NOT giving** information/opinion to the third party?
- If I do disclose information or opine on a topic, what is the **safest way** to do so?

138

Issues to Consider

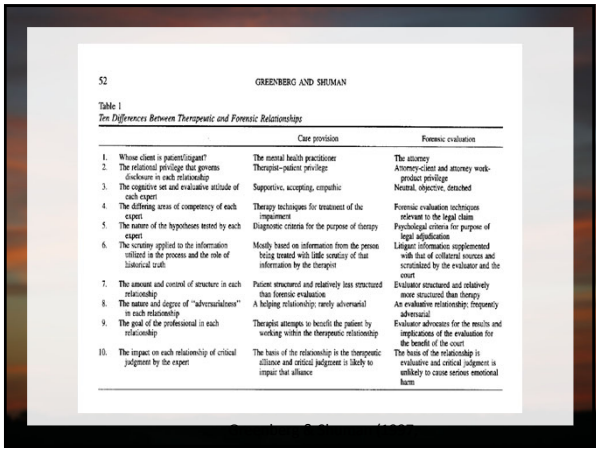
- Are there any relevant **ethics guidelines, regulations, or laws** that I should be aware of?
- Does writing a letter open the door to my **further involvement** in the patient's external situation? If so, what are they, and how would I deal with that?
- If I do provide information/opinion, should I, and/or how should I, **acknowledge any limitations** on the information/opinion?
- Have MHPs gotten into **trouble** for disclosing information/giving opinions on behalf of their patients?

139

Clinical/Ethical Issues

- Would writing the requested letter or providing information to third parties as requested put me in a **forensic role**?
- The Specialty Guidelines for Forensic Psychology (APA, 2013) define a forensic role as occurring
  - "when applying the scientific, technical, or specialized knowledge of psychology to the law to assist in addressing legal, contractual, and ***administrative*** matters. Application of the Guidelines does not depend on the practitioner's typical areas of practice or expertise, but rather, on the ***service provided in the case at hand.***" (APA, 2013, p. 7).

140

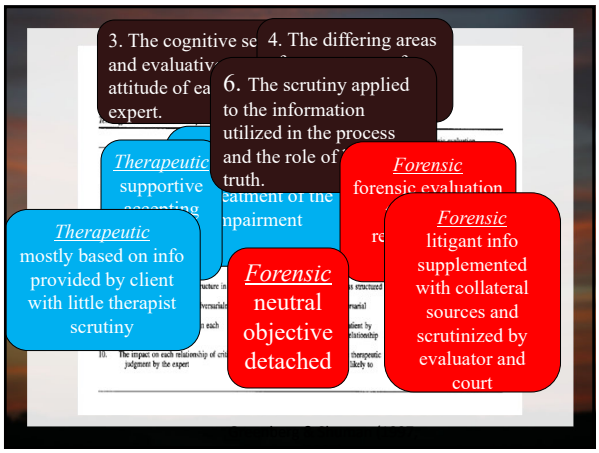


52 GREENBERG AND SHUMAN

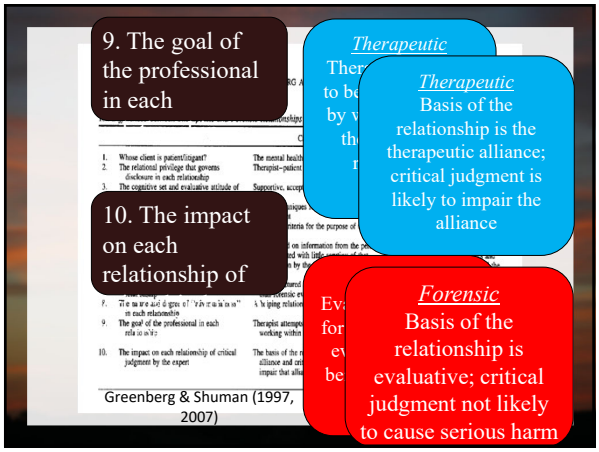
Table 1
Ten Differences Between Therapeutic and Forensic Relationships

		Care provision	Forensic evaluation
1.	Whose client is patient/litigant?	The mental health practitioner	The attorney
2.	The relational privilege that governs disclosure in each relationship	Therapist–patient privilege	Attorney-client and attorney work-product privilege
3.	The cognitive set and evaluative attitude of each expert	Supportive, accepting, empathic	Neutral, objective, detached
4.	The differing areas of competency of each expert	Therapy techniques for treatment of the impairment	Forensic evaluation techniques relevant to the legal claim
5.	The nature of the hypotheses tested by each expert	Diagnostic criteria for the purpose of therapy	Psychological criteria for purpose of legal adjudication
6.	The scrutiny applied to the information utilized in the process and the role of historical truth	Mostly based on information from the person being treated with little scrutiny of that information by the therapist	Litigant information supplemented with that of collateral sources and scrutinized by the evaluator and the court
7.	The amount and control of structure in each relationship	Patient structured and relatively less structured than forensic evaluation	Evaluator structured and relatively more structured than therapy
8.	The nature and degree of "adversarialness" in each relationship	A helping relationship; rarely adversarial	An evaluative relationship; frequently adversarial
9.	The goal of the professional in each relationship	Therapist attempts to benefit the patient by working within the therapeutic relationship	Evaluator advocates for the results and implications of the evaluation for the benefit of the court
10.	The impact on each relationship of critical judgment by the expert	The basis of the relationship is the therapeutic alliance and critical judgment is likely to impair that alliance	The basis of the relationship is evaluative and critical judgment is unlikely to cause serious emotional harm

141



142



143

Clinical/Ethical Issues

- If one does a forensic evaluation, then there are some inherent **conflicts of interest** that would normally prohibit one from being a treating clinician and forensic evaluator. (APA, Guideline 1.03, 2013)
- Even if the forensic argument does not persuade, the Ethics Code requires that we **avoid multiple relationships** where ones' competence, effectiveness or objectivity could reasonably be compromised (APA, 2017, Std 3.05)
- At the very least, **objectivity and judgement**, in the absence of reliable data, is likely affected by taking on an extra-therapeutic role like this

144

Clinical/Ethical Issues

- Thus…
  - the lack of guidelines or standards,
  - the usual reliance on self-report alone,
  - the potential for malingering,
  - the potential forensic role, and
  - the difficulty in engaging in such a role without it being a conflict of interest
- …all argue for either refraining from providing such letters, or only considering this role shift with an abundance of caution

145

Legal and Risk Management Considerations

- Boness et al. (2017) have suggested that treatment consent forms include language like the following:
  - *"Dr. X limits the services provided to you to those that are clinical in nature. Any requests for additional administrative services, like disability certification and special accommodations related to a psychological condition, may need to be provided by another psychologist.*

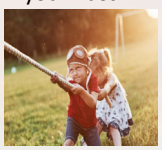
146

But…..what about advocacy?

147

Legal and Risk Management Considerations

If you must…



- Do you have the competence and authorization to provide the requested information?
- Stay within the scope of your role
  - Do not make legal determinations for your therapy clients
- Provide only factual information, NOT opinions
- Provide only the minimum necessary information to respond to the request

148

Legal and Risk Management Considerations

If you must…

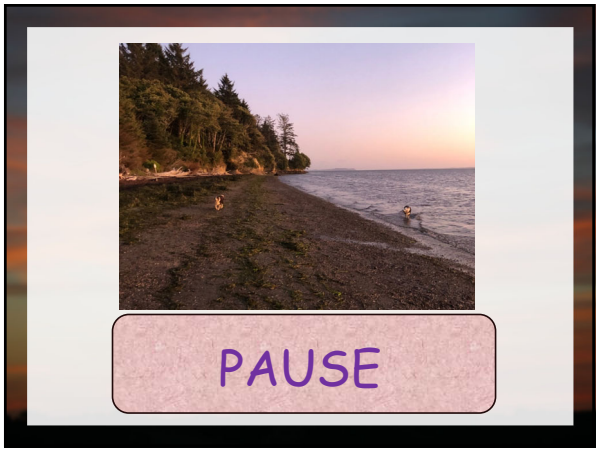
- Discuss limitations and risks with your patient/client
  - Patient/client may disagree with or feel betrayed by your disclosures
  - They may be upset with you or blame you if they do not obtain their desired outcome
- It's ok to say NO (*in most cases*)
- It's ok to charge for your time (*if this was specified in the initial treatment agreement*)

149

Questions?

150

151



152

153

154

"Self-care is not a narcissistic luxury to be fulfilled as time permits; it is a human requisite, a clinical necessity, and an ethical imperative."

Norcross & VandenBos, 2018

155

What is Self-Care?

- The practice of taking an active role in protecting one's well-being and happiness
- Tending to oneself, getting to know oneself
- Being aware of and honoring one's own needs
- Mindfully paying attention to and caring for oneself
- Deliberately acting to promote our physical, mental, emotional, psychological, and spiritual wellness

156

Why It Matters

- Ethical Imperatives
  - Principle A: Beneficence and Nonmaleficence: “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.”
  - Standard 2.03: Maintaining Competence: “Psychologists undertake ongoing efforts to develop and maintain their competence.”

157

Why It Matters: Ethical Imperatives Continued…

- Standard 2.06: Personal Problems and Conflicts:

“(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 activities."

158

Why It Matters: Ethical Imperatives Continued…

- Standard 3.04 Avoiding Harm:

  “Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.”

- Vulnerability, loss of objectivity, impaired judgment

159

Why It Matters: Risks of Not Attending to Self-Care

- Distress
- Burnout
- Vicarious Traumatization
- Errors in Judgment
- Failure to meet legal and ethical obligations
- Licensing board complaints and/or civil suits
- Harm to clients

160

Why It Matters: Risks of Not Attending to Self-Care

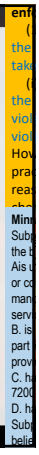
- On the more severe end of the spectrum, it could result in impairment significant enough to require ethical intervention
- APA Code requirements when there appears to be an ethical infraction:
  --Standard 1.04 **Informal Resolution of Ethical Violations**
  --Standard 1.05 **Reporting Ethical Violations**

161

Reporting Impaired Colleagues

- Sixteen states require the reporting of impaired professionals

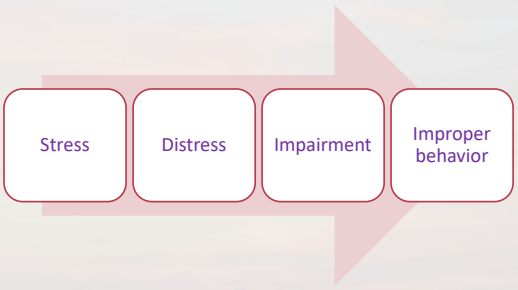
--Some examples



162

Continuum

(APA Board of Professional Affairs Advisory Committee on Colleague Assistance)



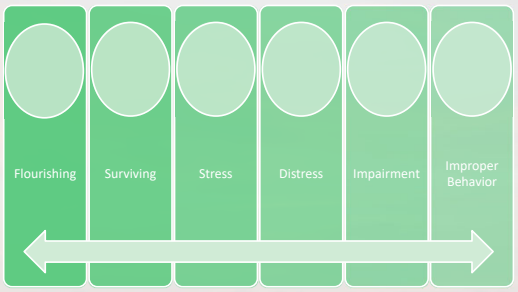
163

Limitations

- Starts at neutral and spirals down
- Envisioning a positive continuum (Wise, Hersh, & Gibson, 2012)
- Allows for spiraling up
- Enhancing functioning and greatly reducing likelihood of progression through the negative stages

164

Broader Continuum Concept



165

Warning Signs

- Unable to acknowledge possibility one may experience distress
- Ignoring the signs of distress or assuming one can simply push through them
- Experiencing significant life stressors and minimizing their impact

- Physical signs (disturbed sleep/eating/ concentration, headaches, stomachaches, lethargy, exhaustion, recurring colds/illness)
- Emotional signs (sadness, prolonged grief, anxiety, depression, agitation, mood swings)
- Isolation

166

Warning Signs continued…

- Overworking, not taking breaks, less enjoyment of one's work, missing meetings, avoiding certain people in the workplace, tardiness
- Boredom, disinterest, easily irritated, feeling overwhelmed, cynicism
- Wishing patients would not show up or daydreaming during sessions

- Self-medicating, overlooking personal needs/ health
- Seeking emotional support or nurturance from clients
- Family/friends say you work too much (50-60 hour weeks), irritability with family/partner
- Violating boundaries

167

"Those who think they have no time for bodily exercise will sooner or later have to make time for illness."

168

How to Interrupt this Cycle?

- Self-awareness
- Self-assessment
- Self-monitoring

169

170

Self-Assessment

- *Professional Quality of Life Scale (ProQOL) (Stamm, 2009)*
  - https://progol.org/ProQol_Test.html
  - A useful way to assess your professional stress, burnout, compassion fatigue, and secondary traumatization
  - Clinicians are sometimes surprised by their scores
  - If you score in the higher range, it's an indication that it may be helpful to increase the frequency and intensity of a number of the following strategies

171

Effective Self Care Is…

- Personal
- Replenishing, nourishing
- Deliberative
- Sustainable
- Integrated into daily life
- Comprehensive and flexible
- Characterized by a complex pattern of strategies

172

In Times of Intensity

* Amp up self-care
* Self-compassion
* Allow for your humanness

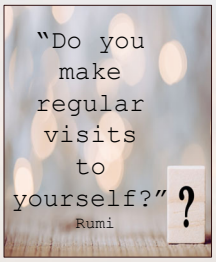
Simple techniques

* Frequent self check-ins
* Beginning/ending of day
* Nature
* Play and humor
* Mindfulness
* Spiritual practices

173

Strategies for Living Self-Care

(Norcross & VandenBos, 2018)



- Strategies vs. techniques
- Research stresses the need to create, strengthen, and utilize *multiple* strategies

174

Strategies…

(Norcross & VandenBos, 2018)

- Value and grow the person of the psychologist
- Refocus on rewards
- Recognize and be realistic about professional hazards
- Tend the body
- Nurture relationships in and out of the office
- Set personal boundaries

175

Strategies…

(Norcross & VandenBos, 2018)

- Engage in relaxation
- Restructure Cognitions
- Sustain healthy escapes
- Maintain mindfulness
- Create a thriving environment
- Make use of personal therapy
- Cultivate spirituality
- Foster your own creativity and growth

176

Strategies…

- Professional Self-Care
  - Continuing education
  - Seek client feedback
  - Consultation and supervision
  - Maintain and nurture professional connections
  - Careful patient/client selection
  - Setting and keep boundaries with patients/clients and colleagues

177

Strategies…

For vicarious traumatization in particular

- Awareness and acceptance of personal reactions
- Limit exposure where possible
- Attend and expand areas of empathy
- Attend to and explore reenactments
- Limit availability
- Maintain professional connection

178

Self-care and VTC

- Differences in traditional telehealth models vs. that brought about by Covid-19
- Various causes of 'Zoom Fatigue':
  - Inability to use full range of non-verbal signals/cues
  - Over-reliance on limited signals/cues from watching the others face
  - Relatively fixed position (to stay w/in camera range)
  - Equipment that is too small for the task
  - Nonstop concentration/focus mandated by video
  - Self-consciousness from watching oneself speak/interact

179

Strategies for Managing "Zoom Fatigue"

https://telehealth.org/blog/zoom-fatigue-what-it-is-what-you-can-do/

- Minimize distractions/tensions
  - External
  - Ergonomics
  - Technical
- Minimize fatigue during sessions
  - Shift your body
  - Look away from the screen intermittently
  - Move around in between sessions
  - Filter (change screen view or cover your own image)
- Consider overall schedule and build in breaks

180

Strategies…

Prevention at the Organizational Level (from Phelps et al., 2009)

- Primary
  - Sources of stress in work setting should be identified and minimized
    - e.g., being isolated, inexperienced, overworked, lacking support or supervision, unclear role definition
- Secondary
  - Early detection of individuals at high risk of developing stress-related problems and those with early signs of problems
- Tertiary
  - For individuals who have already developed stress-related conditions, strategies are needed that:
    - Minimize the effects of the problem
    - Prevent further deterioration or complications
    - Strive to restore the individual to the highest possible level of functioning

181

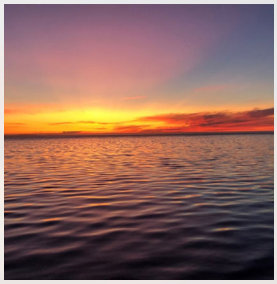
Additional Considerations

Assessment of self-care habits:

- What are you already doing?
- What needs strengthening?
- What needs creating?

Start small

- Changes over time
- Self-compassion
- Challenges and opportunities



182

"Once we have held ourselves with kindness, we can touch others in a vital and healing way."

Tara Brach, PhD

183

184

Risk Management Reminders

- Slow down! And do so by engaging in:
  --Appropriate consultation
  --A comprehensive informed consent process
  --Good recordkeeping practices and strategies
  --A structured decision-making method
- Know the legal and ethical standards governing practice
- Conduct a conservative evaluation of your intellectual, technical, emotional, and cultural competence
- Take all complaints and dissatisfactions seriously
- Notify the insurance carrier and consult with a knowledgeable attorney if a suit or disciplinary complaint is filed against you

185

Risk Management Reminders

- Be aware of your own and your patient's/client's vulnerabilities
- You will make mistakes
- You cannot help everyone
- You will not know everything
- You cannot go it alone
- Practice changes and technological developments will continue to present opportunities and risks
- Humility and a sense of humor are as crucial to risk management as they are to all other aspects of life

186

187