

The Risky Business Of Risk Management

How Risk Management Guidelines Can Increase Risk And Decrease Clinical Effectiveness

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The Risk of Risk Management: Rethinking Ethic in Psychotherapy



This paper is part of an online course on [Ethical Risk Management](#) for 6 CE Credit Hours.
Course fulfills law and ethics requirement in CA and other states.

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Introduction

One of the worst professional or ethical violations is that of permitting current risk-management principles to take precedence over human interventions. (Lazarus, 1994, p. 260)

- Don't touch your clients!
- Minimize self-disclosure!
- Never venture outside the office with a client!
- Do not accept gifts from clients!
- Avoid bartering!
- Don't get close to your clients; keep a professional distance!
- Avoid dual relationships at all costs!
- Never socialize with your patients!

These don'ts and many others whisper to us every time we emerge from one more risk management workshop or ethics and law seminar. They haunt us as we read with trepidation a bulletin from our malpractice carrier or review one more attorney's column in our professional organization's newsletter. Recent graduates still tremble with fear remembering those ethics classes warning us of the dangers lying on our career paths that we must vigilantly avoid. Under the guise of risk management and self-protection, we are told never to touch beyond a handshake, never to disclose "too much", always to stay in the office and to avoid gifts and bartering. Watch out who we schedule as the last appointment of the day, be careful when we extend sessions beyond the 50-minute hour and always steer clear of dual relationships. Beware! The slightest deviation from these ersatz commandments will set us on the 'slippery slope' to perdition.

Linda Jorgenson, a Cambridge, Massachusetts lawyer and member of the state legislative commission on sexual misconduct lists the following on her web site:

A therapist may perform negligent acts that are not sexually oriented. For example, did the therapist have the patient perform services for the therapist such as performing office tasks, repairing personal property, baby-sitting, house cleaning, chauffeuring, writing or editing? Did the therapist treat the patient in a special way? Did the therapist frequently extend therapy sessions? Was the patient scheduled for the last appointment of the day? Did the therapist have frequent and lengthy telephone conversations with the patient? Did the therapist reduce normal fees? Did the therapist direct the patient's career, academic choices or personal life? Did the therapist invite the patient to join in extra-therapeutic activities, such as dining or social visits? (Jorgenson, 2004, Sec. 3 para 2.)

This is an example of a personal injury attorney informing the public, potential litigating clients and/or therapists of what she calls, "negligent acts." I beg to differ – with these and many other risk management prohibitions, as we shall see.

This paper critically examines how the concept of risk management has been articulated, disseminated and put into practice in psychotherapy. It explores its origin, its influence on psychotherapists' attitudes, its effect on therapists' behavior, its impact on clinical effectiveness and its effect on the field at large.

The main concerns that have prompted this paper are what I see as the potentially devastating effects of risk management practices on psychotherapy practices. I believe that behaviors that are known to help clients, facilitate healing and increase therapeutic alliance are being eliminated and, in fact, criminalized (Zur, 2007a). Basic behavior, like touching a distressed client, accepting a simple Christmas gift, bartering with a cash-poor artist, providing pro-bono services to the poor, talking to a hardworking single mother late at night after she has put her children to bed or scheduling a person who works out of town as the last appointment of the day, have been deemed suspicious by risk management experts and attorneys. The real risk is that by following risk management advice, psychotherapists will attempt to protect themselves at the expense of their clients.

In this paper, I readily acknowledge that therapists face a number of hazards in their line of work. Recognizing that some clients pose an imminent danger to themselves, to others and/or even to therapists, this paper neither denies that therapists face real risks nor opposes the idea that therapists should minimize the risk to their clients, the community and themselves. But this paper focuses on the appropriate and inappropriate, ethical and unethical and moral and immoral use of risk management approaches as promoted by many insurance companies, attorneys and a growing cadre of risk management experts. The paper also questions the effectiveness of the most commonly used risk management practices and goes on to explore whether it may put therapists at higher risk rather than lower. Finally, the paper offers guidelines for ethically and clinically responsible ways to minimize risk to psychotherapists without compromising clinical integrity.

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The Concept Of Risk Management

Risk Management, in general, is the name given to the process of identifying and planning for the risks inherent in any action, activity, project, event, etc. It often involves the processes of risk identification, risk assessment, risk analysis and risk control. In psychotherapy, risk management refers to the practice of minimizing risk to clients and/or psychotherapists. In principle, it is reasonable and even important to manage risk to either clients or to ourselves, the psychotherapists (Barnett, 2015, 2017; Reamer, 2014, 2017; Younggren & Gottlieb, 2017). For example, it is our clinical, moral, ethical and legal obligation to minimize the risk of mentally ill clients hurting themselves. As mandated, it is our duty to reduce the eminent risk posed by our clients to identifiable others. Similarly, it is our professional and ethical obligation to minimize risk and harm to abused children, battered wives and any of our clients who are in harm's way. Equally appropriate is our commitment to reduce physical, emotional, professional or financial risk to ourselves as practicing psychotherapists (Zur, 2007a, 2010, 2017). It's not much different from construction workers wearing hard hats and painters wearing face masks.

Also relevant to the concept of risk management is the obvious fact that all actions involve some risk. Driving, taking a shower, practicing medicine or painting a house all involve some risk, however minor. Practicing psychotherapy is not any different. What is often ignored is the fact that inaction can be risky, as well. Avoiding certain foods or medication, neglecting to pay taxes, not your brushing teeth or buckling up are examples of inaction that may increase health or financial risks. Similarly, this paper argues that not making a needed home visit and avoiding touching or bartering with clients may also pose a risk.

While risk management, in general, and particularly in psychotherapy, is undeniably reasonable, this paper will show that it has been largely implemented in an unreasonable manner. From the playground to medicine to psychotherapy, risk management has gone too far. Risk management in psychotherapy is an appropriate practice if it is done thoughtfully, employing critical thinking, applying sensible clinical and ethical judgment and assuring that the welfare of the client is the prime commitment. Doverspike (2004) describes an ideal situation where "Reasonable clinicians protect themselves by protecting their patients" (p. 210). This is easier said than done.

This paper discusses these concerns: that risk management is now often regarded as the standard of care, that it is equated with the professional codes of ethics, that it is confused with state law, and that it has replaced clinical judgment. Additionally, this paper discusses the concern that paranoia and a passion for risk reduction have frequently induced therapists, often unethically, to eschew critical thinking, thus reducing risks at the expense of their clients' welfare.

Further complicating the risk management issue is the disagreement among psychologists, counselors, analysts and psychiatrists as to what constitutes risk or threat in the first place. Tied to this lack of agreement is the prevalent failure to differentiate between clinically helpful boundary crossing and harmful boundary violation. For example, self-disclosure, a hug, flying with a client who suffers from fear of flying or a home visit to a bedridden client are viewed as boundary violations by traditional, psychoanalytically oriented therapists. They see such therapists' behaviors as not only risking clients but also,

actually damaging to therapy and to clients (Simon, 1994; Langs, 1976, 1978). The prominent psychiatrist, Menninger, even asserts that physical contact with a patient is “evidence of incompetence or criminal ruthlessness of the analysts (cited in Horton, et. al., 1995, p. 444). On the other hand, the same therapists’ behaviors are prescribed and endorsed, when appropriate, as legitimate clinical interventions by humanistic, cognitive-behavioral, feminist, family or group therapists. What constitutes risk or danger is apparently in the eyes of the beholder. (Lazarus & Zur, 2002; Williams, 1997, 2003; Zur, 2007a, 2017).

Risk management has been defined in more realistic and pragmatic terms by Gutheil and Gabbard (1993), Fronek and Kendall (2017) and Williams (1997, 2000) as the course by which therapists refrain from implementing certain interventions because they may be misinterpreted and questioned by boards, ethics committees and courts. This approach is similar to what has also been called preventative medicine. These practices serve to protect the practitioners, not the consumers. The stated aim is to prevent or preemptively defend the health care provider against lawsuits, criminal charges or allegations by licensing boards or ethics committees. This approach seems to dominate all aspects of medicine, including behavioral health, and has evolved as a reaction to a litigious culture. In order to minimize risk, this approach advocates several reasonable steps that therapists should consider. These steps include the employment of good record keeping, use of clinical, ethical and legal consultation and establishing well-articulated treatment plans. However, this approach also advocates the avoidance of certain therapists’ behaviors regardless of their scientific basis or clinical effectiveness. Topping the list of risk management behaviors to be avoided are: any form of touch, dual relationships, gifts, bartering, self-disclosure and any intervention that requires therapists to leave the office (Zur, 2007a).

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From The Horse’s Mouth

Following is some directly quoted risk management advice.

“Risk management procedures can save a career by helping practitioners avoid the appearance of impropriety. It has become necessary to think legalistically about even the most seemingly unimportant interactions, because the mere hint of a perception of irregularity, residing as it does in the eye of the beholder, can lead to an accusation in today’s cultural climate.” (Adams, 2001, p. 276)

“From the viewpoint of current risk-management principles, a handshake is about the limit of social physical contact at this time” (Gutheil & Gabbard, 1993, p. 195)

“Clearly, the rule of thumb is to avoid even the appearance of impropriety, which mean setting clear limits and exercising firm boundaries from the first session onward.” (Doverspike, 1999, p. 14)

“... recent court decisions suggest a trend toward findings of liability for boundary violations even in the absence of sexual contact. On this basis, the risk-management value of avoiding even the appearance of boundary violations should be self-evident.” (Gutheil & Gabbard, 1993, p. 189)

“If you have to ask, don’t do it!” (Richard Lesley, quoted by Grosso, 1997, p. 18)

“... the American Trial Lawyers Association had done a “market analysis” which concluded that mental health was especially vulnerable and that there was a potential of one-half billion dollars to be gained through liability suits. With such a lucrative incentive, some injury lawyers will not hesitate to encourage dissatisfied clients to file civil suits and use both the regulatory board and the media to advance their cause.” (Adams, 2001, p. 11)

“... some attorneys seem to presume that because the patient had the last appointment of the day, sexual misconduct occurred.” (Gutheil & Gabbard, 1993, p. 191)

“Do not barter, there is too much risk associated with it.” (Woody, 1997, p. 57)

“Reduce Risk by... Avoid any dual relationships with a client or former client. Specifically this means: 1. No sexual relationships. 2. No business relationships (includes bartering).” (Austin, 1998, p. 55)

“All gifts should be avoided...” (Woody, 1997, p. 58)

“Obviously, the best advice to therapists is not to start down the slippery slope, and to avoid boundary violation or dual relationships with patients.” (Strasburger, Jorgenson & Sutherland, 1992, p. 548)

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The Risk Of Risk Management

The practices of preventative medicine or risk management raise several disturbing issues. Is this preventative, fear-based approach employed at the expense of clinical integrity and clients' welfare? While good records, consultations or well-formed treatment plans are likely to increase the quality of client's care, some other risk management practices may have several potentially negative effects on patients' care. Following are some of these concerns:

- **Risk management practices often advocate the avoidance of interventions that have proven to be clinically effective.** As a direct result of this kind of risk management on clinical work, clients do not always receive the best care possible. An example is a therapist who, following the advice of a risk management expert, will not leave the office to conduct a home visit to an ailing, older patient. Instead, the therapist either does not treat the person or resorts to therapy via the phone or the Internet. The therapist's choice, in this case, is not determined by outcome research, clinical guidelines or the standard of care nor is it a result of thoughtful consideration of what is best for the client. Instead, it stems from adherence to some form of risk management principles. Similarly, clinical effectiveness suffers as therapeutic alliance is diminished when therapists rigidly reject a gift of homemade bread from an appreciative client or decline a proposed bartering arrangement with a cash-poor but talented artist.
- **Risk management practices significantly increase the cost of care.** In December 2004 *Newsweek* reported "... doctors waste \$50 billion to \$100 billion on 'defensive medicine' to prove that they left no stone unturned, no test untried, no medication unprescribed, no specialist unconsulted. That kind of money could buy health insurance for the 40 million Americans who have none" (Taylor & Thomas, 2004, p. 3, para 5).

Williams (2004) notes three additional and important negative aspects of risk management, as follows:

- **Risk management may make the services of psychotherapists less desirable.** As therapists increasingly avoid touch, gifts, self-disclosure and other basic human interactions, the risk is that therapists will no longer deliver the type of therapeutic experience desired by the consumers. Additionally, Williams writes "The risk management presumption here is that one can deliver psychological services without resorting to hugging, touching or self-disclosure and that one can "surgically remove" touching and self-disclosure from one's practice, leaving all the active methods in one's treatment armamentarium undamaged" (p. 203).
- **Risk management increases rather than decreases the rate of complaints against psychotherapists.** Williams accurately asserts that risk management practices, as employed by insurance companies and many ethicists and experts, eventually increases the numbers and types of restricted behaviors which is likely to increase the numbers and types of complaints and charges against therapists.
- **Risk management threatens creativity among psychotherapists.** When therapists avoid self-disclosure, gifts, bartering arrangements and leaving the office and confine themselves to strict and narrow risk management behavior, creativity, spontaneity and other essential features of healing tend to vanish. Thus, the art of healing is being replaced with mechanical and rigid approaches.

In summary, current risk management policies pose several serious risks to our professional effectiveness. It may erode the foundation of healing, i.e., the therapeutic alliance, flexibility and creativity.

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The Generation Gap And The Prevalence Of Risk Management

Risk management has grown as a significant force in modern living in the USA. It affects almost all aspects of our lives. It is the natural companion of the culture of fear and litigation that has penetrated children's playgrounds, doctors' offices, kindergarten classrooms and ministers' chambers (Taylor & Thomas, 2003). In the field of behavioral health, the effects of risk management, especially on the younger therapists, are profound, as well (Williams, 2004). This is doubtless due to the fact that in recent years graduate schools have increased the focus on risk management in their curricula, replacing concerns with morality, ethics, clinical effectiveness, critical thinking and welfare of the community with rigid and fear-based practices aimed supposedly at minimizing risk to therapists and clients (Zur, 2007a).

The biggest proponents of risk management are obviously the insurance companies that understandably are motivated to reduce the occurrences of lawsuits or board complaints. They promote the practice of defensive medicine through their own numerous risk management workshops and seminars. For example, the American Professional Agency, Inc., a professional

liability insurance company, publishes a regular newsletter called, *Insight: Safeguarding Psychologists Against Liability Risks*. *Psychotherapy Finance* and other professional newsletters have regularly published risk management columns. Along the same lines, in the late 1990's, *The Psychotherapist Risk Advisor* was published. Many professional organizations have jumped on the risk management bandwagon. While some of the information they disseminate is helpful and informative, there is often a tinge of fear coloring parts of their newsletters, journals, books and seminars. Some psychotherapists' professional organizations have provided attorneys with regular monthly advice columns in their newsletters or journals.

Within the field of psychology and counseling, we have seen the birth of a whole new industry comprised of post-graduate seminars, continuing education workshops and texts all engendered by the concept of risk management. Austin (1998) entitled his book, *Danger for Therapists: How to Reduce Your Risk*. Woody (1998), an attorney, has published several books on risk management, one of which is, *Fifty Ways to Avoid Malpractice*. Doverspike (1999) published a book titled, *Ethical Risk Management: Guidelines for Practice*. Hedges, et al 1997, published a book, that does not take a strict and rigid risk management approach but the title, nevertheless, is, *Therapists At Risk: Perils of the Intimacy of the Psychotherapeutic Relationship*. Adams (2001) uses a pen name in his book, *On Your Side: Protecting your Mental Health Practice from Litigation*. More recently, Younggren and Gottlieb (2004) publish an article title "Managing risk when contemplating multiple relationships" and Vandenhey et. al. (2003) wrote "Recommendations for Risk-Management Practices." The American Psychological Association Insurance Trust (APAIT) has been sponsoring numerous popular risk management continuing education workshops across the country. The National Association for the Advancement of Psychoanalysis mounted a conference in 2004 entitled, "Facing the Challenge of Liability in Psychotherapy." Most professional organizations' annual conferences include one or more risk management workshops.

As risk management becomes more prevalent, its effect is clearly seen on newer and younger therapists. In the numerous "Ethics with Soul" workshops I have conducted across the country for the last fifteen years, I, like Williams (2003), have noted that older (non-analytically oriented) therapists seem to be less concerned about risk management practices than the young therapists and recent graduates. The survey by Borys and Pope (1989) found a significant relationship between therapists' years of experience in practice and their concerns with the ethics of maintaining dual professional roles with patients. Alarmingly, due to the present orientation of most graduate schools and their ethics professors, many of the newer therapists mistakenly believe that risk management practices are part of the codes of ethics, state laws and the standard of care.

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Confusing Ethics, Law And Risk Management

One of the biggest problems in teaching risk management is the tendency to confuse it with the clinical rationale, codes of ethics and state and federal laws. As a result of this confusion, the biggest problem of all which arises is the confusion of risk management with the standard of care itself (Zur, 2007a). As was noted above, there is nothing wrong with attending to professional risks and hazards that psychotherapists face. Whether working with a borderline patient, dealing with suicidal or homicidal clients or addressing professional burnout, psychotherapists can benefit from managing risks. Also, it has become even more important in recent years to apply ethical risk management to child custody cases. However, dealing with risks to therapists should be attended to separately and in addition to the teaching of law, ethics, clinical practices and the standard of care. Regrettably, this has not been the case. When I consult with practitioners on difficult cases, I always help them separate the legal, ethical, clinical and risk management concerns. While these concerns are often interrelated they, nevertheless, need to be conceptually segregated.

The American Psychological Association Insurance Trust (APAIT, 2004) issued the following statement relative to its position on risk management. It exemplifies how ethics and risk management have been intermingled in the classroom.

The APA Insurance Trust recognizes the importance of a student's early exposure to the concept of ethics and risk management. Ethics courses have been an important part of graduate training in professional psychology. It is only recently, however, that we have begun to recognize that an ethical practice in psychology must also be a risk-managed practice. The APA Insurance Trust has provided risk management workshops, written materials, and phone consultation services for licensed psychologists. These practitioners are better informed about the legal and ethical complexities of modern-day practice. Based on the success of these early efforts, the APAIT Trustees, both practicing psychologists and educators in graduate professional psychology, acknowledged the importance of extending risk management information to graduate psychology programs. We then conceived the idea of creating instructional modules on issues in ethics and risk management that could assist faculty in bringing this important information to the students. (APAIT, 2004, p. 1. para 6)

APAIT clearly states that, “It is only recently, however, that we have begun to recognize that an ethical practice in psychology must also be a risk-managed practice” (APAIT, 2004, p.1, para 6). While one can understand why an insurance company would advocate an overlap between ethics and risk management, we must also be careful that such fusion is not generalized to the entire field.

Like many expert witnesses, many graduate and postgraduate continuing education courses do not differentiate between ethical principles, laws and risk management guidelines. The instructors of these courses are often attorneys whose focus is, predictably, the law and risk management rather than ethical and clinical considerations. They teach these constructs as if they were one, thus indoctrinating students in this defensive professionalism. Another example comes from Grosso’s (1997) ethics text in which he quotes the position of attorney Richard Lesley, the former renowned legal counsel for the California Association of Marriage and Family Therapists (CAMFT), on dual relationships, saying, “If you have to ask, don’t do it!” (p.18). Obviously, this advice is in direct contrast to most clinical and ethical guidelines that encourage therapists to routinely seek advice, consultation and supervision on complex or unusual situations. Grosso reflects on this advice and states: “Though some may experience this approach as severe, it sure is preventive in scope” (p.18). Woody (1997) in his book, *Legally Safe Mental Health Practice*, gives numerous pieces of clinical advice, such as: “All gifts should be avoided because gift giving redefines the relationship” (p.58). Another “legally safe’ and often impossible and clinically ill-advised stricture is about small town dual relationships where he states, “The risk will exist, and there is no safe solution except to serve as a referral source when a dual relationship is apparent.” Again and again, we see how clinical advice is confused with risk management advice.

In summary, most ethics, legal and risk management literature seem to confuse the legal, ethical and clinical domains and treat them as one. As an unwanted result, risk management is being confused with the standard of care. What is lacking is a clear differentiation between these domains and a way to attend to them separately. When such differentiation takes place, one may find that tensions and conflicts are likely to arise in situations where the ethics and law clash or the clinical and risk management approaches are in opposition. Such tensions or conflicts are inevitable and should not be circumvented by endless numbers of prohibitions. These tensions, while complex, ought to lead to a creative inquiry based on critical thinking and awareness of the differences among these domains. When this process is well articulated and guided by what is best for the client, it is very likely to lead to a creative solution that ultimately will also protect thoughtful and ethical clinicians.

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Risk Management vs. Clinical Effectiveness: A Flasher In Alaska

Without any doubt, the biggest problem with risk management is that it increasingly overrides clinical judgment and compromises clients’ care. Inducing fear is the primary means of influencing therapists to comply with risk management practices at the expense of clinical integrity. Fear leads therapists to commit what Lazarus calls, “the worst professional or ethical violations” (1994, p. 260) which is to take care of themselves at the expense of clients’ care.

For example, no one that I am aware of disputes the fact that touch is one of the most elementary ways that humans relate to each other and is also a powerful method for healing (Field, 1998; Hunter & Struve, 1998; Montagu, 1952; Smith, Clance & Imes, 1998). Nevertheless, Gutheil and Gabbard (1993) claim that, “From the viewpoint of current risk-management principles, a handshake is about the limit of social physical contact at this time” (p. 195). In other words, regardless of the enormous healing and therapeutic potential of touch, therapists are instructed to avoid it in order to protect themselves despite any benefits their clients might derive (Nordmarken & Zur, 2005).

Obviously, touch is only one of many interventions frowned upon by risk management experts even though they are known to be clinically effective. Except for strict psychoanalysts, very few would challenge the fact that self-disclosure is a highly effective way to help some clients relate to us therapists as full human beings and to learn from us through modeling, a proven scientific cognitive-behavioral intervention (Lazarus & Zur, 2002). No one, even the strict analysts, challenges the indisputable fact that a home visit is, at times, the only way to care for the elderly, the sick or those who are home-bound due to severe agoraphobia. Very few will disagree that a simple gift can be an important way for a client to express gratitude and connectivity, especially in the humanistic or feminist-oriented therapies and in many non-European cultures (Zur, 2007b). Nevertheless, we have been frightened out of all of these and many other behaviors by the so-called “risk management” experts.

Cognitive Dissonance theory (Festinger, 1957) can further explain why therapists comply so readily with risk management practices. The fear of licensing boards, attorneys and litigation has led most therapists to abide by risk management guidelines and to adhere to only-in-the-office, detached therapy. As the Cognitive Dissonance theory would predict, such fear-based avoidance behaviors also alter clinicians’ attitudes towards risk management practices. In order to justify their compliance

with rigid rules, even clinicians who do not believe in them will, according to this theory, ultimately come to view them as helpful and appropriate. Consent, in this case, has been manufactured by instilling fear; this results in alteration of behavior and the subsequent change of attitudes to justify the behavior.

The detrimental effect of risk management on clinical work is, in fact, significant. For example, flying with a client who has a fear of flying is a mandated exposure-intervention to the behavioral therapist, but a no-no from a risk management point of view because it involves an out-of-office experience (Zur, 2001). A nature walk with a depressed client might be part of a strategically planned intervention for a behavioral or biologically based therapist, but another no-no from a risk management point of view. Staying in the office regardless of the presenting problem may seem right to analysts, ethicists or attorneys, but may not help those who are home-bound or suffering from agoraphobia, social phobia, fear of flying or depression. Treating these clients often requires leaving the office and going to open places, mixing with crowds, getting on an airplane or making a home visit. Practicing risk management by staying in the office – aloof and reserved – is like the story about the flasher in Alaska – it was too cold to flash, so he just described it. It didn’t work for the flasher and it doesn’t work for our clients.

The conflict between fear-inducing messages by attorneys and risk management experts and interventions beneficial to clients seems to be at the heart of the imbroglio in the ethics of risk management. As Lazarus’ asserts in the opening quote of this paper, “One of the worst professional or ethical violations is that of permitting current risk-management principles to take precedence over human interventions” (1994, p. 260).

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The Frightening Power Of Fear

The question then becomes, why are therapists willing to sacrifice their professional integrity and follow risk management practices? The answer, alluded to above, is: fear. Fear is risk management’s primary tool. Fear of greedy attorneys, fear of punitive licensing boards or fear of vindictive ethics committees (Lazarus, 1994; Lazrus & Zur, 2002; Zur, 2009a, 2009b). By instilling fear, risk management teachings induce therapists to abandon their commitment to the welfare of clients and replace it with “self protection.” As Williams (2003) states, “Fear is a great motivator, and risk management is driven by fear” (p. 202).

Fear is often invoked in texts, lectures and seminars by way of clinical vignettes. These vignettes typically describe an innocent, well-meaning, caring therapist who sincerely but naively tries to help a client in any way possible. However, by not following risk management practices of physically and emotionally distant, only-in-the-office therapy, they end up entangled with their clients in an unprofessional and messy web. As a consequence, these well-meaning therapists find themselves enmeshed in lengthy administrative, civil or criminal litigation and ultimately lose their licenses, professional standing and their life savings. The literature is filled with hundreds and probably thousands of such vignettes. Koocher and Keith-Spiegle (1998) organized their entire widely read ethics text on such vignettes. In the same way, Grosso, (1997), Nagy (2000) and many others use such fear-inducing vignettes to frighten therapists into compliance. Similarly, risk management and ethics classes are filled with such frightening vignettes aimed at influencing therapists to comply with risk management principles.

Williams (2004) eloquently articulated the relationships between fear and risk management practices:

As I have discussed elsewhere (Williams, 2000), the actual likelihood of a lawsuit or licensing complaint for any given practitioner is very low. Because these high cost events are unlikely ever to occur in a given practitioner’s career, the stage is set for psychotherapists to engage in various superstitious behaviors. Hence, the therapist who curtails hugging his or her patients, for example, may well believe that this risk management decision will have prevented a lawsuit over the course of his or her career. In fact, that psychotherapist may never have been sued regardless of whether or not risk management changes were made to his or her practice. Many psychotherapists who currently believe that they are protecting themselves with risk management restrictions to their practices may be doing nothing more effective than throwing salt over their shoulders. Because the likelihood of a suit is so low, and because the risk management rhetoric is so prevalent these days, one may be too easily convinced that risk management is highly effective. Risk management behavior, like all phobic avoidance behavior, becomes its own reward-convincing the phobic individual that the avoidant behavior (e.g., the flight phobic individual’s not getting on the airplane) has averted catastrophe (p. 202).

In summary, fear is the strongest motivator. The risk management industry has successfully struck fear into the hearts of many, if not most, clinicians. They, in turn, are wedded to phobic avoidance behavior that gives them the illusion of protection and safety. While most paranoid people who engage in such behaviors primarily hurt themselves, in the case of psychotherapists, they primarily hurt their clients by providing sub-standard care.

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A Culture Of (Litigating) Victims

Risk management in medicine and behavioral health is part of a bigger and more complex phenomenon: the American litigation explosion and the rights movement (Dershowitz, 1994; Etzioni, 1987). We have become a culture where everyone tramples everyone else in the fight for rights and entitlements (For an extensive review of the topic see [Zur, 1994](#)). While accountability is important, this lawsuit-happy culture, combined with the culture of victims, demands an extreme level of accountability and creates an atmosphere of dread that changes the way we do (or don't do) business, play or heal (Dineen, 1996; Sykes, 1992). We all know about the playgrounds across the country that have been stripped of monkey bars, high slides and swings due to the thousands of lawsuits filed by parents after their children have 'gotten hurt' while playing. Ministers, teachers, coaches and youth counselors avoid touching – especially children, girls or women (Taylor & Thomas, 2003). People have actually sued McDonald's for the obesity resulting from too many Big Macs! and won law suits against the cigarette manufacturers for not sufficiently advertising the dangers of smoking – as if anyone could still be unaware after the years of public warnings through the media, classroom, on cigarette packages, etc. We live in an age of litigation gone wild, indeed.

Flowing directly from this trend, fear-induced risk management has driven physicians to practice "defensive medicine" and to routinely order a huge number of diagnostic tests, such as lab and radiology procedures, not because they believe they are medically necessary but as part of their risk management strategy. The rationale is that the physician will not be accused of having failed to do everything in his power to rule out even the most unlikely diagnosis. Some estimate that doctors waste a shocking amount – between \$50 to \$100 billion annually – on defensive medicine (Taylor & Thomas, 2003). Even worse, as previously quoted, some also estimate that this is the amount that could buy health insurance for the forty million uninsured Americans. While many attorneys laugh all the way to the bank, our risk management-intoxicated, phobic culture ends up settling for inferior care of every kind; children are deprived of touch and opportunities for play; spiraling medical costs continue to burden the country; and mental health clients often receive sub-standard care.

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Forces Behind Risk Management

While the general background of the proliferation of risk management practices is our litigious culture, within this context there are four forces that have fueled the psychotherapy risk management movement. These are the insurance companies, attorneys, expert witnesses and therapists themselves (Zur, 2007a). As will be explained below, each of these groups has something to gain by promoting or adopting risk management practices. Following is an inquiry into the likely motivation of each of these groups.

1. The primary force behind risk management, defensive medicine or what some attorneys call "healthy defensiveness", is the malpractice insurance carrier. While a lawsuit or a licensing discipline for a psychotherapist is highly unlikely (Williams, 1997), in the rare event that it does take place, it can be very costly to the insurance company and emotionally and financially devastating to the practitioner. The rare, but nevertheless outrageously costly, judgments drive the malpractice insurance companies to advocate strict risk management practices and the avoidance of any behavior that may give a jury reason to suspect inappropriate behavior and levy an expensive penalty (Williams, 2003). Ironically, this strategy, as will be discussed later, is more likely to backfire on the insurance companies rather than to help them save money.
2. Aiding and abetting the insurance companies, many attorneys have also fueled the risk management fire, inspiring fear and likewise causing the upsurge of educational programs in risk avoidance behavior. Attorneys' advice columns seem to have become a regular feature in our professional journals. Scheduled sessions with legal professionals abound at our professional conferences. At times, *without any clinical training whatsoever*, they sternly give therapists long lists of what to avoid. They tell us never to leave the office even though going to an open space with an agoraphobic patient as part of a behavioral therapy systematic desensitization is the appropriate, if not mandated, scientifically-based clinical intervention. They tell us never to socialize with clients even though it is often impossible to avoid doing so in rural areas, at military bases, colleges and in small communities. They tell us never to share a meal with a client even though an "anorexic lunch" can be part of a perfectly executed family system-based treatment plan. In short, they tell us to ignore outcome research, theoretical orientations, intuition, creativity and other sources of clinical wisdom so we can stay "safe" by "managing our risk." They tell us to avoid some basic human behaviors, such as non-sexual touching or hugging child or adult patients. When it comes down to it, *risk management can be defined as attorneys' advice overriding clinical judgment and*

the code of ethics (Lazarus & Zur, 2002, 2007a, 2017). While insurance companies promote risk management to avoid paying money, some attorneys promote risk management so they can make money. Convincing the profession, and more importantly, the courts, that strict risk management practices are part of the standard of care, helps attorneys litigate civil lawsuits and benefit from high settlements.

3. For attorneys to be able to win their cases, they often must utilize expert witnesses to testify in courts or boards' hearings as to what constitutes the standard of care and these attorneys regularly call on psychoanalytically oriented expert witnesses for that purpose. The analytic model is consistent with risk management in its focus on rigid physical and emotional boundaries. In the most unethical, unprofessional and immoral manner, these experts often describe risk management and analytic practices as if they were the prevailing professional standard of care in one's community. They hold accused therapists, whose background is behavioral, cognitive-behavioral or humanistic, to analytic standards even though these therapists neither trained in nor practice analytic therapy (Lazarus & Zur, 2002; Williams, 1997; Zur, 2007, 2017). They hold therapists in small communities – where dual relationships are unavoidable and, in fact, normal, expected and helpful – to the standard of New York, Chicago or other big metropolises and psychoanalytical institutes. They have even succeeded in convincing judges that the strictly psychoanalytic and illusive theoretical construct of transference is part of the standard of care (Jorgenson, Hirsch & Wahl 1977; Williams, 1997). What is most alarming is that these experts have then succeeded in convincing the courts to hold practitioners, despite their non-analytic orientation, to the analytic standards. The influence of these plaintiffs' experts is, obviously, far reaching. When courts and boards rely on these expert testimonies, the consequent decisions serve as precedents and, as such, these witnesses significantly impact the field.
4. The fourth force driving the adoption of risk management as policy is the practitioner him/herself. While fear coupled with ignorance is one motivator that has induced therapists to embrace risk management practices with alacrity, one must wonder if there are other motivations, as well. Zur (2005) suggests that the rigid boundaries imposed by risk management guidelines lead to an isolated therapeutic environment, which in turn increases therapists' influential power. He writes:

The private nature of psychotherapy has been known to enhance clients' self-disclosure, reduce feelings of shame, and increase their sense of trust and safety. However, the same private or isolated nature of therapy may also exponentially increase the power of therapists over their patients. In the isolation of the office, clients are left to rely on their imaginations and, as a result, many tend to unrealistically idealize their therapists and to attribute great power, wisdom, and beauty to them. Such an idealization or projection without any real life corroborative references or support is likely to give many therapists, not only the gratification of being adored, but also power over their unrealistically adoring clients. Psychoanalysis, in particular, has emphasized the importance of therapy in isolation and the anonymity of the therapists for transference-clinical reasons. While this may apply to psychoanalytic techniques, there is no therapeutic reason to make the "blank screen" approach an industry-wide standard. It is unpleasant to acknowledge but military basic training and cults are a couple of examples of institutions that, like psychotherapy, use isolation to increase influential power and conduct brainwashing. Although there are several compelling reasons for therapy to be conducted in a private and confidential environment, the obsession with privacy and the resultant rigidly imposed isolation may ultimately be more damaging than enhancing to the clients' welfare. This self-serving obsession with isolation has been unfortunately translated into laws, ethics codes, and guidelines that imbue therapists with undue power. This power can be used positively, but it may also increase the risk of exploitation and harm to clients by therapists (p. 25).

The isolation promoted by risk management further perpetuates the illusion of omnipotence and the grandiose notion among therapists that they have extraordinary and unrealistic power to manipulate, control, exploit and irreversibly harm clients at will. This isolation also protects therapists from being known by the clients and helps them successfully hide aspects of their lives of which they may be ashamed, such as depression, bad relationships, their own badly behaved children, addiction or poverty. Lastly, Zur (2005) discusses how the ideology of isolation leads to lack of accountability and ultimately enables therapists to stay in business regardless of their clinical effectiveness. In the isolation of the office, therapists can easily lay the blame for lack of therapeutic progress at the feet of their clients. While Zur acknowledges that privacy, confidentiality and proper boundaries are important to effective therapy, he also asserts that they should be implemented appropriately and, above all, with flexibility. He concludes:

Risk management’s pretense is that rigid therapeutic boundaries must be maintained for the clients’ protection and privacy, however, there are several less high-minded reasons for these demands. These have to do with the professional, emotional and financial benefits that therapists reap from the implementation of these beliefs. In the isolated setting, therapists can bask in their clients’ idolization, experience the attendant increased power and influence, and enjoy the therapeutic mystique that develops in an isolated, therapeutic environment. In the rigidly segregated consulting rooms, therapists can also blame the client for lack of progress and use terms such as “resistance” to justify the continuation of charging clients, at times for many years, even though nothing is being accomplished (p.26).

In summary, risk management practices have been supported and promoted by four elements, each of which is to some degree self-serving. The insurance companies would like to save money, many attorneys have fueled the litigation culture as it serves them financially, many expert witnesses have a financial, theoretical-ideological and/or professional investment in their stated position, and many psychotherapists, while primarily operating out of fear and ignorance, are also likely to benefit financially, emotionally and professionally from the increased isolation advocated by risk management guidelines.

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The Concern With Boundaries

Boundaries in therapy refer to issues of time, place, space, money, gifts, services, clothing, language, self-disclosure and physical contact (Gutheil & Gabbard, 1993). Central to risk management practices, just as in psychoanalysis, is the immense importance of clear boundaries in therapy. Accordingly, supporters of this line of reasoning view any deviation from these boundaries as a threat to the therapeutic process and regard such transgressions as potential, if not inevitable, precursors to harm, exploitation and sexual relationships between therapists and clients (Borys, 1994; Brown, 1994; Katherine, 1993; Koocher & Keith-Spiegel, 1998; Pope, 1989; Pope & Vasquez, 1998; Sonne, 1989; Strasburger et. al., 1992).

Risk management experts have been influenced primarily by psychoanalysis and its rigid attitude towards any type of boundary crossing, such as non-sexual touch, self-disclosure or out-of-office experiences (Zur, 2007a). Most traditional analysts conceive boundary crossings to be intrinsically negative and invariably to interfere with and undermine clinical work (Epstein & Simon, 1990; Langs, 1976; Simon, 1992). According to traditional analysts, effective management of transference and other therapeutic work requires clear and consistent boundaries that enable the therapist to preserve the analytic frame of therapy (Langs, 1988). Transgressions that detract from therapists’ neutrality are said to contaminate the transference and hence are a detriment to analysis. Langs (1976) is an avid believer in the necessity of unyielding boundaries for therapeutic progress. His work has been widely quoted by ethicists, risk management experts and those who view dual relationships as harmful. He asserts that “poor boundary management” impedes transference work and has other serious ramifications, such as the dilution of the therapist’s influence. Simon (1995) operates from a similar perspective and has numerous publications that glorify the case for rigid boundaries. Adhering to traditional analytic principles, his main guidelines state:

Maintain therapist neutrality. Foster psychological separateness of the patient. Obtain informed consent for treatment and procedures. Interact only verbally with clients. Ensure no previous, current, or future personal relationships with patients. Minimize physical contact. Preserve relative anonymity of the therapist. (Simon, 1994, p. 514)

The concern with boundaries is not limited to analytically oriented therapists. Most ethics texts also advocate rigorous adherence to strict boundaries. Koocher and Keith-Spiegel (1998) claim in their widely used ethics text, “... we are convinced that lax professional boundaries are often a precursor of exploitation, confusion and loss of objectivity” (p. 171). Borys & Pope (1989), Brown (1985), Kagle & Geibelhausen (1994), Katherine (1993), Kitchener (1988), Pope and Vasquez (1998), Simon (1995), Sonne (1994) and many others, generally view professional distance between therapist and client as essential, indeed, as a sine qua non for effective clinical work.

Risk management proponents, like their analytic colleagues have consistently failed to distinguish between boundary crossings and boundary violations. Boundary violations refer to actions on the part of the therapist that are harmful, exploitative and in direct conflict with the preservation of clients’ dignity and the integrity of the therapeutic process. Examples of boundary violations are sexual or financial exploitation of clients. A boundary crossing is a benign, and often beneficial departure from traditional therapeutic settings or constraints. Examples of boundary crossings are: making home visits to a bedridden client; taking a plane ride with a client who has a fear of flying; attending a client’s wedding, bar mitzvah, or other function; or conducting therapy while walking on a trail with a person who requests it and seems to benefit from it.

Risk management experts have also failed to recognize that rigid boundaries often conflict with acting in a manner that is clinically helpful to clients. Rigidity, distance and coldness are incompatible with healing. Lambert (1992), Williams (2003) and many others affirm, through outcome research, the importance of rapport and warmth for effective therapy. Boundary crossings are likely to increase familiarity, understanding and connection and hence increase the likelihood of success for the clinical work.

The exclusive reliance of risk management on analytic theory has resulted in the avoidance of virtually all boundary crossings and consequently has been detrimental to the overall impact of psychotherapy. Behavioral, cognitive-behavioral, humanistic, group, family and existential therapeutic orientations are the most practiced orientations today. These treatment approaches tend to endorse what are considered clear boundary violations by most ethicists, psychoanalysts and risk management advocates (Williams, 1997). In fact, feminist, humanistic and existential orientations view the tearing down of artificial boundaries as essential for therapeutic effectiveness and healing (Greenspan, 1995; Zur, 2007a, 2017).

Another obvious fact that has eluded most risk management experts is that the maintenance of rigid boundaries between therapists and patients in many close-knit communities is unrealistic and impossible. These communities include the *military* (Hines, Ader, Chang, & Rundell, 1998; Johnson, 1995; Staal & King, 2000), *rural* (Hargrove, 1986; Jennings, 1992; Schank & Skovholt, 1997), *religious* (Geyer, 1994; Montgomery & DeBell, 1997), *feminist* (Greenspan, 1995; Lerman & Porter, 1990; Stockman, 1990), *gay* (Brown, 1991; Smith, 1990), and *ethnic minorities* (Sears, 1990). Social norms in these communities include flexible and permeable boundaries and often favor mutuality between professionals, including therapists, and their clients.

In summary, the unduly restrictive risk management, analytically based emphasis on clear, rigid and inflexible boundaries often interferes with sound clinical judgment, which ought, on the contrary, to be flexible and personally tailored to clients' needs rather than to therapists' dogmas or fears. The biggest risk of risk management is that it may impose an analytic standard on the entire field.

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Out-Of-Office Experiences

Crossing the boundaries of the office has been one of the many prohibitions of risk management practices. However, as this section illustrates, leaving the office can be clinically effective and consistent with behavioral, cognitive-behavioral, systems, humanistic and other non-analytic orientations (Zur, 2007a, 2017). In fact, this section illustrates situations where following strict risk management guidelines may be unethical and counter-clinical as it may deprive patients of quality care and may even harm them. In some settings seeing a client out the office is common and 'normal' (Barnett, 2017b; Bucky et. al. 2015; Bucky & Stolberg, 2017; Zur, 2007a, 2017b)

Zur (2001) published a paper entitled, [Out-of-Office Experience](#): The paper attempts to shed a new light on the rarely discussed issue of deliberate and strategic crossing of the office boundaries. It identifies three types of out-of-office experiences.

The first type is where the out-of-office experience is part of a considered, carefully constructed, research-based, treatment plan. Here are a couple of vignettes illustrating the argument.

This is the case of a woman, age 30, who is now my patient, who lost her first and only infant son in a drunk driving accident. At the time of this tragedy, the pain of her loss was, of course, immense. She could not stop crying and the pain seemed unbearable. Her family was aware that she was contemplating an escape from her agony through suicide. At their insistence, she agreed to an emergency appointment with a psychiatrist. In this grief-stricken state, barely able to stand, she entered the doctor's office and sobbed uncontrollably. In her desperation and isolation she begged the psychiatrist to hold her. He instructed her to sit down and explained that therapy is about talking, not touching, and cited something about professional boundaries. At the end of the session, he pulled out his prescription pad, prescribed Valium for her and set an appointment for a couple of days later. Eight years later, addicted to Valium and alcohol, divorced and with two failed rehab programs behind her, she began therapy with me. After an intense few months of therapy, we went to her son's grave. It was the first time she had ever visited the grave. There we stood, holding each other tight and both weeping. We stood there for a long time as she cried and I cried. She had finally begun facing her baby's death and mourning for him and grieving for the years lost in drugged denial. That psychiatrist followed risk management guidelines to perfection. He took the "safe" path that forbids touch. In his mind, he probably also followed the dictum of "do no harm" when he refused to hold her in her grief. However, undoubtedly, by practicing risk management, adhering to the "no touch" dogma, he inflicted needless additional suffering on this woman. He sacrificed his humanity and the core of his professional being to the demands of a heartless and destructive protocol.

An athletic-looking, depressed young man was referred to me by his family following a drug-induced, single psychotic episode that landed him in the hospital. He neither wanted to be in therapy nor saw any reason for it. He was sarcastic, uncooperative and unpleasant. We simply were not connecting. Working with his parents and brothers, it came out that, like me, he loved to play basketball so I suggested that we meet on the basketball court in a nearby park for our next session. I could see that he was rather taken aback by this surprising approach to therapy, nevertheless, he reluctantly agreed. He was obviously also a bit amused, sizing me up as if to say, "What can an old man like you do on a basketball court?" But we met on the court as planned and, after a few minutes of warm-up, we decided to play one-on-one. Trailing 1:5 in the opening minutes he turned to me and asked, "How old are you?" When he continued to trail, his frustration grew and his jock-ego started wondering about the situation. His energy picked up, his game improved and his connection with me intensified. After a couple of more games, we walked across the street to a coffee shop with him doing most of the talking this time. The connection was made. Therapy had begun. Following "only in the office" and "do not touch" risk management principles would have kept us in the office ineffectively wasting time, money and above all hope that his situation could change.

Following are several more examples, taken from the Zur (2001) paper, illustrating situations where out-of-office experiences are carried out as part of a treatment plan:

By the time he sought my services, John was on the brink of bankruptcy; his business was suffering gravely due to his debilitating fear of flying. I outlined behavioral, biological, and psychodynamic treatment options for him. His sense of urgency induced him to start with systematic desensitization. Following the standard behavioral protocol, I introduced him to gradual, progressive exposures to anxiety-eliciting images culminating with an in-vivo experience of flying. To carry out this last step, he booked us on a round trip flight from San Francisco to Los Angeles with an hour layover in LA. He was able to fly thereafter and salvaged his business.

Jean was anorexic and bulimic. She had undergone both cognitive and psychodynamic therapy without success. Wanting to try a different approach, we developed a family-systems and behavior-based treatment plan which included individual lunches and family dinners in which I participated. We discussed privacy concerns and ways to deal with the possibility of friends or colleagues approaching us during our restaurant meetings. Jean attributed the success of our therapy to the multiple approaches and the flexibility of the in and out-of-office experiences.

Max was a young mechanic with unusual schizotypal features characterized by connecting with machines rather than human beings. He came to see me at the insistence of his mother who was concerned with his increased isolation and suicidality. He clearly did not like my office. Five minutes into the first session, on his way to the door, he offered to show me his newly restored car. I had to choose between stopping treatment before it had even started and accepting his offer. For the next couple of years, he would enter my waiting room punctually and from there we would depart to various destinations. As he welded and tinkered, I learned about his relationships with his parents, and between carburetors and distributor caps, I found insights into his distrust of people and love of machines. As our "under the hood" therapy progressed, he gradually came to trust me, and a few others. He even developed his first (arm's-length) relationship with a woman. Since that first day, he has never entered my office (p. 97).

The second type is where the out-of-office experience is geared to enhance therapeutic effectiveness. Here are a couple of vignettes from Zur's (2001) paper exemplifying this approach:

After three months of pre-marital, system-based therapy, a couple invited me to their wedding. I accepted the invitation and was surprised and honored when they publicly acknowledged my role in cementing their nuptial commitment.

An adolescent girl sought therapy to help her with her fear of public speaking, which prevented her from participating in her school play. Her performance on opening night, to which she invited me, was magnificent.

A sculptor came to see me for a severe artist’s block. After three years of in-office, intensive, psychodynamically oriented therapy, he invited me to his first one-man show at a local gallery. It was an impressive exhibit.

After a couple of months of dealing with issues of work, creativity, and drug addiction, a landscape architect suggested that we spend a session viewing the actual gardens he had designed. The tour increased my understanding of him and my capacity to help him.

Several couples and individuals, over the years, have invited me to their house-warming parties, weddings, anniversaries and funerals of loved ones. When appropriate, I have accepted these invitations (p. 98).

The third type of out-of-office experience is comprised of encounters that naturally occur as part of normal living in one’s community (Bucky & Stolberg, 2017; Hyman, 2002; Koocher & Keith-Spiegel, 2017; Zur, 2017). While the first two types do not constitute dual relationships, this third one does (McCutchen, 2017; Sanders, 2017; Silberstein & Boone, 2017). Following are a couple of examples of this approach taken from the Zur (2001) paper:

Susan and I have children the same age. We have chaperoned field trips and sat on committees together at school. At the outset of therapy, we discussed the complexities and potential difficulties of our multiple relationships. She made it clear that she chose me because she knew and trusted me and appreciated my parenting methods and the importance I attach to marriage, family and community. She thought that my knowledge of her would speed up therapy. The daily “Good morning” greetings at school neither interfered with therapy, which progressed well, nor with psychodynamic and transference work.

Sue is a retail clerk at one of the local stores that my wife and I frequent. Unbeknownst to me, she chose to tell my wife, as she checked us out of the store, how I “saved her marriage and helped her children.” (My wife is used to it) (p. 98).

In summary, therapists must avoid leaving the office if there are compelling clinical, ethical or safety reasons. As Lazarus and Zur (2002) and Zur (2007a, 2017) emphasized, crossing boundaries with a borderline or highly paranoid client is often ill advised. Of course, if leaving the office causes the client embarrassment, inappropriately revealing the fact that they are in treatment, or if it may be harmful in any other way, it should be avoided. The decision must not be based on fear or risk management or analytical advice, such as that given by Simon (1991) and various risk management experts, but founded rather on clinical and ethical judgment.

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Slippery Slope – Sloppy Thinking

One of the core issues in risk management is the concern with what has been termed the “slippery slope.” The term ‘slippery slope’ refers to the idea that failure to adhere to rigid risk management standards will undeniably lead to harm, exploitation and/or foster sexual relationships. This process is described by Gabbard (1994) as follows: ” . . . the crossing of one boundary without obvious catastrophic results (making) it easier to cross the next boundary” (p. 284). Insurance companies view the risk management approach as their best means to reduce the risk of sliding down the slippery slope towards danger and harm (Williams, 2003).

Kenneth Pope, a psychologist who has almost single-handedly popularized the notion of the slippery slope and risk management, makes a statement that has been confused with the standard of care: ” . . . non-sexual dual relationships, while not unethical and harmful per se, foster sexual dual relationships” (1990-b, p. 688). Similarly, Strasburger et. al., (1992) conclude, “Obviously, the best advice to therapists is not to start (down) the slippery slope, and to avoid boundary violations or dual relationships with patients.” (p. 547-548). Also in agreement is Simon (1991), who decrees that: “The boundary violation precursors of therapist-patient sex can be as psychologically damaging as the actual sexual involvement itself” (p. 614). These poignant restrictive statements summarize the risk management stance that the chance of exploitation and harm is significantly reduced or nullified by simply refraining from engaging in any boundary crossing regardless of its clinical effectiveness.

A careful review of the ‘slippery slope’ argument reveals that it is founded primarily on the paranoid assumption that any boundary crossing, however trivial, inevitably leads to boundary violations and sex (Lazarus & Zur, 2002; Zur (2007a). To assert that self-disclosure is likely to lead to social relationships, that an appropriate hug is most likely to end with intercourse or accepting a gift is the first step towards inevitable business relationships is irrational and illogical. Sonne (1994) discusses how a therapist and client who are sports teammates can easily move their relationship to encompass activities, such as carpooling or drinking. She concludes that, “With the blurring of the expected functions and responsibilities of the therapist and client comes the breakdown of the boundaries of the professional relationship itself” (p. 338). The risk management literature is saturated with articles and books describing therapists’ behaviors (e.g. self-disclosure, hugs, home visits, socializing, longer sessions, lunching, exchanging gifts, walks, playing in recreational leagues) that the authors contend are precursors to or on the slippery slope to sexual or other harmful dual relationships (Austin, 1998; Borys & Pope, 1989; Craig, 1991; Kitchener, 1996; Keith-Spiegel & Koocher, 1985; Lakin, 1991; Pope, 1991; Pope & Vasquez, 1998; Rutter, 1989; St. Germaine, 1996). This is a part of the more widespread cultural and professional problem which includes risk management experts’ tendency to sexualize all boundaries (Dineen, 1996). Woody (1998) asserts, “In order to minimize the risk of sexual conduct, policies must prohibit a practitioner from having any contact with the client outside the treatment context and must preclude any type of dual relationships” (p. 188). The ‘slippery slope’ argument is even more pronounced in the work of Evans (1997), who contends that from an ethical, legal and clinical perspective, non-sexual and sexual dual relationships are absolutely equal and ought to be dealt with in the same manner.

In a critical examination of the slippery slope argument, Zur (2000) reflects that to assert that self-disclosure, a home visit, a hug or accepting a gift are actions likely to lead to sex is like saying that doctors’ visits cause death because most people see a doctor before they die. Lazarus calls this thinking “an extreme form of syllogistic reasoning” (1994, p. 257). We learn in school that sequential statistical relationships (correlations) cannot simply be translated into causal ones. Despite the popularity of the term, the ‘slippery slope’ is a paranoid, baseless and illogical construct claiming that any deviation from risk management or rigid analytic guidelines is likely to lead to harm, exploitation and sex.

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Transference Abuse

Transference is a psychoanalytic term referring to feelings that are evoked in the therapeutic environment where clients transfer early feelings for their parents to the therapists. Analysis of the transference is the core of psychoanalytic psychotherapy. “Transference abuse” is a term that attorneys and their experts use when accusing therapists of misusing their power. It implies that patients cannot give real consent to any action because of their emotional reaction to their therapists. The transference reaction, according to this view, renders clients helpless and gives the therapists immense power. It is the concept preceding “boundary violation” (Williams, 1997).

Jorgenson, an attorney, and her colleagues (Jorgenson, et. al., 1977) state that, “Negligently mishandling the transference phenomenon can also result in civil liability for therapists and other health care professionals” (p. 59). They cite an example where the court stated that the plaintiff, Dr. Freeman, departed from “recognized professional standards” (p. 59) when “He mishandled the transference phenomenon” (p. 59).

What is shocking is that a pure psychoanalytic theoretical construct, such as transference is being used as a weapon against therapists who are neither trained in nor practice psychoanalysis. As Gutheil (1989) has pointed out:

It seems that professionals who belong to a school of thought that rejects the idea of transference, behaviorists, or psychiatrists who provide only drug treatment, are being held to a standard of care they do not acknowledge. (p. 31)

At the heart of the problem are attorneys and boards who hire psychoanalytic expert witnesses to inform the courts and the boards about the standard of care (Gutheil, 1989; Lazarus & Zur, 2002; Williams, 1997). They convince courts and boards that the standard of professional psychotherapeutic care is indeed similar to the analytic guidelines. They ignore the fact that most psychotherapists in the US are not psychoanalytically oriented (Williams, 1997) and that these therapists do not utilize the construct of transference in their work. As a result, therapists are unjustly convicted, fear reigns and the extreme/paranoid form of risk management flourishes.

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The Ethics Codes And Risk Management

One of the most damaging consequences of risk management teaching is that it has been systematically confused with and introduced into the teaching of professional ethics with the misleading implication that it is based on professional codes of ethics. It is extremely important to understand the ethical codes are principles aimed at helping clinicians navigate the course of their interventions with clinical integrity. It is important to note that the codes of ethics are routinely and appropriately used in civil trials and licensing boards' administrative hearings to establish the standard of care for psychotherapists. Judges and juries refer to the codes to make decisions about psychologists' liability for civil damages and whether to revoke or suspend their licenses. While clients' welfare is the concern of the teaching of ethics, therapists' well being is the focus of risk management teaching. Although both may be important, it is of utmost importance not to confuse the two, yet most ethics texts go back and forth between risk management and ethical advice without any meaningful differentiations (i.e. Doverspike, 1999, Grosso, 1997). Similarly, the APA Insurance Trust (APAIT, 2004) recognizes the importance of a student's early exposure to the concept of ethics and risk management. It states: "Ethics courses have been an important part of graduate training in professional psychology. It is only recently, however, that we have begun to recognize that an ethical practice in psychology must also be a risk-managed practice" (para 6).

Following is a brief summary of how the different codes of ethics relate to some of the most important elements of risk management, such as dual relationships, bartering, touch and boundaries in therapy.

Codes of Ethics On Dual Relationships:

The American Psychological Association (APA) *Ethical Principles of Psychologists and Code of Conduct* (2016), Section 3.05 on Multiple Relationships clearly states: "Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical."

The National Association of Social Workers (NASW) Code of Ethics (2017), states: "(c) Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries. (Dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively.)"

California Association of Marriage and Family Therapists (CAMFT) *Ethical Standards for Marriage and Family Therapists* (2011), Section 1.2 states: "Not all dual relationships are unethical, and some dual relationships cannot be avoided. When a concurrent or subsequent dual relationship occurs, marriage and family therapists take appropriate professional precautions to ensure that judgment is not impaired and that no exploitation occurs." (Responsibility to Patients, Section 1).

As the above clearly demonstrates, among the codes of all major psychotherapists' organizations, there is no blanket prohibition of non-sexual dual relationships. Many risk management principles falsely imply that their dual relationship prohibition guidelines are based on the codes of ethics. As this section clearly documents, they are not. There are unified principles among the codes of ethics of all major professional organizations concerning dual relationships in psychotherapy. Once the hindering factors of misinformation and prejudice are discarded, the platform of these codes is clear: a. Sexual dual relationships with present clients are always unethical. b. Non-sexual dual relationships are not always avoidable. c. Non-sexual dual relationships are not always unethical. d. Therapists must avoid only the dual relationships that might impair their judgment and objectivity, interfere with performing therapy or supervision effectively or harm or exploit patients.

Codes Of Ethics On Bartering:

The Psychological Association (APA) *Ethical Principles of Psychologists and Code of Conduct* (2016), states in section 6.05: Barter With Clients/Patients: "Barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative."

California Association of Marriage and Family Therapists (CAMFT) 2011 Code of Ethical Standards for Marriage and Family Therapists refers to bartering of services in section 9, Financial Arrangements, where it states in section 9.5: "Marriage and family therapists ordinarily refrain from accepting goods, services, or other non-monetary remuneration from patients in return for professional services. Such arrangements often create conflicts and may lead to exploitation or distortion of the professional relationship." (CAMFT 2011, Section 9).

The National Association of Social Workers (NASW) 2017 Code of Ethics in section 1.13, Payment for Services, provides the following lengthy paragraph about bartering: “Social workers should avoid accepting goods or services from clients as payment for professional services. Bartering arrangements, particularly involving services, create the potential for conflicts of interest, exploitation, and inappropriate boundaries in social workers’ relationships with clients. Social workers should explore and may participate in bartering only in very limited circumstance when it can be demonstrated that such arrangements are an accepted practice among professionals in the local community, considered to be essential for the provision of services, negotiated without coercion, and entered into at the client’s initiative and with the client’s informed consent. Social workers who accept goods or services from clients as payment for professional services assume the full burden of demonstrating that this arrangement will not be detrimental to the client or the professional relationship.” (NASW 2017, Section 1.13, para 2).

Like so many other professional codes, the above, strongly cautious statement gives a double message. On the one hand the code surprisingly forbids bartering of services, (which creates dual relationships) and on the other it reluctantly allows it acknowledging that it may be appropriate under specified circumstances. The above statement on bartering seems to be in direct contrast with the statement regarding Section 1.05, Cultural Competence and Social Diversity, which states: “(a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures; (b) Social workers should have a knowledge base of their clients’ cultures and be able to demonstrate competence in the provision of services that are sensitive to clients’ cultures and to differences among people and cultural groups; (c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.” (NASW, 2017, Section 1.05). In summary, while the most recent APA Code of Ethics is more accepting of bartering practices, the CAMFT and NASW codes are more wary of it. These codes, like most other codes reluctantly face the reality that bartering is a common and normal arrangement in many communities and cultures and can be the only way that cash poor clients can get counseling or therapy. Consequently, they grudgingly imply that bartering may not always be avoided and give certain conditions when bartering may be acceptable. These provisions usually include an assurance of what is obvious, i.e., that the bartering is acceptable if it is not exploitative or potentially harmful to clients.

Codes Of Ethics On Non-Sexual Touch:

The American Psychological Association (APA) *Ethical Principles of Psychologists and Code of Conduct* (2016) and the California Association of Marriage and Family Therapists (CAMFT) *Ethical Standards for Marriage and Family Therapists* (2011) do not mention specifically any guidelines in regard to touch or physical contact that is intentionally employed as part of therapy.

The National Association of Social Workers (NASW) *Code of Ethics* (2017): Standard 1.10 Physical Contact: “Social workers should not engage in physical contact with clients when there is a possibility of psychological harm to the client as a result of the contact (such as cradling or caressing clients). Social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact.”

Apparently, none of the above codes, nor most other professional codes, set forth a clear prohibition of non-sexual physical touch in psychotherapy.

Codes Of Ethics On Boundaries:

Professional associations’ codes of ethics, in general, do not deal directly with boundary crossing concerns beyond the sections described above on dual relationships, bartering and non-sexual touch. Of course, all the codes forbid boundary violations, such as sexual relationships with current clients and exploitative business relationships. They make no reference to whether therapy should take place at the office, home office or client’s home nor articulate any guidelines in regard to self-disclosure, gifts, length of sessions or whether therapists should leave the office with their clients or not. All the codes clearly mandate that therapists treat clients with respect and dignity and avoid behaviors that are exploitative and harmful or may reasonably result in harm to clients. In summary, the mandate of keeping strict and rigid boundaries is not based on the code of ethics. It originates from psychoanalysis and risk management teaching.

Ethics Codes Online: Following are direct links to the online texts of

- * [American Psychological Association \(APA\)](#)
- * [California Association of Marriage and Family Therapists \(CAMFT\)](#)
- * [National Association of Social Workers \(NASW\)](#)
- * [Additional Codes of Ethics](#)

In response to many concerns that the prior code of ethics could too easily be inappropriately aggressively over-interpreted, those who were responsible for revising the former American Psychological Association (APA) Code of Ethics of 2010 attempted to reduce the ambiguity and more explicitly define illusive terms, such as “reasonably”, “appropriate” or “potentially,” that have troubled therapists for quite some time. An example of how such terms currently appear in the code is Section 3.05 on Multiple Relationships of the American Psychological Association (APA) *Ethical Principles of Psychologists and Code of Conduct* (2010 and 2016), which states: “A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist’s objectivity, competence, or effectiveness . . .” The question that haunted psychologists and other therapists has been “reasonably” according to whom? Over the years many risk management specialists, attorneys and expert witnesses have told licensing boards and courts that some interventions often used by behavioral and humanistic practitioners are unreasonable or below the usual professional standard of care (Williams, 1997, 2000). Finally, the 2010 revision, and later in the 2016 version, of the APA code, in its section of Introduction and Applicability, has shed some light on these terms:

As used in this Ethics Code, the term *reasonable* means the prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge the psychologist had or should have had at the time. (par. 6).

The importance of this new section is that it will, hopefully, reduce the injustice by focusing on the testimony of experts familiar with ethical principles and the standard of care in the specific practice at hand. Many people hope that this paragraph will prevent inappropriate criticism of rural therapists who inevitably have routine social encounters with their clients; behavioral therapists who accompany clients experiencing fear of flying on board a plane; humanistic psychologists who hug their clients supportively; or therapists who made home visits. According to the new code, complaints against practitioners should no longer judged by rigid and arbitrary analytic or risk management guidelines but must be evaluated in the context of standards and practices commonly applied by therapists with similar orientation working in comparable types of situations and communities.

It will be up to the test of time to see if so-called expert-psychologists who continue to apply rigid, iconoclastic, analytic or risk management based criticism or employ excessively narrow ethical lenses will be deemed unethical and sanctioned accordingly.

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Standard Of Care And Risk Management

The Standard of Care is one of the most important constructs in medicine and mental health. Most broadly, the standard of care has been defined as the usual and customary professional standard practice in the community. It has been described as the qualities and conditions which prevail, or should prevail, in a particular mental health service, and that a reasonable and prudent practitioner follows. The standard is based on community and professional standards and, as such, professionals are held to the same standard as others of the same profession or discipline with comparable qualification in similar localities (Caudill, 2004; Doverspike, 1999; Woody, 1998). There is no one textbook or set of rules that define the standard of care, and some (i.e., Williams, 2003) go as far as to suggest that it is nothing more than a perception. Reid (1998) suggests that the standard of care is determined by what is good for patients. The standard of care, he asserts, “is usually correlated with professionally accepted clinical texts, clinical journal articles, clinical training programs, and what real doctors do across the country” (p.1). Some authors (i.e., Grosso, 1997) have described three standards of care, clinical, ethical and legal, that must be integrated to form the final standard of care.

The standard of care in courts and licensing board hearings is primarily determined by testimonies from expert witnesses. Attorneys on both sides often present conflicting expert testimonies about the standard of care. Adding to the complexity, in recent years one of the biggest problems is that risk management practices, spurred on by the insurance companies, have often been confused with the standard of care (Williams, 1997, 2003).

The fact that there are hundreds of different psychotherapeutic orientations (Lambert, 1991), and many different types of communities and cultures, make the concept of the standard of care extremely complex, illusive and controversial. Besides the agreement never to harm or exploit clients, to treat them with respect and dignity, and to protect their privacy and autonomy, there is little agreement among practitioners in the field about what constitutes proper care. A New York City psychoanalyst’s treatment of anxiety is likely to be very different than an existentialist’s treatment of the same condition in rural Idaho or the local counselor’s treatment on the Indian reservation in Arizona.

In order to operate within the standard of care, obviously one must first understand it and the complexities therein. Regrettably, most therapists have only a vague notion of the standard of care (Caudill, 2004). Even more disturbing and dangerous is when expert witnesses themselves do not understand the essence of the standard of care, and in their court and board testimonies erroneously equate risk management or analytic guidelines with the standard (Barnett, 2015, 2017a; Lazarus & Zur, 2002; Williams, 1997, 2003; Younggren & Gottlieb, 2017). The field in general has been led to view the standard of care in a narrow and inaccurate way, primarily through the influence of attorneys' presentations and columns in professional newsletters, risk management expert's teaching at continuing education seminars, and by graduate school and continuing education ethics instructors.

Following are the six elements from which the standard of care is derived. Several of these elements, have also been described by Caudill (2004), Doverspike (1999), Reid (1998) and Williams (1997, 2003) and Zur (2007a, 2017b), among others.

1. **Statutes:** Each state has many statutes, such as Child Abuse, Elder Abuse, Domestic Violence Reporting and other laws. Obviously, if the statute mandates that therapists act in a certain way, such as reporting a suspicion of child abuse, not doing so is clearly below the standard of care.
2. **Licensing boards' regulations:** In most states, there are extensive regulations governing many aspects of psychotherapy practices. These often include the rules about mandated continuing education for licensed psychotherapists, who may or may not take the licensing exam, licensing fees, how to renew one's license, regulation of supervision, etc.
3. **Case law:** Case law is one of the cornerstones of the standard of care. No case is more famous for having created a duty for psychotherapists than the Tarasoff decision of the California Supreme Court in Tarasoff v. Regents of the University California. This case articulated the duty to warn of a patient's threat to harm a third party. Since then, many other states also obligate their mental health professionals to do the same. Along the same line of thought, several experts have predicted that HIPAA regulations will become the standard of care through case law (Newman, 2003; Zur, 2003).
4. **Ethical Codes of professional associations:** The professional associations' codes of ethics are an important but also controversial part of the standard of care. American Psychological Association (APA, 2016) ethical principles apply to APA members, but in most situations they are also applied to non-member licensed psychologists. Similarly, social workers are often held to standard set by the National Association of Social Workers (NASW, 2017) code of ethics, regardless of whether they are NASW members or not. Most counselors are held to the standards set by the ethics codes of the American Counseling Association (ACA, 2014) or the American Association of Marriage and Family Therapists (AAMFT, 2012). Many states have officially adopted APA or NASW codes of ethics as the licensing boards' standard for psychologists and social workers respectively.

Unlike most statutes, case law and regulations, the codes of ethics are unclear about what kinds of behavior are mandated or prohibited. Bersoff (1994), Fleer (2000), Williams (2003) and others have noted how the ambiguity of the APA ethics code can be easily misinterpreted and used against psychologists. In other words, the breadth and vagueness of the codes has enabled many attorneys, boards and their so-called experts to interpret the codes in a way that has led to the sanctioning of therapists who supposedly practiced negligently, below the narrowly interpreted standard of care.

To further complicate things, while the state licensing boards may have adopted the codes of ethics of major professional organizations as their guidelines, the APA Ethics Code of 2016 states clearly "The Ethics Code is not intended to be a basis of civil liability" (Introduction and Applicability). In other words the codes of ethics are not supposed to be simply equated with the standard of care, which is the basis for civil liability. The code further states, "Whether a psychologist has violated the Ethics Code standards does not by itself determine whether the psychologist is legally liable in a court action, whether a contract is enforceable or whether other legal consequences occur." (Introduction and Applicability).

Practitioners who present themselves as specialists or practice in a more specialized area are likely to be held to the ethical standard articulated by a more specialized professional association. For example, those who present themselves as sex therapists or practice sex therapy are likely to be accountable to the code of ethics of The American Association of Sex Educators, Counselors, and Therapists (AASECT). Similarly, those who present themselves as body psychotherapists or practice body psychotherapy are required to follow the United States Association of Body Psychotherapists (USABP) code of ethics.

5. **Consensus of the professionals:** In a field that is comprised of hundreds of therapeutic orientations (Lambert, 1991), consensus is hard to come by. This relatively vague aspect of the standard of care is primarily derived from professional publications, guidelines and presentations. It may include official guidelines published by professional associations, such as the general practice guidelines published by the American Psychiatric Association (ApA, 2013) or by more specific professional association guidelines for child custody, such as those by the American Psychological Association (APA, 2016).

A highly controversial issue is the application of treatment protocols of what have been called Empirically Supported Therapies (EST) or Evidence Based Therapies (EBT). These guidelines were published by several organizations, such as Division 12, Society of Clinical Psychology, of the American Psychological Association (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). These guidelines have met with enormous opposition from all corners of the field of psychology (Koocher, 2004; Lampropoulos, 2000; Levant, 2004). These protocols have been criticized for their lack of validity, narrow focus and even for being biased and discriminatory against therapeutic orientations that cannot be standardized or easily quantified. These therapeutic orientations include Humanistic, Existential, Psychoanalytic, Psychodynamic, Family and Systems. Also, in response to the Division 12 Task Force report, the Division of Humanistic Psychology (Div. 32) of APA responded with a report of its own in 1997 titled, *Recommended Principles and Practices for the Provision of Humanistic Psychosocial Services: Alternative to Mandated Practice and Treatment Guidelines*. (Task Force for the Development of Practice Recommendations For The Provision of Humanistic Psychosocial Services, 1997).

To follow the standard of care, therapists are expected to also be aware of the contents of their professional associations' official publications, such as newsletter and journal articles. While therapists are not required to follow the recommendations or guidelines in such publications, they are expected to be aware of them and, when appropriate, consider them in their clinical and ethical decision-making. Some recent examples of such concerns involve the validity of and clinical approach to, repressed memories and dual relationships.

The standard of care is a particularly difficult issue in psychotherapy, as there are hundreds of different orientations and approaches to treatment (Lambert, 1991). Each is based on a different theoretical orientation, a different methodology, philosophy, belief system and even worldview. Beyond the agreements of do not harm, and do not have sex with current clients, and always respect clients' dignity, autonomy and privacy, there is no consensus on how to intervene, help or heal. For example there is no one standard, or method or way for the treatment of anxiety. Psychoanalysis, cognitive-behavioral, existential, biologically based psychiatry, Gestalt and pastoral counseling all define, explain and treat the anxiety in very different terms. Not one of them will follow the others' standards.

An additional complexity of this part of the standard is what has been called "respected minority." This doctrine may apply if the scientific or research support of the technique is not well established (Reid, 1998). An example is the employment of psychoanalytic or existential psychotherapy for major depression. While there is a lot of research to support a biological intervention, there is also a substantial body of knowledge that provides a theoretical framework for analytic or existential treatment of major depression. Prudent practitioners can apply psychoanalytic or existential treatment for major depression without falling beneath the standard of care. However, in an ideal world the practitioners' clinical notes would indicate that they are aware of and considered the treatment option of psychotropics.

As a result of the multitude of legitimate, established and highly diverse therapeutic orientations in the field of psychotherapy, most experts agree that when it comes to the standard of care, majority should not rule and diversity should be upheld.

6. Consensus in the community: The standard of care is also bound by community norms. Consequently, different communities, which abide by different cultural customs and values, have different standards. Gifts, touch and attending ceremonies and rituals are normal and expected in Hispanic, Jewish or American Indian communities (Lazarus & Zur, 2002; Zur, 2001). Bartering and social dual relationships between therapists and clients are an unavoidable part of rural living (Zur, 2004). Complex dual relationships between therapists and clients are inherent, and, in fact, mandated by law, in the military (Zur & Gonzalez, 2002). However, dual relationships are not as common in highly populated metropolitan areas and large cities as they are in rural areas. As will be discussed below, this important part of the standard of care, which is based on community standards, has often been erroneously ignored and dismissed by experts, boards and courts.

The standard of care has often been viewed in inaccurate ways. Following is a non-exhaustive list of what the standard of care is not.

- It is not a standard of perfection. It is the standard based on the average practitioner and on reasonable actions.
- It is not guided by risk management principles.
- It does not follow psychoanalytic or any other particular theoretical orientation.
- The standard is not determined by outcome.
- It is not determined by cost.
- The standard is not permanent or fixed.

The proliferation of risk management practices, regrettably, is also likely to influence the standard of care. Following is a borrowed example from gynecology, where there is a requirement that a woman chaperone be present during a pelvic exam. Williams (2003) describes how the chaperone's primary role is to protect the physician from false accusation, criminal complaint or lawsuit. Before chaperoning became part of the standard of care, some women preferred not to have such a witness, especially if they had a long, trusting relationship with their physician or if the physician was a woman. However, today, not having a witness is considered practicing below the standard of care. This kind of trend is likely to lead psychotherapy towards an extremely narrowly defined standard of care, which will tie the hands of most practitioners who are not wedded to analytic or risk management practices. Lazarus reflects on this trend. "One of the worst professional or ethical violations is that of permitting current risk-management principles to take precedence over human interventions" (1994, p. 260).

One of the most disturbing developments in regard to the standard of care has been its increased susceptibility to influences from insurance companies and litigating attorneys. As with the example from gynecology above, we see slow but steady influences of risk management practices on the standard of care. Because there is no single text that articulates an agreed upon standard of care, the standard is primarily determined in courts and licensing board hearings by testimonies of expert witnesses. Attorneys on both sides often present conflicting expert testimonies about the standard of care. Hired by the boards or the plaintiffs' attorneys, many experts apply narrow analytic principles, limited ethical codes and rigid risk management principles to determine what actions fall below the standard of care. As a result, many legitimate clinical, ethical and legal behaviors, such as touch, gifts, bartering, extended length of session, and pro bono services, often fall below the standard of care according to these experts. Therapists who barter with clients who are poor, make home visits to those who are homebound or employ the behavioral intervention of flooding with an agoraphobic patient by leaving the office have being unjustly accused of operating below the standard of care (Lazarus, 1994; Williams, 1997, Zur, 2001, 2004).

The danger is not only for therapists who are unjustly judged by the risk management yardstick, but in fact, for the entire profession. As therapists are being frightened by risk management experts, attorneys and insurance companies into avoiding touch, bartering, home visits, gifts, non-sexual dual relationships and other boundary crossings there is an increased chance that a new standard of care may develop. As more and more practitioners, especially young ones, practice risk management, there is increased risk that it will become the standard of care (Lazarus, 1994; Williams, 2003; Zur, 2017).

In summary, the standard of care has been defined by some as the usual and customary professional standard practice in the community. There is no one textbook or set of rules that define the standard of care and some suggest it is nothing more than a perception. One of the biggest problems with risk management practices is that they have often been confused with the standard of care. Attorneys and expert witness often treat the two as the same. As a result, prudent and competent therapists who adhere to professional principles, follow the precepts of their orientation and community standards but do not follow strict analytic guidelines or fear-based risk management practices, are unjustly accused of practicing below the standard of care.

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Tort – Elements of Malpractice

Tort is a private or civil wrong. It is harm done to an individual in such a manner that the law can order the person who does the harm to pay damages to the injured party. When clients believe their therapists have committed a tort, they have several options for handling their grievance. Clients, who feel they were wronged by their therapists may, informally, confront the therapists or seek mediation or some form of arbitration. They may also file a complaint with the therapist's licensing board where administrative or criminal action might be taken. They may file a report or complaint with a law enforcement agency that may possibly result in criminal charges being filed. They can also bring suit in civil court for damages. In tort liability litigation, the accused therapist is held to the reasonable standard in which liability is assessed with regard to the circumstances surrounding the alleged act and the standard of care that would reasonably be expected of another professional with similar education, training and experience in a similar situation. To defend against liability, therapists must show that their behavior was not only professional but also consistent with accepted standards of care and practice for the profession.

There are four basic elements that must be fulfilled in order to win a civil malpractice suit: a) a professional relationship must exist (i.e. therapist-client relationship), which establishes the therapist's duty of care; b) there must be a demonstrable standard of care and an illustration that the practitioner breached this standard or operated below this standard; c) the client must demonstrate that s/he was harmed or injured; and, d. the client must demonstrate that the breach of the standard of care caused the alleged injury.

Risk management is primarily geared to avert problems or risks such as those described above. It is aimed to either prevent clients from assessing that they have been wronged in the first place or provide a pre-emptive defense in the event of administrative, civil or criminal proceedings.

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Laws And Risk Management With Emphasis On California Law

The importance of differentiating between what are the laws – including established case laws – and what are risk management recommendations cannot be underscored enough. Regretfully, the legal management and risk management of psychotherapy practices have been blended and confused.

Beside criminal and other laws under which all citizens are governed, mental health professionals are regulated by civil laws that define malpractice, and by three other laws: (1) Statutes, such as the Elder or Child Abuse Reporting Law. Obviously, the statute or the law must be followed according to the provisions of each state. (See below for California laws and regulations.). A therapist who does not conform to the law is clearly operating below the standard of care. (2) Case Law: The most famous one, probably in the entire country is the 1976 California Supreme Court case of Tarasoff v. Regents of the University of California. This case articulated the duty to warn of a patient’s threat to harm a third party. Other states have split over whether they will impose such a duty on mental health professionals. And, (3) Administrative Law and licensing board regulations: In several states, such as California (see details below), there are extensive regulations, which govern numerous aspects of psychotherapy practice. This may include rules about how one may qualify for a professional license, what defines the license, scope of practice, rules about supervision, continuing education, etc. (Caudill (2004)).

In general it is important to understand that risk management is not part of any state or federal statue. While some states may mandate continuing education courses in certain areas, risk management is not one of them.

Following is additional information for California Psychologists, MFTs and Social Workers on California Regulations of the Practice of Psychotherapy and Counseling.

The concept of risk management is not part of any California law or statue. While there are clear requirements for courses on law and ethics, these requirements should not be confused with the teaching of risk management.

Law And Ethics CE Requirements In California:

[BOP 2013 Continuing Education Changes FAQs](#) states:

Law & Ethics requirement

Under the current regulations, there is no hour requirement or certificate required for Laws & Ethics. Licensees must check a box self-certifying that they have kept abreast of changes to laws (statutes and regulations) and ethics. There is no specified method regarding how the information must be obtained. Licensees can take a continuing education course, review Web sites, participate in grand rounds, etc.

Business And Professional Code Of California:

The parts of California law most relevant to the practice of psychotherapy and counseling are in the following sections of *Business and Professional Code of California*:

- Psychologists: Chapter 6.6.
- MFTs are located in Division 2. (Healing Arts), Chapter 13, Article 1-7, Sections 4980 through 4989.
- LEPs are located in Division 2, Chapter 13, Article 5, Section 4986 – 4987.
- LCSWs are located in Division 2, Chapter 14, Articles 1-4, Sections 4990 – 4998.7.

For Regulations Online:

- [Psychologists’ regulations](#)
- [Board of Behavioral Sciences Licensing Laws and Regulations](#)

Brochures By California Department Of Consumer Affairs:

In addition to the above legal regulations the California Department of Consumer Affairs has produced a couple of important brochures geared to the public and consumers of psychotherapy and counseling services. Following are links to these brochures online.

- [Professional Therapy Never Includes Sex](#)
- [For Your Peace of Mind: A consumer guide to psychological services](#) (Published by the California BOP)

Additional Online Resources:

- [BOP-CA home page](#)
- [BBS- CA Home page](#)

Brochures By California Department Of Consumer Affairs:

Professional Therapy Never Include Sex States That According To California Laws:

Any kind of sexual contact, asking for sexual contact, or sexual misconduct by a therapist with a patient is illegal, as well as unethical, as set forth in Business and Professions Code sections 726, 729, 2960(o), 4982(k) and 4992.3(k). “Sexual contact” means the touching of an intimate part of another person, including sexual intercourse (p. 7).

Sexual contact can include sexual intercourse, sodomy, oral copulation, fondling and any other kind of sexual touching. Sexual misconduct also covers a broader range of activity, including nudity, kissing, spanking, verbal suggestions, innuendoes or advances. This kind of sexual behavior by a therapist with a patient is sexual exploitation. It is unethical, unprofessional and illegal (p. 7)

Sexual exploitation of patients by therapists is wrong. The law makes it a crime for a therapist to have sexual contact with a patient. For a first offense with only one victim, an offender would probably be charged with a misdemeanor. For this charge, the penalty may be a sentence of up to one year in county jail, or up to \$1,000 in fines, or both. Second and following offenses, or offenses with more than one victim, may be misdemeanors or felonies. The penalty in such felony cases can be up to three years in prison, or up to \$10,000 in fines, or both.

Examples Of Mandated Reporting In California:

- The California Penal Code, Sections 11164-11166, requires that mandated reporters, such as psychotherapists, make a report of child abuse whenever a “reasonable suspicion” of child abuse exists. A child abuse report is mandated whenever a therapist learns about the abuse in his or her professional capacity.
- Sections 15610, 15630-15634 of the California Welfare and Institution Code require reporting of physical abuse, abandonment, isolation, financial abuse, or neglect of any elder or dependent adult under certain circumstances. A report is required if the therapist observes or has knowledge of the abuse, or the patient reveals information about being abused.
- Types of child abuse: physical abuse, sexual abuse, neglect, willful cruelty, unjustifiable punishment, and unlawful, corporal punishment and injury.
- California Civil Code 43.92 clarifies the Tarasoff Statute and states, with regard to the duty to warn “where the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.” In these situations, the psychotherapist’s duty is to make a “reasonable effort to communicate the threat to the victim or victims and to a law enforcement agency.”
- Important New Ruling regarding Tarasoff Mandated Reporting: In July 2004 California Court Extends Tarasoff Mandated Reporting Standard. *Ewing v. Goldstein* is a recent California appeals court decision that extended the interpretation of the Tarasoff warning law. The court expanded the definition of Civil Code § 43.92 to “**include family members** as persons covered within the statute who, upon communication to a therapist of a serious threat of physical violence against a reasonably identifiable victim, would trigger a duty to warn.” The court states in *Goldstein*: “The intent of the statute is clear. A therapist has a duty to warn if, and only if, the threat which the therapist has learned – whether from the patient **or a family member** – actually leads him or her to believe the patient poses a risk of grave bodily injury to another

person.” The expanded duty from now on applies to credible threats received from the patient, or the patient’s family, however, the court made clear that its decision did not go beyond “family members.”

For additional information regarding California law:

- [California law-Imposed Dual Relationships](#)
- [California law on bartering](#)

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Practice Guidelines

Practice guidelines are guidelines that are put out by professional organizations, such as American Psychological Association or American Psychiatric Association. These are different than the, legally binding, guidelines that are put out by state licensing boards or state departments of consumer affairs. Some states have adopted some of the professional associations’ guidelines the way they have adopted the professional associations’ codes of ethics. General guidelines that have been put out by recognized professional organizations are one of the components that determined the standard of care.

Following are examples of often referred to professional association guidelines:

- [Guidelines for Psychological Evaluations in Child Protection Matter by American Psychological Association](#)
- [American Academy of Psychiatry & the Law Ethical Guidelines for the Practice of Forensic Psychiatry](#)
- [Specialty Guidelines for Forensic Psychologists by American Psychological Association](#)
- [Record Keeping Guidelines by American Psychological Association Guidelines for Child Custody Evaluations in Divorce Proceedings, by American Psychological Association](#)

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How Risky Is The Risk?

A number of reports over the years have all documented clearly that the actual likelihood of a licensing complaint or lawsuit for psychotherapists is very low (Kirkland & Kirkland, 2001; Williams, 2000, 2003). Van Horn (2004) reports that between 1996 and 2001 less than 2% of psychologists faced any consumer licensing complaints. The percentage is probably much lower because the 2% reflects multiple complaints against the same individual psychologists and discipline by different states of the same psychologists. 40% of the (less than) 2% of complaints are not even investigated by the boards and are simply dismissed. Of the remaining ones that are actually investigated, about 30% are concluded with determination of no violations. Of those remaining in which a violation is established, 16% are not reported to the data pool of the Association of State and Provincial Psychology Boards Disciplinary Data System (DDS). In summary, less than 0.4% of psychologists will face any reportable action by licensing boards.

The percentage of complaints against counselors and social workers is likely to be even lower if their rate of malpractice insurance is any indication. Traditionally, counselors and social workers have paid lower insurance premiums than psychologists for the obvious reason that they are less likely to be sued and less likely to be much of a liability to insurance companies. For example, a standard insurance policy with a limit of 1M/3M is offered to psychologists by the American Professional Agency Insurance for \$958/year and to counselors for only \$358/year (see example at: <http://americanprofessional.com>). The number of civil lawsuits against therapists is likely to be even lower than the 4 therapists in 1,000 because plaintiffs often pursue a civil law suit only after they get a favorable judgment in a licensing board hearing.

Such proceedings, as rare as they are, can be very costly and traumatizing. Williams (2000), in his excellent article, “Victimized by victims”, and many others, such as Adams (2001), Van Horn (2004) and Lazarus and Zur (2002), describe the pain and suffering that therapists go through while dealing with civil, administrative and criminal proceedings. Even when therapists “win” their cases, the anxiety, shame and fear may have cost them heavily. Additionally, some of the few cases that are successfully prosecuted or enforced may result in a seven-figure judgment and/or a shameful write-up about the therapist’s unprofessional behavior and loss of license in local and professional newsletters.

In summary, the likelihood of discipline by licensing boards’ and/or patients’ lawsuits is minimal. Research, surveys and relatively very low malpractice insurance premiums support this fact. However, the emotional, professional and financial cost of these rare events when they take place can be very high.

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If The Risk Is Low, Why Is The Fear So High?

Once the fact that therapists are at very low risk for licensing disciplinary actions or lawsuits has been documented, the obvious question becomes why fear-driven risk management practices are so prevalent? The answer to that lies in our extensive clinical understanding of phobias (Williams, 2004). For example, patients who are afraid to drive base their fear on the fact that driving accidents occur and they can be devastating. Similarly, patients who are phobic about germs and wash their hands obsessively base their fear on the fact that infection takes place sometimes. Phobic reactions are obviously exaggerated fearful responses to rare occurrences. People who are phobic about driving, like may phobic patients, simply avoid any behavior that may trigger their fear. People who are germ phobic engage in ritualistic, compulsive behavior that supposedly averts the threat.

Williams (2003) further explains therapists’ phobic response:

As I have discussed elsewhere (Williams, 2000), the actual likelihood of a lawsuit or licensing complaint for any given practitioner is very low. Because these high cost events are unlikely ever to occur in a given practitioner’s career, the stage is set for psychotherapists to engage in various superstitious behaviors. Hence, the therapist who curtails hugging his or her patients, for example, may well believe that this risk management decision will have prevented a lawsuit over the course of his or her career. In fact, that psychotherapist may never have been sued regardless of whether or not risk management changes were made to his or her practice. Many psychotherapists who currently believe that they are protecting themselves with risk management restrictions to their practices may be doing nothing more effective than throwing salt over their shoulders. Because the likelihood of a suit is so low, and because the risk management rhetoric is so prevalent these days, one may be too easily convinced that risk management is highly effective. Risk management behavior, like all phobic avoidance behavior, becomes its own reward-convincing the phobic individual that the avoidant behavior (e.g., the flight phobic individual’s not getting on the airplane) has averted catastrophe. (p. 202)

When it comes to psychotherapy, Williams’ (2003) “superstitious behaviors” and avoidance include touch, bartering, gifts, home visits, self-disclosure, lengthy sessions, out-of-office experiences and dual relationships. Like the phobic person who fears that avoiding flying would avert a catastrophe, therapists rigidly avoid touching clients or bartering with them to avert a feared catastrophic board investigation or a lawsuit. Obviously, the fear-based, slippery slope myth, described above, goes hand in hand with the phobic risk management approach.

The second reason why the fear is high even though the risk is low has to do with the insurance companies paying the rare, but often expensive, jury lawsuit judgments. While such judgments are indeed very uncommon, they, nevertheless, can easily reach a seven-digit figure. Understandably, the insurance companies’ objective is to reduce the risk as much as possible because even one large settlement or judgment can hurt their bottom line. As a result, they have heavily promoted risk management education and practices. They have been offering reduced rates of 5% to 15% (i.e. APA Insurance Trust (APAIT) and the American Professional Agency) for therapists who have completed a risk management continuing education workshop. Additionally, they have been sponsoring risk management articles and newsletters, written primarily by attorneys, advising therapists of ways to reduce risk.

The third reason for the exaggerated fear, as articulated earlier in the paper, stems from the self- serving fear campaign by many personal injury attorneys who, as part of a more general litigious culture, make their living from pursuing lawsuits and obtaining financial rewards for patients in civil malpractice suits.

In summary, psychotherapists clinical understanding of phobic responses explains their phobic response to the rare but potentially costly possibility of a lawsuit or discipline by a licensing board. As often happens with paranoid people, their worst fears come true due to their obsessive fear and ritualistic or superstitious behaviors. As a result, in the very attempt to avoid law suits and boards’ disciplinary action, we are likely to see an increase in such litigation. Meanwhile, clinical integrity is deteriorating and moral and ethical reasoning is being replaced by paranoid thinking. Thus, some clients receive substandard care and too many therapists live with avoidance behaviors and fear rather than with joy and creativity in the art of healing.

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Where Are The Real Risks?

Even unreasonable fears often have an element of truth. Although the chance of being sued or have a licensing board complaint launched against therapists is negligible, nevertheless, psychotherapists do face some risks in their line of work. The types of risks have changed over the years in conjunction with the cultural forces that surround the practice of psychotherapy. In the 1990's, the patients with repressed memory syndrome seemed to present certain risks for therapists. Therapists had the (still very low) risk of either being accused of ignoring signs of childhood molestation or of implanting such memories by suggestions. More recently, concerns with child custody have accounted for more than half of licensing boards complaints. Some states report, in 2004, that about 80% of all licensing boards complaints stem from child custody evaluations (Brandshaw, 2004).

Some risky situations have been more constant over the years. Concerns with therapist-client sexual relationships have always been a major concern from a risk management point of view and so were therapist-client exploitative business relationships. Borderline Personality Disorder, depressed, homicidal and suicidal clients have also always been considered to pose a high risk. Welch, the attorney for the American Professional Agency stated "You are as close as your next borderline to the end of your career" (In Adams, 2001, p.11),

Numerous surveys, board reports and articles have listed the most important risk management practices (i.e. Pope & Vetter, 1992). The most frequently cited concerns are sexual, social, business and forensic dual relationships (i.e., providing therapy and conducting custody evaluation) confidentiality, record keeping, boundary issues (such as touch, self-disclosure and gifts), informed consents, clients' autonomy, scope of practice, billing and invoices, diagnosis, terminations and supervision and other vicarious liabilities. Similarly, working with clients who are dangerous to themselves or others, borderline, narcissistic and paranoid personalities, impulsive, litigious (meaning clients who have a long history of law suits against others or expect to use therapy in ongoing or pending litigation) and drug abusing clients. Cases involving child custody and domestic violence have also topped the list of risk management concerns (Adams, 2001; Smith, 2003a, b).

Since insurance companies no longer pay damages for sexual contacts with clients, many law suits have shifted to accusations other than sexual contact even when there were sexual relationships (Adams, 2001, Williams, 2000). Instead of claiming sexual misconduct, lawyers have been accusing therapists of causing harm in other ways, such as self-disclosure or social dual relationships or misdiagnosis.

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Risk Management May Increase The Risk Of Misconduct Rather Than Decrease It

Paradoxically, the mandate to adhere to 'only in the office' policy tends to increase the probability of boundary violation and exploitation of clients rather than to decrease it. In the isolation of the office, therapists have much more perceived power, which actually puts clients at greater risk. A therapist's power is increased in isolation because clients tend to idealize and idolize them. While privacy is often an important component in increasing psychotherapeutic effectiveness, it can also be a double-edged sword when it is used as an excuse for isolation. Most instances of exploitation occur in isolation, including spousal and child abuse (Walker, 1994). Sexual exploitation is less likely to occur if the therapist is also working with the client's spouse, friend and parent or has another community connection with the client, either directly or through the client's family and friends. Therapists are less inclined to exploit those with whom they have a long-term or significant relationship outside of therapy (Tomm, 1993). Contrary to the risk management assertion, dual relationships and familiarity with clients tend to reduce the probability of exploitation and risk rather than increase it. The power differential in a more egalitarian relationship becomes attenuated so that the client is more likely to forestall any improprieties that may arise. As concluded in studies of cults, exploitation flourishes in isolation (Singer & Lalich, 1995). Those who vigorously propound the "only in the office" policy and the isolation it imposes on the therapeutic encounter are more likely to foster exploitation and sexual misconduct (Zur, 2000a, 2001b). When implemented with care and integrity, dual relationships with clients and the familiarity that follows are more likely to curb exploitation and harm than encourage them.

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Risk Management May be More Costly to Insurance Companies

As more and more risk management practices infiltrate the profession and become more common, the standard of care is changing accordingly. As a result, more therapists' behaviors are looked upon suspiciously. Longer sessions, lower fees, lack of charging, missed invoices or scheduling a patient for the last session of the day are suddenly appearing on the risk

management “red flag” list. They are slowly added to the list of “usual suspects,” such as self-disclosure, gifts, bartering, non-sexual touch, out-of-office experience and, of course, dual relationship. Along with the paranoid concept of the slippery slope (Pope, 1991 ; Strasburger, et al, 1992), these behaviors are often viewed as some type of boundary violation and precursors of harming sexual relationships. There are attorneys who find so-called experts to testify that these kinds of behaviors are below the standard of care resulting in favorable rulings for litigating clients and greedy lawyers.

As the bar is raised and more interventions seem frowned upon by the boards, courts and attorneys, there is an increased likelihood that insurance companies and therapists will be sued or sanctioned (Fleer, 1999; Williams, 2003). Risk management, without any doubt, has come to haunt the insurance companies – an unforeseen retribution for their shortsighted, cost-saving strategies.

Williams (2003) explains further:

For example, there is nothing about unbilled sessions that goes below the standard of care. Therapists are presumably free to develop any billing style they wish, including providing pro bono services, or being sloppy about billing and forgetting to bill, or being sloppy about time and billing for hour-long sessions that actually lasted two-hours. It has been good risk management advice to counsel therapists to carefully bill for all time and neither to under bill nor over bill. This risk management advice is designed to prevent claims of unduly close, personal relationships between therapist and patient. In other words, if the therapist failed to bill for some number of sessions, and if there were to be a later claim of an unethical multiple relationship, e.g., professional and personal, the lack of billing could be used to support the claim that the therapist envisioned the relationship with the patient to be a personal one, or an unhealthy blend of the personal and professional.

Careful billing would preclude this particular allegation against a therapist. The therapist could document that each and every contact was billed and that the line was never crossed between the professional and the personal. Over time, the idea of carefully billing for all clinical time has gradually evolved from a risk management recommendation to what some experts would put forth as a new standard of care. Nowadays, it would not be surprising to hear expert testimony that failure to carefully bill for services constituted negligence in and of itself-with no reference made to the issue of multiple relationships (p. 204).

As more and more behaviors are added to the list of forbidden practices and the bar climbs, more standard interventions start falling below the evolving-mythical standard of care. This is the standard of care that is driven by litigation, attorneys, expert witnesses, ethics committees, court rulings and licensing boards’ decisions. Paradoxically, as the bar gets higher and more behaviors are sanctioned and the standard of care becomes stricter, more therapists are likely to be sanctioned and sued. As a result, in the long run, insurance companies are likely to pay more rather than less. This is truly ironic.

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Towards Ethical Risk Management

Risk management in itself is merely a set of precautions advocated by malpractice insurance vendors, ‘risk management experts’ and attorneys, to minimize the chances of being sued or face administrative or criminal liabilities. Practitioners attempt to reduce their risks by conducting risk assessment, risk analysis and devising ways to reduce and control risk. While such management of risk is reasonable, it is of the utmost importance to separate it from legal, ethical and above all, clinical considerations ensuring that they are never equated. Likewise, it is just as important to differentiate risk management guidelines from the standard of care (Zur, 2007a, 2017).

The fear campaign by various insurance carriers, attorneys, ethicists and “risk management experts ” has too often succeeded in paralyzing therapists and forcing them to restrict their clinical interventions to rigid and constipated ways of relating to clients and to a narrowly circumscribed set of supposedly legally foolproof interventions. As a result, clinical effectiveness is often compromised. The danger that risk management poses to clinical effectiveness can be clearly seen in its injunction against touch or self-disclosure, which obviously has a significant negative effect on therapeutic alliance, the number one predictor of effective therapy. I cannot think of any more effective way to enhance therapeutic alliance then a reassuring or comforting hug or pat or appropriate and equally comforting self-disclosure on the part of the therapist. Therapists have increased the sense of connection and therapeutic alliance by accepting a client’s invitation to a stage play in which he had a major part, viewing a house that a client had designed, and bartering with an client who was simply short of funds. Additionally, in order to increase clinical effectiveness, therapists have reported playing tennis or other athletic activities with teenagers who would not open up in the office but did so in the more informal sports setting; taking depressed clients on pleasant walks

in nature and accompanying a schizophrenic client on a first job interview. Similarly, I obliged several Jewish and Christian clients by bringing back some rocks from Jerusalem and water from the Jordan River. All of this may not follow 'risk management' guidelines, but it is basic good therapy.

Good therapy carried out by a competent and ethical practitioner is likely to result in the highest form of risk management. This kind of risk management is motivated neither by fear of boards and ethics committees nor by attorneys' advice. It is based on solid therapeutic philosophy or clinical orientation; when possible, it relies on outcome research; it follows the code of ethics and the standard of care; it includes good records and a clearly articulated treatment plan that is based on the client's problem, personality, history, culture, gender, etc. When necessary, it includes consultations with experts and above all it puts the clients' welfare foremost in determining the course of treatment.

One of the questions that obviously arises is, 'What is the future of risk management and where is our profession heading?' At this point in time, the culture of litigation and entitlement, fueled by personal injury attorneys and enabled by the legal system, is not about to change. The hope and is that graduate and post graduate education and especially ethics instructors will learn to separate risk management from legal, ethical and clinical teaching. It is equally important that critical thinking replace the stultifying list of prohibitions and that moral precepts will replace paranoid thinking.

One of very few encouraging developments that took place was the American Psychological Association's 2010 code of ethics. It defined the previously ambiguous word "reasonable" in the code to mean the "...prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge the psychologist had or should have had at the time." The importance of this section is that it can reduce the injustice that therapists have endured at the hands of the licensing boards and courts that rely on experts who, when testifying, equate risk management practices and analytic theory with the standard of care. *The hope is that this new APA code establishes that it unethical for an expert to judge rural therapists who inevitably socialize with their clients, behavioral therapists who fly with clients suffering from fear of flying, humanistic psychologists who hug their clients, or therapists who make home visits, by using the analytic or risk management yardstick.* These therapists, according to the new code, must be judged by standards and practices that are commonly applied by therapists with similar orientations, working in comparable types of communities.

Risk management is a controversial topic in the culture at large and in psychotherapy, as well. Beyond some basic violent and sexual behaviors, there is no agreement among theoretical orientations as to what constitutes proper care, harm or damage. The lack of agreement results in deep divisions among psychotherapists regarding what constitutes the standard of care vis-a-vis clinical or other risks, and, therefore, what constitutes risk management. The revival of the concept of risk management in the last couple of decades has been linked to the emerging litigious American culture. While on the face of it, managing any risk would seem reasonable and important, the recent wave of risk management teaching and practices have propelled the profession in the direction of fear-based interventions that often compromise clinical integrity.

Risk managed practices may sound as if they adhere to practical or pragmatic advice but in fact most of the time it is a misnomer for a practice in which fear of attorneys and boards, rather than intelligent clinical considerations, determine the course of therapy. As therapists, we are trained, hired and paid to provide the best care possible for clients. We are not paid to act defensively. This fear of board investigations and malpractice lawsuits pushes therapists to take protective measures. Consequently, we lower the quality of care for our clients.

Arnold Lazarus (1994) appropriately view modern risk management practices as one of the worst professional or ethical violations. Clinical interventions must be determined by empirically-based treatment plans, clinicians' intuitive and creative sensitivities, and specific client factors, such as the client's problems, situation, personality, degree of functionality, history, and culture — never by fear of boards and courts. We would do well to remember, as I have stressed, that the odds of being sued or disciplined are extremely low but, in any case, this should not be a factor. Clinically sound and clearly articulated treatment trajectories, combined with clinical records and consultations, provide a more ethical and moral way of managing risk without losing professional integrity.

In order to fulfill our professional, ethical and moral obligations to our clients, we must escape the anxiety and fear imposed by risk management experts, licensing boards and attorneys who often have very little clinical understanding. Instead, we need to arm ourselves by learning about psychotherapy outcome research, the codes of ethics and state laws; to elevate our effectiveness by keeping good records, consulting, when necessary, with experts, stimulating our creativity, increasing our capacity to be intimate with our clients and employing the principles of critical thinking when making clinical and ethical decisions. Let us remember that we became therapists because we were motivated by an unabashedly idealistic desire to help, care and act with integrity. When we reconnect with that original, courageous inspiration, we will be able to truly serve our clients well and fully realize the potential of our vocation.

Guidelines for Ethical Risk Management

- Always do whatever it takes to help clients while insuring that you do no harm to them in the process.
- Never exploit a client. Place the client's interest above your own and avoid situations where there are conflicts of interest.
- Always show respect for your clients, taking care never to humiliate them or assail their dignity.
- Place clients' welfare above your fear of boards, courts, ethics committees and attorneys. Putting your fear above clinical effectiveness is immoral, unethical and may be illegal.
- Remember – you are not paid to practice defensive medicine or risk management. Your duty is to help clients with the concerns and problems they are paying you to remedy.
- Intervene with your clients according to their problems, concerns, needs, gender, personality, situation, venue, environment and culture.
- Provide a safe and trusting place for healing and growth. Cold, distant, disconnected and punitive relationships do not promote healing and are likely to harm clients.
- Protect and respect the clients' privacy and confidentiality unless by doing so you would fail to safeguard the client, community, society, etc., from harm or as required by the law.
- Intervene with your clients in a way that is most likely to be clinically effective. Do not intervene according to any graduate school professor or supervisor's dogma or even your own beloved theoretical orientation. In other words, different problems often require different clinical interventions. Technical eclecticism is often the most helpful approach.
- Be aware of the standard of care in your community. This is often referred to as the usual and customary professional standard practice in the community. It has been described as the qualities and conditions that prevail or should prevail in a particular mental health service. The standard of care is the standard that a reasonable and prudent practitioner follows and is based on community and professional standards.
- Adhere to the following different components or aspects of the standard of care:
 - Statutes, such as the child or elder abuse reporting laws.
 - Licensing boards' regulations, such as those on supervision.
 - Ethical principles of your professional associations or of the professional association that is most relevant to your practice and/or profession.
 - Case law, such as the duty to warn.
 - Consensus of the professionals and the community as often articulated in professional literature or continuing education workshops.
 - Official guidelines published by professional associations, such as guidelines for child custody, record keeping or forensic evaluations.
 - Professional literature regarding recent research findings, new theoretical developments, etc.
 - Professional standard practices within certain established theoretical orientations, such as psychoanalytic, humanistic or cognitive behavioral therapy.
- For each client, develop an individualized treatment plan which articulates:
 - Presenting problem or the problem(s) you are attending to.
 - The objectives of treatment. Developing short, intermediate and long-term goals may be beneficial in some cases.
 - The means employed to achieve these objectives and the theory, research or philosophy that guide you in choosing the intervention.
 - Ways to assess the effectiveness of the intervention.
 - Make sure to update the treatment plan, as necessary.
- Keep good records. Your records are extremely important from clinical, ethical, legal and risk management points of view. Make sure that your records include:
 - Informed consents and office policies.
 - Initial and updated treatment plans.
 - Records of consultations, tests, etc.
 - Releases or authorization to release information.
 - Important phone conversations, correspondence, emails and faxes to and from clients.
 - Details about termination, who initiated it and how was it was carried out.
 - HIPAA compliance when applicable.
 - Referrals to medication evaluations and other tests and evaluations, other mental health professionals, twelve step or drug and alcohol rehabilitation programs, physicians, dieticians, physical training, smoking cessation programs,

attorneys and other resources.

- Consult with experts and educated colleagues for their input and assistance in complex and unusual cases. Choose an expert in the area and topic of the consultation. Differentiate between clinical, ethical and legal concerns and choose your consultants accordingly. Document the consultation in your clinical notes. Of course, it is just as legitimate to seek risk management consultation, as well.
- There are several types of cases or situations that merit our special attention and higher level of cautiousness because historically they have presented challenges to therapists. Some of these types of cases are:
 - Child custody
 - Repressed memory
 - Domestic violence
 - Child abuse
- There are several types of clients and Dx that merit our special attention. Some of these are:
 - Borderline Personality
 - Repressed memory
 - Paranoid
 - Suicidal and homicidal
 - Antisocial
 - Drug and Alcohol addiction
 - Clients with a history of litigation
 - Multiple Personality and other dissociative disorders
- Never have sexual contact or sexual relationships with current clients.
- Be very careful and cautious before entering into sexual relationships with former clients. Seek ethical, clinical and legal advice before entering into such relationships.
- Handle clients' debts with sensitivity. Be very cautious before resorting to debt collection agencies as it may trigger clients' complaints to licensing boards.
- Practice within the limits of your expertise and within your scope of practice as determined by your education, supervised training and clinical experience.
- Work collaboratively with other health care providers or other professionals when appropriate.
- Respect and protect clients' confidentiality, privacy and autonomy unless by doing so you would fail to safeguard the client, community, society, etc., from harm or as required by the law. Obtain releases before releasing information.
- Terminate thoughtfully. Prepare for termination and offer referrals and follow-ups when appropriate. Document clearly: who initiated it, when, the nature of the discussion, and potential referrals. Summarize the whole treatment in the records: what was achieved, to what extent, what was not achieved according to the last treatment plan.
- If the client terminates abruptly against your clinical judgment: Send a polite letter expressing your concerns in a clinically appropriate and sensitive way. Offer to continue therapy or to refer the client to another therapist. Add that you will be willing to help with the transition to another therapist if the client requests it. (Of course, get a written release before you discuss the case with anyone.)
- Follow your state, professional and ethical rules and guidelines about supervision. Remember that you are responsible for the welfare of your supervisees' clients.
- Collect and document collateral information when appropriate.
- Prevent your own burnout by creating balance in your life. Such balance includes balance between professional work, familial, recreational, communal, political and/or spiritual activities.
- Be thoughtful with boundary crossing, such as home visits and other out-of-office experiences, gifts, bartering, touch, and self-disclosure. Document these interventions and, when appropriate, include them in the treatment plans and ground them in a theoretical orientation.
- Be thoughtful with dual relationships. While many forms of dual relationships are unavoidable, ethical and potentially helpful, therapy never involves sexual or exploitative business relationships. Document all dual relationships; include a statement on dual relationships in the office policies and the informed consent; and, consult on complex cases. Avoid dual relationships that, in your assessment, may result in a decrease in objectivity or clinical judgment.
- Pay attention to vicarious liability, such as renters or co-workers.

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