Fast Forward:
Advanced Topics in Ethical Practice

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Topical Agenda

- Your cases!
- Cyber Ethical Challenges in Mental Health Practice
- Ethical Issues in Electronic Service Delivery
- Record Keeping
- Ethical Behavior in the Face of Social Safety Net Failures
- Ethical Challenges for Mental Health Practitioners in Health Care Systems
- Challenges of the EMR
- Ethical Issues in Psychological Assessment
- Discredited Mental Health Treatments & Tests

Your questions
When working with a couple who end up splitting up, how do you handle their requests to see you individually?

- How did you frame the original contract?
- Informed consent about mode of treatment prospects of treatment outcome?
- How can you best avoid any foreseeable harm?
  - What is the context of the treatment?
  - Infidelity, domestic violence, life issues
  - Will a child custody dispute follow?
  - How do hazards of treating one differ from hazards of treating both?
- Who made the request (first)?
- What are the parties relative needs?
- What other resources exist in the community?
- What information can/should you provide the couple before agreeing to individual work and who must agree (or who can veto)?

How much information should get shared when making a referral to another provider? The referral contact would be made prior to obtaining signed consents to release information.

- It depends on your relationship with the patient and what you know. In some cases you may have little information in other cases you may be referring someone you have treated for years.
- In general, make a referral by giving the provider a general description of the patient and issues (e.g. a 47 year old with an alcohol problem or a 32 year old woman with bulimia symptoms). Provide more data (if you have it) after getting a signed release. The patient may not follow through with the referral.
- HIPAA allows sharing PHI (personal health information) for necessary for TPO (treatment and payment operations) including consultation between providers regarding referrals.

Client loses health insurance and is unable to pay for sessions. I had (foolishly) agreed to provide pro-bono services for a time and then find out he is buying "stuff" (new TV, computer) but can’t pay his bills.

- Sex, death, and money – the three most challenging topics in psychotherapy because of transference/countertransference
- Contracting for payment
  - Usual and customary fees versus reduced fees
  - Think about how what you offer will affect your feelings about the client and bear on the course of treatment.
  - The importance of consistent policies and written notice
    - What are you offering?
    - For how long?
    - What circumstances might trigger changes?
    - Bringing up the issue
    - Avoiding accumulation of unrealistic client debt and client abandonment
Why is charging for supervision not a breach of ethics – it is seen as a dual relationship. In Ontario, Canada it is seen as unethical to charge for supervision.

- What is context?
  - Supervision versus consultation
  - Supervisor as employee of agency?
  - Trainee as employee of supervisor?
  - Private fee for service supervision?
    - What is the intended use of supervision (covering unlicensed practice, accumulating hours for licensing)?
    - Jurisdictional requirements and regional differences?
- The fundamental conflict of paying for supervision: will you be honest, direct, and rigorous in evaluation of the supervisee, if you’re counting on the income you earn from the supervisee?

What to do when
- an adolescent patient discloses that she is pregnant [or plans to engage in sexual activity]
- a minor who has come to you for counseling regarding alcohol and/or drug abuse (and the general question of what you choose to disclose to the parents of clients who are minors).
  - Consider your confidentiality obligations, the HIPAA warnings you provided, and any exceptions that may apply.
  - Consider any statutory obligations and emancipation or mature minor statutes.
  - Consider the vulnerabilities of the client and others.
    - Discuss it with the client and seek their engagement in resolving the issues.
    - Create a hierarchy of vulnerability and take appropriate steps consistent with any statutory obligations.

-a client who discloses that she has HIV-AIDS but is not willing to inform her partner(s) (partners whose names might--or might not--be known to the therapist)
  - The Tarasoff rulings set case law precedent. But, over the years as states have passed laws to address these issues, the precedent has been codified into law.
  - Twenty-seven states (including Vermont) impose a duty to breach psychotherapist-patient confidentiality and warn of potential violence against a third party
    - Peck v. Counseling Services of Addison County, 499 A.2d 422 (Vt. 1985)
      - John Peck set fire to his father’s barn and the Vermont Supreme Court ruled:
        "Thus, we hold that a mental health professional who knows or, based upon the standards of the mental health profession, should know that his or her patient poses a serious risk of danger to an identifiable victim has a duty to exercise reasonable care to protect him or her from that danger."
Vermont Law on HIV Notification

- Vermont law provides for disclosure of HIV status under specifically prescribed circumstances:
  - Court Ordered Disclosure: Under Vermont law, a court may order that an individual disclose HIV-related testing or counseling information if it finds that the person seeking the information has "demonstrated a compelling need for it that cannot be accommodated by other means."
  - HIV and AIDS Reporting for Epidemiological Tracking: All states require that numerous health conditions be reported to state health officials in order to assess trends in the epidemiology of diseases and develop effective prevention strategies. Vermont law requires that a broad range of health care providers, hospitals, and managed care organizations report a diagnosis of HIV infection or AIDS to the Department of Health.

Mandated Reporting Responsibilities

Vermont Statutes Online – Title 33, Chapter 49

- § 4913. Reporting child abuse and neglect; remedial action
  - (a) Any physician…., dentist, psychologist, pharmacist, any other health care provider, child care worker, school superintendent…., or member of the clergy who has reasonable cause to believe that any child has been abused or neglected shall report or cause a report to be made in accordance with the provisions of section 4914 of this title within 24 hours.
    - See clergy exemptions at: http://www.fep.state.vt.us/statutes/fullsection.cfm?Title=33&Chapter=049&Section=04913
Mandated reporting affords protections and well as obligations

- When done in good faith
- Protects against defamation claims (libel and slander)
- Protects against retaliation by employers
- Can trigger incremental services for vulnerable persons
- Does hearsay = reason to believe?
  - Mandated reporting versus testimony about allegedly abused patients

Mixed Messages and Ethical Safety

- Vermont statutes read “…reasonable cause to believe…”
- Vermont Department for Children & Families web site states “…once you suspect…”
- Some states specify knowledge in a professional capacity, but Vermont does not.
- Some states designate all citizens as mandated reporters, but Vermont does not.
- When in doubt, consult and document
  - Colleagues
  - Vermont Child Abuse Hotline: 1-800-649-5285

Vermont Statutes Online - Title 33, Chapter 69: Reports of abuse, neglect, and exploitation of vulnerable adults

- "Vulnerable adult" means any person 18 years of age or older who:
  - (A) is a resident of a facility required to be licensed under chapter 71 of this title;
  - (B) is a resident of a psychiatric hospital or a psychiatric unit of a hospital;
  - (C) has been receiving personal care services for more than one month from a home health agency certified by the Vermont department of health or from a person or organization that offers, provides, or arranges for personal care; or
Vermont Statutes Online - Title 33, Chapter 69 (continued):

- (D) regardless of residence or whether any type of service is received, is impaired due to brain damage, infirmities of aging, or a physical, mental, or developmental disability:
  - (i) that results in some impairment of the individual's ability to provide for his or her own care without assistance, including the provision of food, shelter, clothing, health care, supervision, or management of finances; or
  - (ii) because of the disability or infirmity, the individual has an impaired ability to protect himself or herself from abuse, neglect, or exploitation.

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**Ethical Issues in Training and Supervision**

- Design of Education and Training Programs
- Descriptions of Education and Training Programs
- Accuracy in Teaching
- Student Disclosure of Personal Information
- Mandatory Individual or Group Therapy
- Assessing Student and Supervisee Performance
- Sexual Relationships with Students and Supervisees

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**Ethical Focus on the More Vulnerable Party**

- Design of Education and Training Programs
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- Accuracy in Teaching
- Student Disclosure of Personal Information
- Mandatory Individual or Group Therapy
- Assessing Student and Supervisee Performance
- Sexual Relationships with Students and Supervisees
• Student Disclosure of Personal Information
  Do not require students or supervisees to disclose personal information in course- or program-related activities regarding sexual history, history of abuse and neglect, psychological treatment, and relationships with parents, peers, and spouses or significant others except if…
  • (1) the program or training facility has clearly identified this requirement in its admissions and program materials or
  • (2) the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training- or professionally related activities in a competent manner or posing a threat to the students or others.

• Mandatory Individual or Group Therapy
  (a) When individual or group therapy is a program or course requirement, those responsible for that program allow students in undergraduate and graduate programs the option of selecting such therapy from practitioners unaffiliated with the program.
  • (b) Faculty who are or are likely to be responsible for evaluating students’ academic performance do not themselves provide that therapy.

• Assessing Student and Supervisee Performance
  • Do it in a timely manner, focusing on appropriate data and criteria.

• Sexual Relationships with Students and Supervisees
  • Don’t do it.
Appropriate Foci of Clinical Supervision

- Monitoring
- Legal Responsibility
- Ethical Knowledge & Behavior
- Clinical Competence
- Personal Functioning

Monitoring & Legal Responsibility

- Responsibility for knowledge of cases assigned to supervisee:
  - What should you know and when?
- Degree of oversight required in each case:
  - Interaction of competence & case complexity
- Jurisdictional requirements:
  - Access, frequency, documentation
  - Vicarious liability and doctrine of respondeat superior
    (Latin for "let the master answer")

Ethical Knowledge & Behavior

- Knowledge and modeling of standards and behaviors
- Ethical acculturation as a developmental process
- Inviting discussion of complexities and alternatives
Clinical Competence

Flowing as traffic on a superhighway—Shifting lanes as the situation requires

- Ethical Knowledge
- Practice Skills
- Content domains
  - Assessment
  - Consultation
  - Psychotherapy

Personal Functioning

- Where does the boundary between fostering growth and unwarranted intrusion lie?
- To what extent can or should a supervisor reasonably inquire into the personal lives of supervisees?
- When should personal issues trigger requiring professional consultation or suspension of clinical work?

The Next Level - Mentoring

- The nuance between supervision and mentoring – characteristics of effective mentors include—practical and emotional intelligence, patience, caring, wit, emotionally health, competence...
- Essential functions: enhance learning the ropes, sponsorship, coaching, protection, and generally enhancing the protégé’s sense of competence.
- Obstacles occur at many levels (systemic, organizational, relational)

Issues in Group Supervision

- Supervising trainees in groups can provide for efficient supervision and group peer supervision can help experienced clinicians avoid feeling isolated and gain broader perspective on their cases.
- Inherent ethical hazards:
  - Excessive use of group supervision can reduce the individual attention each trainee gets, and may lead to inadequate supervisory oversight.
  - Depending of differential needs and case load sizes, the benefits of shared wisdom and peers support may be outweighed by feelings of relative neglect on the part of some trainees or by letting a weaker trainee fall off the supervisor’s radar screen.

More Issues in Group Supervision

- Group settings may also inhibit some disclosures by trainees, especially if they worry about criticism, embarrassment, or loss of esteem among their peers as a result of raising their concerns.
- Group supervision models may also generally reduce confidentiality assurances and alter legal privilege.
- Clients may also have a right to know about and withhold consent to having their cases discussed in such contexts, assuming that the data presented might enable the others in the supervision group to identify the client.

Letters of Reference

- The binary effect in letters of reference:
  - If the letter offers effusive praise, includes supportive data, and comes from a respected colleague it will likely have a positive effect on the candidate’s chances. On the other hand, faint praise can be damning and critical comments of any sort can tend to torpedo a candidate’s chances.
  - Although we may want to help advance our students’ and colleagues’ careers, we also owe a responsibility to the recipients of our letters not to lie or put clients at risk by endorsing unqualified or ethically challenged candidates.
Letters of Reference

• How to negotiate ethical reference letters writing without worrying about legal problems:
  • Supervisees: ask supervisors, before listing them as references, whether they feel comfortable in providing a "strong positive letter." If the supervisor balks or hesitates, the wise supervisee will look elsewhere.

Letters of Reference

• Most supervisors worry about avoiding defamation in written (libel) or oral (slander) forms. Defamation occurs when a person knowingly makes false statements causing harm to another (damages). The truth constitutes a defense against claims of defamation, but opinions vary widely across individuals.
  • When writing letters of reference or giving oral recommendations do not assume perpetual confidentiality. Anticipate that the candidate will at some point see your letter.
  • Make your comments honest, direct, and focused on behavioral indicators and objective evidence, avoiding opinion or innuendo.

Letters of Reference

• If supervisors don’t believe they can write a strong letter, discuss this problem with the candidate or just say, "No."
  • In situations where a supervisor’s experiences with the supervisee are mixed, one can draft a letter, show it to the supervisee, and ask whether they would like it sent.
  • If the former supervisee needs an official attestation of graduation, completion of a number of supervised hours, or you must write a letter in an official capacity (as a training director) attesting to a factual matter ("The candidate completed his Ph.D. degree requirements.") the letter can focus only on necessary facts. Providing such confirmation is not the same as writing a positive endorsement. One cannot ethically withhold confirmation of factual or legitimate accomplishments, simply because one had other concerns about a former supervisee.
Case Example: Confronting Racism in Supervision

- Paul, an African American psychology intern, with a white supervisor, has begun treating a seven year old boy of Irish-American heritage whose parents brought him to the clinic seeking treatment of school failure and enuresis. During the second session the boy sets up a row of toy soldiers and knocks them down one by one alternately shouting out, “bam,” “pow,” and “kill that n*****,” while making sidelong glances at Paul. Paul reported this to his supervisor at the next session, noting that he attempted to address the boy’s implicit anger, while ignoring the blatantly racist comments.

Case Example: The Deceptive Trainee

- One of her clients has relapsed and seemed certain to die within the next six months, but Amy’s fellowship will was to end in eight more weeks. The supervisor indicated he would take on the case as a transfer, and encouraged Amy to begin termination work. For the next several weeks Amy discussed the progress of termination in her weekly supervision sessions. After her departure from the training program, the supervisor went to visit the child who asked, “Where’s Amy?” The trainee had never told the child she was leaving and had fabricated her discussion about the termination process in her reporting to her supervisor and in her progress notes.
Case examples: The Harassing Supervisor

- Melissa - a young, petite, single intern approached the training director with concerns about the behavior of a testing supervisor, a married man, thirty years older, who had persistently asked personal questions about her social life and invited her on social outings. These events had occurred amid "joking" sexual innuendo within the first six weeks of the internship program.

Case Example: The Gift

- During the last week of internship a trainee has her last session with an eleven-year old Native American female and her mother. About ten minutes after the session began, the supervisor gets a call from the supervisee asking for an urgent consult. The supervisee rushes in:

  "I don’t know exactly what to do... Noa gave me a present — here it is — she says... and she and her mom shopped for it for months and saved their money to get it. It is a piece of turquoise in a setting — and she says it reminds her of how perfect our time together was, and makes sure you will always remember me! At first I was just going to accept it and thank her, because I think culturally, that would be the right thing. But then I started thinking about the value and the financial sacrifice... and what it would mean to them if I take it and what it would mean if I DON’T take it! So I don’t know what to do! I think they will be very upset if I don’t accept it, but I am feeling very uncomfortable accepting because it feels like it changes our relationship — and it is hurting them by costing do much."

For more information


Cyber Ethical Challenges in Mental Health Practice

Changing Terrain
- Service delivery via telemetry
- On an upward trajectory
- Record keeping
  - The rules and practices are evolving rapidly
- Access to information and the death of privacy
  - Messaging and communication
  - Privacy
  - Social Networking

Access to Information in the Internet and Social Media Age
Just a few sample options for data collection

- Anywho
- CriminalSearches
- DetectiveMagic
- Dexonline
- emma.mscr.org
- Facebook
- Familywatchdog
- Fundraise
- Google
- Guidestar
- Intelsis
- Netronline
- NSOPR.gov
- Peoplelookup
- Pip
- Searchsystems
- Spock
- Spokeo
- Switchboard
- Whitepages
- Whois
- Zabasearch
- Zoominfo

What about the ethics of searching?

- Your clients will search for information about you.
- What do your electronic footprints look like?
- How can you control them?
- What (if anything) does our ethics code have to say about using electronic media and search engines to check on clients?
- Not much.

Professional Web Sites:
When you control the message

- Access to Information
- Marketing your practice/products
- Directions to your office
- Downloads
- Access to Documentation
- Efficient communication
- Effective promotion of psychologist’s skills, experience, and competencies/specialties.
But beware...

- Site security
- Boundary issues
- Appropriate marketing
- Blogging challenges
- File transfer and e-mail confidentiality

Chapel Hill NC Herald Sun
Clients’ confidentiality inadvertently breached
October 2, 2012, By Gregory Childress

• CHAPEL HILL – As Monday’s go, Town Councilwoman Donna Bell didn’t have a good one. Over the weekend, Bell, a licensed clinical social worker, inadvertently attached confidential client information to an email message she forwarded that was intended for her council colleagues. The 51-page attachment also included a copy of Bell’s and her husband’s income tax returns for 2011.

• The message was sent to an email account for council members and Mayor Mark Kleinschmidt that is available for public viewing. Town Manager Roger Stancil quickly discovered Bell’s mistake Saturday, and he promptly called IT staffers to have it taken down. “We removed it when we realized it was a potential issue,” Stancil said.

But on Monday the email reappeared after a staffer unaware of the sensitive information in the email’s attachment, pulled it from a nonpublic folder and sent it to individual council members via an email list that also included the address for the public account. The email message remained available for public view until late Monday afternoon.

Practical Security Tips

• Have a strong password – at least 12 characters. Most eight-character passwords can be cracked in about two hours, but 2-character password that uses case changes, letters, numbers, and symbols takes so long to crack that hackers will likely move on to easier targets.

• Don’t use the same password everywhere.

• Change your passwords regularly.

• Do not place your password on a sticky note under your keyboard or in your top drawer or other obvious location.

• Change the defaults that came with your devices.

• Your laptop should be protected with whole-disk encryption – no exceptions.

• Thumb drives, are easy to lose, and should be encrypted.
Worst Passwords of 2012

- 1 password Unchanged
- 2 123456 Unchanged
- 3 12345678 Unchanged
- 4 abc123 Up 1
- 5 qwerty Down 1
- 6 monkey Unchanged
- 7 letmein Up 1
- 8 dragon Up 2
- 9 111111 Up 3
- 10 baseball Up 1
- 11 iloveyou Up 2
- 12 trustno1 Down 3
- 13 1234567 Down 6
- 14 sunshine Up 1
- 15 master Down 1
- 16 123123 Up 4
- 17 welcome New
- 18 shadow Up 1
- 19 ashley Down 3
- 20 football Up 5
- 21 jesus New
- 22 michael Up 2
- 23 ninja New
- 24 mustang New
- 25 password1 New

Interactive Information Access

- Facebook
- MySpace
- Twitter
- Personal/professional web sites

Social Networking Issues

The Ethics Code Differentiator: Professional vs. Private Conduct

“This Ethics Code applies only to psychologists’ activities that are part of their scientific, educational, or professional roles as psychologists … These activities shall be distinguished from the purely private conduct of psychologists, which is not within the purview of the Ethics Code.”
Understand the risks!

- Why are you doing it?
  - Clinical purposes
  - Administrative purposes
  - Marketing purposes
- But wait – it may not be confidential
  - Privilege may not apply
  - Client confidentiality may be compromised

Facebook, LinkedIn, Twitter, Google Voice, What’s Next?

- Security issues
- Retention of files
- Friends of friends boundary issues
- Fan?
- Harassment
- Stalking
- PHI
- Failure to terminate

Do you Need a Friending Policy

Sample policy per APAIT:

“I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.”
APAIT Suggestion on “Following” Policy

- "I publish a blog on my website and I post psychology news on Twitter. I have no expectation that you as a client will want to follow my blog or Twitter stream. However, if you use an easily recognizable name on Twitter and I happen to notice that you’ve followed me there, we may briefly discuss it and its potential impact on our working relationship.
- My primary concern is your privacy.”

More on Following

- “Note that I will not follow you back. I only follow other health professionals on Twitter and I do not follow current or former clients on blogs or Twitter. My reasoning is that I believe casual viewing of clients’ online content outside of the therapy hour can create confusion in regard to whether it’s being done as a part of your treatment or to satisfy my personal curiosity”

In July 2012 Vermont became the 14th state to require private-sector insurance companies to pay for telemedicine services.

Ethical Issues in Electronic Service Delivery
Service Delivery Trends

- At least 69% of all professional psychologists have provided services by phone.
- At least 75% have offered services to residents of a state other than where they hold a license.
- The Office for the Advancement of Telemedicine (HHS) has identified state license limitations as a major barrier to the development of telehealth services.
- Both nursing and medicine have plans to deal with interstate practice issues on a national basis.
- The China American Psychoanalytic Association (CAPA) has organized training programs involving seminars, supervision, and psychoanalysis via Skype.

A Word on Telepractice in Vermont

http://vtprofessionals.org/or/s/psychologists/telepractice.asp

- Supervision and New Rules
  - Professionals who provide service via the Internet or other electronic means should provide as much information as possible to individuals who access their services. At a minimum, the psychologist should prominently disclose:
    - Name and location of the psychologist
    - Type of license and jurisdiction where licensed
    - What the psychologist is licensed and trained to do
    - To whom the client may make a complaint and how
    - The limits and limitations of Internet practice/service delivery

Psychology’s Inter-jurisdictional Practice Has Lagged Behind

- ASPPB
  - Certificate of Professional Qualification
  - Inter-jurisdictional Practice Certificate
- APA
  - Revised model Licensing law
  - Funding for the joint task force on telehealth practice (APA, ASPPB, and APAIT) has been funded for a second year.
Ethical Considerations on Remotely Delivered Services

- **APA Ethics Committee Opinion:**
  - The APA has not chosen to address teletherapy directly in its ethics code and by this intentional omission has created no rules prohibiting such services.
  - The APA Ethics Committee has consistently stated a willingness to address complaints regarding such services on a case-by-case basis, while directing clinicians to apply the same standards used in "emerging areas in which generally recognized standards for preparatory training do not yet exist," by taking "reasonable steps to ensure the competence of their work and to protect patients, clients, students, research participants, and others from harm" (American Psychological Association, 2010, 2.01e).

Primary Ethical Issues in Remotely Delivered Services

- **The three C's:**
  - Consent
  - Competence
  - Confidentiality

Ethical Principles

- **2.01 Boundaries of Competence**
  - (a) psychologists provide services only within the boundaries of their competence
  - (c) Psychologists planning to provide services...involving techniques and technologies new to them undertake relevant education, training, supervised experience, consultation or study.
  - (e) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm.
Ethical Principles

3.10 (a) Informed Consent

When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code.

Section 4: Privacy & Confidentiality

4.01 Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium…

4.02 Psychologists discuss with persons…(1) the relevant limitations to confidentiality

Hazardous clients online or not

- Cluster B Personality Disorders (Borderline/Narcissistic)
- Dissociative Identity Disorder (DID/MPD)
- PTSD (complex)
- Patients who were abused as children or are in abusive relationships
- Potentially suicidal patients
- Potentially violent patients
- Patients involved in unrelated lawsuits
- Patients with recovered memories of abuse
Hazardous situations
- Potential multiple relationships
- Child custody related cases
- Third party evaluations
- Supervision
- Isolated, vulnerable or narcissistic therapists

An Extreme Example

Rapid Eye Institute
Salem, Oregon
- Ranae N. Johnson is the mother of 7 children and 22 grandchildren and 4 great grandchildren.

Education:
- American Pacific University, Honolulu, Hawaii
  - Ph.D. (Doctor of Philosophy/Psychology); June 1996
- American Institute of Hypnotherapy
- Doctor of Clinical Hypnotherapy, April 1994
- Institute of EMDR, Pacific Grove, California
- Eye Movement Desensitization and Reprocessing Certificate; March 1991
- Long Beach State, Long Beach, California; 1959-1962
- Brigham Young University, Provo, Utah; 1957-1959
- Western Business College, Salt Lake City, Utah; 1956

Certifications
- National Guild of Hypnotists (Certified Hypnotherapy 1996)
- Master Neuro-Linguistic Programming (NLP) Technician (July 1996)
Rapid Eye Technology

- A natural, safe way to release stress and trauma.
- Rapid Eye Technology (RET) is among the many new forms of energy medicine emerging into the mainstream to facilitate rapid healing.
- Learn how to release stressful emotional, mental and physical patterns using:
  - Blinking
  - Breathing
  - Stress reduction energy work
- At the heart of Rapid Eye Technology is the sense of the sacred – an awareness that each person is in essence a perfect spiritual being.
- Rapid Eye Institute

Risk Management Challenges

- Legal & Jurisdictional
- Ethical & Risk Management
  - Efficacy
  - Cost/benefit remote vs. in-person
  - Informed Consent
  - Safety Concerns
    - Emergencies
    - Resources
  - Confidentiality
  - Service Reimbursement

Risk Management Advice

- Before engaging in the remote delivery of mental health services via electronic means, practitioners should carefully assess their competence to offer the particular services and consider the limitations of efficacy and effectiveness that may be a function of remote delivery.

*Listed on Board of Psychology California website. From Koocher, G. & Murray Regulation of Telepsychology: A Survey of State Attorneys General Professional Psychology: Research and Practice, 31(3) 503 – 8.*
Risk Management Advice

- Practitioners should seek consultation from colleagues and provide all clients with written guidelines regarding emergency practices.
- Because no uniform standards of practice exist, thoughtful written plans that reflect careful consultation with colleagues may suffice to document professionalism in the event of an adverse incident.

Risk Management Advice

- A careful statement on limitations of confidentiality should be developed and provided to clients at the start of the treatment. The statement should inform clients of the standard limitations (e.g., child abuse reporting mandates), any state-specific requirements, and cautions about privacy problems with electronically transmitted conversations.

Risk Management Advice

- Clinicians should thoroughly inform clients of what they can expect in terms of services offered, unavailable services (emergency or psychopharmacology coverage), access to the practitioner, emergency coverage, and similar issues.
- If third parties are billed for services offered via electronic means, practitioners must clearly indicate that fact on billing forms.
### Federal/State Regulatory Issues

- Where does an electronic interstate transaction take place?
  - Where consumer resides—in which case the consumer state gets to regulate the transaction
  - Where the provider provides the service from his/her office in state of licensure—in which case licensure state
  - In cyberspace for which regulatory authority is at this point unclear

- Regulation of professions has been assigned to states, although interstate commerce via telemetry raises new issues.
  - Licensure laws and administrative bodies to enforce them
  - Enforcement laws and regulations differ from state to state
  - Education and Training
  - Privacy and Confidentiality
  - Disciplinary procedures and perspectives
- States feel they need local control to protect their own citizens as consumers

- Some jurisdictions have taken the position that the transaction takes place where the client sits:
  - California
  - Massachusetts
  - Wisconsin
  - ASPPB (no surprise—run by state boards)
- Much of the literature on this subject accepts that assertion sufficiently to urge great caution.
- There are many reasons to suspect that licensing boards lack enforcement authority on out-of-state psychologists.
Legal & Jurisdictional

- Board Perspectives
  - Boards are conservative by nature.
  - Boards are complaint driven.
    - Hard cases make bad law.
  - Boards will have difficulty with enforcement against those who are not licensed by the Board.
  - Only recourse is to charge them with practicing psychology without a license which is a criminal offense.
  - 40 Legislatures have provided for temporary practice policies.

Legal & Jurisdictional

  - Federal government has recognized the importance of use of electronic technology and provision of telehealth services.
  - Federal Agencies Efforts to promote telehealth
  - Fed benefits for remote services Medicaid, Medicare
  - Interstate practice is essential for full benefits
  - Best way to accomplish this is by voluntary compact between state licensing boards
  - Grants for medical and nursing boards

Legal & Jurisdictional

  - "If collaboration between states is unable to develop effective licensure polices to reduce barriers to electronic practice across state lines within the next 18 months, then Congress should intervene to ensure that Medicare and Medicaid beneficiaries are not denied the benefits of e-care."
Legal & Jurisdictional

• Federalism Issue
  • State licensing authority cannot interfere with the regulatory authority of the federal government such as interstate commerce or an effective military.
  • Military Psychologists
  • Health Care can involve interstate commerce
    Anti Trust Cases
    ERISA v. state mandates

Legal & Jurisdictional

  • "In the absence of specific agreements…states may not discipline healthcare professionals not licensed in their state if patient harm occurs as the result of the provision of health care services by an out of state practitioner." (HSRA)

Regulatory Challenges

• Federalism Issue
  • Regulates Interstate Commerce
  • Courts have long tradition of dealing with conflict of state laws and jurisdictional issues.
  • Federal government has recognized the importance of use of electronic technology.
  • Federal Agencies
  • Federal benefits for remote services
  • US Army and other federal facilities
  • Private insurance experiments
  • HIPAA
Federal Courts: Minimum Contacts Rule

- The state where the patient resides (the forum state) can assert jurisdiction over an out-of-state provider, only when that provider has made a purposeful attempt to promote or provide services in the forum state or has otherwise availed him/herself of the laws of the forum state to his/her advantage.  
  Wright vs. Yackley (1972), 459 F. 2nd (United States Court of Appeals, Ninth Circuit, 1971).

Federal Courts: Minimum Contacts Rule

*Prince vs. Urban*

- Facts of the case: California woman with headache goes to Illinois and comes home with drugs that caused her significant problems  
  - "In short, we should decline to adopt a rule to the effect that when out-of-state doctors elect to practice medicine in California by telephone and mail, they will be immune from suit here."  

Tentative Conclusions

- Unless a psychologist actively promotes services in an interstate manner, forum state licensing boards will be unable to gain jurisdiction.
- What level of marketing is required to give a forum state jurisdiction is not yet clear.
- Websites are unlikely to be seen as promotional.
- Psychologists who actively market themselves on an interstate basis are taking risk.
- Extradition is very unlikely.
Tentative Conclusions

- Psychologists who actively market non-therapeutic services such as coaching with appropriate disclaimers, appropriate case selection, and appropriate referrals when issues require therapy will also be safer, providing that their language describes what they actually do.
- Psychologists who provide services across state lines will be subject to review by their own state licensing boards.

Record Keeping

Electronic Records

- Not simply keeping records on a computer!
- Not simply practice management software!
- New modes of record keeping, inter-operability, security, and storage are coming quickly (or already here).
Definitions

- Electronic Health Records (EHR)
  - Focus on total health of patient across providers
- Electronic Medical Records (EMR)
  - Digital clinical charts; not easily shared
- Practice Management Software
  - Demographics, scheduling, billing
- Interoperability
  - Ability to exchange and use information
- Role segregation
  - An HER function that limits personnel access to need-to-know elements of record (clerk/clinician)

Electronic Medical Records vs. Electronic Health Records

- Medical records – digital version of paper charts
- Health records – go beyond one practice and integrate care across all practitioners
- Meaningful use of interoperable systems sought - not simply transferring files
- No mandate for psychologists yet - but soon.

The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009.

- Excluded psychologists and most other non-physician providers from the list of “meaningful users” of electronic health records
- Not eligible for Medicare and Medicaid incentive payments designed to encourage adoption of expensive complex systems
- Lobbying in process
Cloud Computing

- Where’s the cloud
- How robust is the cloud
- What’s in the cloud
  - Software
  - Data storage
- Who has access to the cloud
- Accessing remote computers

No mandate for psychologists (outside hospitals) yet, but when it comes how will access influence what you write?

- Multi-practitioner access
- Patient real-time access
- HIPAA and HITECH both mandate role segregation
- Special mental health data segregation to be developed

Ethical Behavior in the Face of Social Safety Net Failures
• What happens when patients' needs exceed the control or abilities of the provider?
• How can we ethically address gaps in service
• Managing the other 167 hours in the week when the patient has…
  • Difficulty complying with medications,
  • No place to refer to for continuing care,
  • Issues of abandonment in cases of high acuity high acuity,
  • And staff must work harder to remain financially solvent as patients take up more time and services than we can afford.

General strategies

• Apply best practices that promote well being and do no harm to the extent possible (e.g., non-adherence).
• Breach confidentiality as legally authorized when protective steps become necessary.
• Document all actions taken.
• Advocate with regulatory and government agencies with parens patriae obligations, and consider use of public pressure.
• Take steps to avoid professional burnout.

Preventing Burnout as an Ethical Imperative

Working in Ethically Challenging Environments
Five Aspects of Care Giver Burnout

- Physical
- Emotional
- Behavioral
- Interpersonal
- Attitudinal

“Look, it’s not you, it’s me O.K.”

Symptoms of Burnout

- Anger/Hostility
  - Often displaced onto patients and colleagues
- Chronic Frustration
- Depression
- Apathy
- Exhaustion
  - Emotional and physical
- Malice and aversion toward the trigger person(s)
- Reduced productivity and effectiveness at work

Pre-Disposing Workplace Factors

- Role ambiguity
- Vague or inconsistent expectations/demands
- Conflicts
- Discrepancy between real/ideal work functions
- Unrealistic pre-employment expectations
- Lack of support or bullies at work
### Pre-Disposing Workplace Factors

- **The Asshole Factor**
  - *The No Asshole Rule: Building a Civilized Workplace and Surviving One That Isn't* -- by Robert I. Sutton
- Temporary and certified status
- Demeaning, bullying, hypercritical...all too common in medicine
  - Example: medical error and near-miss reporting

### Insulating Factors in the Workplace

- Role clarity
- Positive feedback and recognition
- Enhanced staff autonomy
- Providing for stress recovery at work
- Social support at work

### Predisposing Personal Attributes

- Perfectionistic personality
- Losses in the family
- Chronic helplessness
- Permeable boundaries
- Substance abuse
- Expectations
  - The Savior Complex
  - External control orientation
Insulating Personal Attributes

- Sense of personal accomplishment
- Realistic criteria
  - Including patient outcome expectations
- Accurate awareness of personal strengths and weaknesses
- Internal control orientation

Business Relationships

Business Associates and Vendors

- Assuring HIPAA compliance and respectful treatment
- Your obligations for employee and vendor behavior
  - Office staff
  - Billing services
  - Collection agencies
  - Document destruction
  - Computer and off-site storage
Breaking up is hard to do...
Sedaka & Greenfield (1962)

- Beginning and ending practice arrangements
- Are you planning a professional “marriage” or just “living together”?
- What are the costs and benefits?
- Shared facilities and expenses
- Cross coverage
- Talk about the divorce (or at least the separation) during courtship.
- Put details in writing
  - Obligations of each party
  - Restrictive covenants (if any/if allowed by law)
  - Covenants not to compete and liquidated damages

Ethical Challenges for Mental Health Practitioners in Health Care Systems

"Hi, my name is Kevin. I’ll be your doctor for today."

Strangers in a Strange Land
- The content and culture of training programs in psychology differ substantially from medicine and nursing. We use:
  - Different core content
  - Different educational sequences and pedagogy
  - Different socialization approaches
  - Different regulatory models
  - Different specialization models
Strangers in a Strange Land

- We sometimes don’t even speak the same language.
- A “progressive disease” is one that gets worse and “positive findings” are a bad sign when discovered during a physical examination.
- Some physicians seem too willing to see physical complaints as psychological, and some mental health practitioners seem all too eager to go along with them.

The Bad news:

- Psychologists’ education and training has typically not prepared us well to function within the culture of the health care system.
- Non-physicians in a physician dominated system.
- Psychiatry has at times played the role of an ambivalent partner or outright adversary.
- Ally in coverage advocacy
- Opponent in Rx privileges

“This is gonna hurt like hell.”

But the Times They are a Changing

- “Most of the prescribing of psychotropic medications has been dominated by general physicians who do the bulk of prescribing, estimated at more than 75 percent of all prescriptions for psychiatric medications in the U.S…” (Sharfstein, 2006)
- “Psychiatric residents increasingly claim that they have no interest in psychotherapy and therefore see no point in attending seminars on the subject or meeting with a psychotherapy supervisor for one-to-one instruction…” (Gabbard, 2005)
In 2011 3% of psychiatric residency slots went unfilled and 25% were filled by International Medical Graduates (only 50% of whom match overall).

The number of residency slots available has increased by only 40 in the last 5 years (2007-2011).

The Better News

- Psychological techniques and approaches have attracted significant attention among non-psychiatric physicians.
- Integrated care service models will increasingly draw on psychological practitioners.
- Interprofessional practice has become a “buzz word.”

“Let's play health care!”

Interprofessional Ethics in Health Care

- Quality of Care
  - Communication
  - Integration and collaboration
  - respect for conflicting points of view
  - Solution focused
  - Follow through
- Patient Choice
  - Access to information v. understanding
  - Non-medical variables (e.g., personal preference, quality of life, spirituality)
Sample Issues

- Autistic Spectrum Disorders
- Caregiver Stress (Distress!)
- Child Abuse/Neglect
- Dementia
- Disability Evaluation Requests
- End of Life
- Habit-related health problems
- Pain
- Payment and Diagnosis Issues
- Procedure Eligibility (bariatric surgery, transplantation)

To gain proficiency at ethical decision making, students need a sense of professional presence, place, and direction in the patient care setting.

In ethics parlance:

- **Professional presence** refers to the virtues and obligations attached to the health professions.
- **Professional place** requires comprehension and appreciation of the moral context of health care: the relationships that define the health care setting, the particular vulnerabilities inherent in the patient role, and the patient's experience of illness.
- **Professional direction** presupposes knowledge and acceptance of what the goals of the health professions are and how those goals are determined.

Excellent Online Training Site

- Individual team members communicate with patients in different ways about different matters, the complex of impressions and information must be synthesized in order to understand and appreciate fully patients' values and goals.
- [http://www.vhct.org/studies.htm](http://www.vhct.org/studies.htm)
Evolving Professional Roles and Conflicts of Interest in Emerging Payment Systems

- What will happen as fee-for-service systems become supplanted by incentivized integrated care or "global payment" systems or will we suffer the ills of poorly run capitation systems?
- Can we focus on the "virtuous circle of care" and value based competition?


"While it's not a cure, it does mean a guaranteed income for me."

The West German Headache Center: Integrated Migraine Care

Michael E. Porter, Clemens Guth, Elisa Dannemiller Describes the joint efforts of the German health plan KKH and Essen University Hospital to develop an integrated practice unit (IPU), and the West German Headache Center's efforts to improve the quality of migraine care. Provides an overview of the German health care system detailing its provider, health plan, and reimbursement structure. Following new legislation in 2004 which allowed health plans and selected providers to contract outside of the regular group purchasing scheme, KKH and Dr. Deiner of Essen University Hospital developed a novel delivery structure for migraine care. Challenges and hurdles to implementation are described for both the health plan and the IPU. Provides detailed data to allow students to evaluate success, identify current challenges, and recommend improvements to the integrated care system.

Fundamental Intervention Strategies

- Avoid parallel service delivery; partner with physician.
- Focus on family intervention whenever possible.
- Pay attention to symptom relief.
- Normalize the family's distress.
- Suggest active coping strategies; providing sense of control.
- Engage around common fears and attributions.
Challenges of the EMR

Electronic Medical Records

Legal Hazards Associated with EMRs

- **Risk:** Because EMRs allow users to move quickly through patient records, cutting and pasting information along the way, incorrect information can easily get repeated.
  Prevention: Avoid cutting and pasting data in EMRs, and use caution when moving from one patient’s record to the next.
- **Risk:** Practitioners charting in EMRs may lead to some less thorough documentation than with paper charts.
  Prevention: Electronic notes should include full and careful documentation.
- **Risk:** Computerized expert systems can offer actuarial guidance in differential diagnosis and clinical decision making, but they cannot possibly cover all contingencies.
  Prevention: Avoid over reliance electronic assessment and diagnostic aids.
- **Risk:** Safeguard confidential electronic patient data can prove challenging.
  Prevention: Use encryption and secure access on all electronic access devices and discourage employees from taking records or unsecured content out of the office.
- Risk: Some EMR systems may not clearly document changes to records. Prevention: Optimal systems should document modifications and have a program lockout period after which no further modifications can be made to a record.

- Risk: Many states have notification requirements in the event of a data breach. Prevention: Understand and follow state law requires if a data breach occurs, making sure that all employees understand and follow requirements.

- Risk: Destruction or delete of electronic records can easily occur by accident or sometimes intentionally if a lawsuit looms. Prevention: If sued, all records (including electronic data) related to the patient in question must be preserved, including emails, phone messages and computer records.

- [http://www.ama-assn.org/amednews/2012/03/05/prsa0305.htm](http://www.ama-assn.org/amednews/2012/03/05/prsa0305.htm)

Other Common Problems
Disagreement with Tx Advice

- If you only have a hammer, every problem looks like a nail.
- Cardiac surgery vs Interventional Cardiology
- You want me to take drugs for that?
- Using data and patient preference to drive the agenda.
- The case of Jonathan…

Medical Non-Adherence

- Please fix my patient, so they’ll do what I told them.
- First you need to understand why they’re not.
  - Knowledge: information & understanding
  - Culture/economics
  - Psychological resistance
  - Informed choice

- Major Predictors of Poor Adherence to Medication, According to Studies of Predictors

Clinicians must take care not to surrender their professional integrity or standards.

Bertram Botch, M.D., served as the chief of neurology at a pediatric hospital and often chaired interdisciplinary case conferences. Reporting on her assessment of a low-functioning mentally retarded child, Melissa Meek, Ph.D., presented her detailed findings in descriptive terms. Dr. Botch listened to her presentation and asked for the child’s IQ. When Dr. Meek replied that the instruments used were developmental indices that did not yield IQ scores, Dr. Botch demanded that she compute a specific IQ score to use in his preferred report format.

After sitting in on some lectures that Ralph Worthy, Psy.D., was giving to a group of medical students in regard to projective testing, the chief of medicine called him in to set up a workshop on the topic for medical residents. The chief told Worthy that he thought it would be a good idea to teach the residents how to use “those tests” and assumed that it could be done in “a half-dozen meetings or so.”

Teri Slim found herself referred to a major pediatric teaching hospital for the treatment of anorexia nervosa. She had always been petite and slender, but seemed unusually thin to her father just prior to her 14th birthday. She was medically evaluated at a large hospital near her home and the staff referred her on to the specialized pediatric hospital for treatment. The admission evaluation at the second hospital confirmed the diagnosis of anorexia, and admitted Teri to their “psychosomatic unit” for treatment. The hospital staff easily identified family stressors that might account for Teri’s emotional problems. Her parents had recently divorced, her father had lost his job as business executive, and her mother who lived in another state, allegedly had a serious addiction problem.
At the end of 2 months of treatment, Teri remained malnourished and had made "no progress" in treatment. The staff contemplated initiating intravenous feeding in the face of her progressive weight loss. They prepared to transfer Teri to surgical ward for placement of a venous feeding line. Only then did senior pediatrician sent to screen her for transfer ask, "Has anyone evaluated her for Crohn's disease?" Several weeks later, Teri went home from the hospital minus a segment of inflamed intestine and taking anti-inflammatory medication. She continued to do well in response to the treatment for Crohn's disease.

Anna Margarita vs. Chief of Surgery

- The patient:
  - 5 years old, Spanish-speaking, from Puerto Rico
  - Mayer-Rokitansky-Kuster-Hauser (MRKH) syndrome: an uncommon variation in the prenatal development of the female genital tract. Its features include an absent or very short vagina and an absent or malformed uterus.

- The procedure:
  - A skin graft taken from the buttocks is used to cover a stent, which is then inserted into a surgically created space between the bladder and the rectum. A dilator must be used during the months following the procedure to keep the vagina open.

- The problems:
  - The child experienced serial infections and significant pain associated with treatment.
  - The mother spoke very little English and had difficulty gaining full cooperation and compliance from the child.
  - The surgeon: "Why don’t you just get it done, and why can’t you learn English? You’ve spent enough time here."
Lesson Learned

• Standing up to a bully strategically and doing the right thing can work!

Melanie Visits Toys R Us

• The patient:
  • A 5 year old developmentally-disabled old boy with idiopathic pulmonary artery hypertension, a progressive, fatal disease of unknown cause.
• The procedure:
  • Long-term therapy had not helped much and pulmonary or pulmonary-cardiac transplantation seemed the last resort.

• The problem:
  • The child would not cooperate with pulmonary function tests, a key diagnostic indicator of rejection and could not be “listed” for transplant unless cooperative.
  • How can we get this physically and intellectually challenged child to a state of transplant eligibility?
Lesson Learned

• Thinking outside the box can literally save a life.

Burkitt’s Lymphoma and the Dirty Jeans

• The patient:
  • An 8 year old boy with “sporadic type” stage IV Burkitt’s lymphoma (also known as “non-African” type). It is believed that impaired immunity provides an opening for development of the Epstein-Barr virus.
  • This very rare and extremely aggressive tumor is the fastest growing cancer known, capable of doubling in size every 14 hours.
  • About 300 cases occur in children ages 4-20 in the U.S. annually; most commonly boys.
  • Approximately half of those with Burkitt’s lymphoma can be “cured” with intensive chemotherapy, if the cancer has not spread to the bone marrow or spinal fluid.

• The situation:
  • Standard chemotherapy had failed.
  • An experimental “compassionate use” drug protocol with high toxicity potential was the only remaining option.
  • The parents could not finalize a decision on the treatment option.
  • They agreed to engage the child in the discussion.
Burkitt’s Lymphoma and the Dirty Jeans

• The Contrast Effect:
  • Well educated mother and her 8 year old daughter cannot agree on a dress code…so, bring her to therapy.

Lesson Learned

• Swallow the irritation, help put “the problem” in perspective, and don’t sweat the small stuff!

Our Own Problems in Health Care Ethics

Big Pharma
Managed Care
Uncoordinated Services
Moral Hazards of Insurance

- Medicare’s historic introduction of procedure based reimbursement.
- Porter’s Model of Integrated Care in a “virtuous circle.”

Anything but Child’s Play...

- In the mid-1990s Joseph Biederman and Janet Wozniak proposed the notion that many children with conduct disorder or ADHD diagnoses might have “juvenile bipolar disorder,” and proposed treating them with medications developed for adults with significant mood disorders.
- Is this valid diagnosis or one driven by “Big Pharma?”

Commercial Hazards

- Pharmaceutical Sponsorship: Controlled Seduction?
  - Research
  - Lectures
  - Meetings
  - Junkets
  - Trinkets

Discouraging data on the antidepressant.
Ethical Issues in Psychological Assessment

Planning the Assessment

Who Is the Client?

- Clarify the assessment role and its implications with all parties to whom a professional duty is owed.
- Individual adults, children/families, and third parties (e.g., potential employers, the courts, and health insurers) may all be involved in some way.

Informed Consent

- Even when a third party controls the evaluation, the person being assessed has a right to know and understand nature of the evaluation, the referral questions, and the goals of the assessment.
- This should occur using language the client can readily understand.
- Any limitations of the assessment procedures should be discussed with the client.
- To the extent possible, the psychologist also should remain mindful of the goals or interests of the individual being assessed, and clarify misunderstandings, and correct unrealistic expectations.
Test User Competence

• Psychologists can easily face situations that require skills exceeding their personal competence, such as forensic assessments or evaluation of special populations.
• Psychologists are ethically bound not to promote the use of psychological assessment techniques by unqualified persons, except when such use is conducted for training purposes with appropriate supervision.
• Ascertaining what constitutes competence or qualifications in the area of psychological assessment has been a difficult endeavor due to the complex nature of assessment, the diverse settings and contexts in which psychological assessments are performed, and the differences in background and training of individuals providing psychological assessment services.

Use of assessment tools by non-psychologists

• Are some physicians competent to use psychological tests?
• After all, Hermann Rorschach was a psychiatrist, and so was J. Charnley McKinley, one of the two originators of the Minnesota Multiphasic Personality Inventory (MMPI). Henry Murray, a non-psychiatric physician, co-invented the Thematic Apperception Test (TAT) with Christiana Morgan, who had no formal training in psychology.
• Historically, the APA addressed this issue only in a very general manner in the Ethical Principles and Code of Conduct for Psychologists. In earliest versions of the Ethical Standards of Psychologists (American Psychological Association, 1953), the ethical distribution and sale of psychological tests was to be limited to unspecified “qualified persons.”

• A system of categorization of tests and concordant qualifications that entailed three levels of tests and expertise was subsequently developed.
  • Vocational guidance tools, for example, were at the low end in terms of presumed required expertise.
  • At the high end of required competence were tests designed for clinical assessment and diagnoses such as intelligence and personality assessment instruments.
  • The rationale involved in this scheme was based on the need to understand statistics, psychopathology, and psychometrics in order to accurately draw clinical inference or make actuarial predictions based on the test data.
  • Although the three-tier system is no longer discussed in APA ethical standards, it was adopted by many test publishers, and variations continue in use. When attempting to place orders for psychological test materials, would-be purchasers are often asked to list their credentials, cite a professional license number, or give some other indication of presumed competence.
Teaching Psychological Testing

- Teaching testing without the basic scientific foundations to people unaccountable to professional codes or licensing laws creates regulatory problems.
- When and how might this qualify as "unethical?"

Should Forensic Psychiatrists Conduct Psychological Testing?

- "The issue at hand is not one of territoriality—as some might surmise—but rather one of forensic standards and professional ethics, particularly as they pertain to protecting the public. The appropriate selection, administration, scoring, and interpretation of psychological tests require extensive training and supervision, of a sort that cannot be obtained during a weekend seminar or on the basis of casual, incidental supervision… In keeping with the current trend in professional training and development, psychological testing should be viewed as a 'competency.'"

Planning the Evaluation

- Selection of Instruments
  - The psychologist should have a sound knowledge of the available instruments for assessing the particular construct related to the assessment questions.
  - This knowledge should include understanding the psychometric properties of the instruments to be used (e.g., their validity, reliability, and normative base) as well as an appreciation of how the instrument can be applied in different contexts or with different individuals across age levels, cultures, languages, and other variables.
• Adequacy of Instruments
  • Those who develop, administer, score, interpret, or use assessment techniques, interviews, tests, or instruments ethically do so only in a manner and for purposes appropriate in light of the research on or evidence of the usefulness and proper application of the techniques in question.
  • Psychologists who develop and conduct research with tests and other assessment techniques are expected to use appropriate psychometric procedures and current scientific or professional knowledge in test design, standardization, validation, reduction or elimination of bias, and recommendations for use of the instruments. The ethical responsibility of justifying the appropriateness of the assessment is firmly on the psychologist who uses the particular instrument.

Appropriate Assessment in a Multicultural Society

• When working with diverse populations, psychologists are expected to use assessment instruments whose validity and reliability have been established for that particular population.
• When such instruments are not available, the psychologist is expected to take care to interpret test results cautiously and with regard to the potential bias and potential misuses of such results.
• When appropriate tests for a particular population have not been developed, psychologists who use existing standardized tests may ethically adapt the administration and interpretation procedures only if the adaptations have a sound basis in the scientific and experiential foundation of the discipline.

Getting Around Language Barriers

• Some psychologists incorrectly assume that the use of an interpreter will compensate for a lack of fluency in the language of the person being tested.
  • Aside from the obvious nuances involved in vocabulary, the meaning of specific instructions can vary widely. For example, some interpreters may tend to simplify instructions or responses rather than give precise linguistic renditions.
  • At other times, the relative rarity of the language may tempt an examiner to use family or community members when professional interpreters are not readily available. Such individuals may have personal motives that could lead to alterations in the meaning of what was actually said, or their presence may compromise the privacy of the person being assessed.
• Psychologists using the services of an interpreter must assure themselves of the adequacy of the interpreter's training, obtain the informed consent of the client to use that particular interpreter, and ensure that the interpreter will respect the confidentiality of test results and test security.
• In addition, any limitations on the data obtained via the use of an interpreter must be discussed in presenting the results of the evaluation.
Psychologists also need to have an understanding of the impact of bilingual background on performance on psychological tests.

Some psychologists mistakenly assume that they can compensate for language or educational barriers by using measures that do not require verbal instructions or responses.

- When assessing individuals of diverse cultural and linguistic backgrounds, it is not sufficient to rely solely on nonverbal procedures and assume that resulting interpretations will be valid.
- Many human behaviors, ranging from the nature of eye contact; speed, spontaneity, and elaborateness of response; and persistence on challenging tasks may be linked to social or cultural factors independent of language or semantics.
- Research has demonstrated, for example, that performance on nonverbal tests can be significantly affected both by culture and educational level

What’s in a Norm?

- Psychologists must have knowledge of the applicability of the instrument’s normative basis to the client.
- Are the norms up-to-date and based on people who are compatible with the client?
- If the normative data do not apply to the client, the psychologist must be able to discuss the limitations in interpretation.
- In selecting tests for specific populations, it is important that the scores be corrected not only with respect to age but also with respect to educational level.

When does a test become obsolete?

- It is important to remember that psychologists must not base their assessment, intervention decisions, or recommendations on outdated data or test results. But what’s outdated?
- In some instances, a psychologist may reasonably use an older version of a standardized instrument, but he or she must have an appropriate and valid rationale to justify the practice and document this in the report.
- For example, a psychologist may wish to assess whether there has been deterioration in a client’s condition and may elect to use the same measure as used in prior assessments.
Conducting the Evaluation

Climate

- A conducive climate is critical to collection of valid test data. In conducting their assessments, psychologists strive to create appropriate rapport with clients by helping them to feel physically comfortable and emotionally at ease, as appropriate to the context.
- The psychologist should be well-prepared and work to create a suitable testing environment. Most psychological tests are developed with the assumption that the test takers’ attitudes and motivations are generally positive.
  - For example, attempting to collect test data in a noisy, distracting environment or asking a client to attempt a lengthy test (e.g., an MMPI-2) while the client is seated uncomfortably with a clipboard balanced on one knee and the answer form on another would be inappropriate.

Climate

- With the increasing use of computer administered tests, psychologists need to be aware of the test taker’s experience and facility with a computer.
- Particularly in older individuals, lack of comfort with this response method, can compromise performance and affect validity of the testing
• The psychologist should also consider and appreciate the attitudes of the client and address any issues raised in this regard.
  • Some test takers may be depressed or apathetic in a manner that retards their performance, whereas others may engage in disimulation, hoping to fake bad (i.e., falsely appear to be more pathological) or to fake good (i.e., conceal psychopathology).
  • If there are questions about a test taker’s motivation, ability to sustain adequate concentration, or problems with the test-taking environment, the psychologist should attempt to resolve these issues and to discuss how these circumstances ultimately affect test data interpretations in any reports that result from the evaluation.

### Data Collection and Report Preparation

- In some contexts—particularly in neuropsychological assessment, in which a significant number and wide range of instruments may be used—technicians are sometimes employed to administer and score tests as well as to record behaviors during the assessment.
- Adequacy of data collection, including the training and competence personnel engaged in test administration remains the responsibility of the psychologist directing the assessment procedures.
- This becomes especially relevant in circumstances where classroom teachers or other non-psychologists are used to proctor group-administered tests.

### Payment Issues and Withholding Reports

- Many practitioners require advance payment or a retainer as a prerequisite for undertaking a lengthy evaluation.
- In some instances, practitioners who have received partial payment that covers the time involved in record review and data collection will pause prior to preparing the actual report and await additional payment before writing the report.
- Such strategies are not unethical per se but should be carefully spelled out and agreed to as part of the consent process before the evaluation is begun. Ideally, such agreements should be made clear in written form to avoid subsequent misunderstandings.
- In contexts where third party reimbursement is used, the procedures codes for psychological testing include the professional time spent integrating findings and preparing the report.
Automated Test Scoring and Interpretation

- The psychologist who signs the report remains responsible for the contents of the report, including the accuracy of the data scoring and validity of the interpretation.
- When interpreting assessment results—including automated interpretations—psychologists must take into account the purpose of the assessment, the various test factors, the client's test-taking abilities, and the other characteristics of the person being assessed (e.g., situational, personal, linguistic, and cultural differences) that might affect psychologists' judgments or reduce the accuracy of their interpretations.
- If specific accommodations for the client (e.g., extra time, use of a reader, or availability of special assistive technology) are employed in the assessment, these accommodations must be described; automated testing services cannot do this.
- Although mechanical scoring of objective test data is often more accurate than hand scoring, machines can and do make errors. The psychologist who makes use of an automated scoring system should check the mechanically generated results carefully.

After the Evaluation

Feedback Requests

- Psychologists are expected to provide explanatory feedback to the people they assess unless the nature of the client relationship precludes provision of an explanation of results.
- Providing feedback should be seen as a critical component of the assessment process which can have a significant therapeutic impact with respect to treatment and helping the client understand interventions recommended.
Requests for Modification of Reports

- On some occasions, people who have been evaluated or their legal representatives may request modification of a psychologist’s assessment report.
  - One valid reason for altering or revising a report would be to allow for the correction of factual errors.
  - Another appropriate reason might involve release of information on a need-to-know basis for the protection of the client. For example, suppose that in the course of conducting a psychological evaluation of a child who has experienced sexual abuse, a significant verbal learning disability is uncovered.
  - Psychologists must remain mindful of their professional integrity and obligation to fairly and accurately represent relevant findings.

Release of Test Data

- This issue comes into focus most dramatically when the conclusions or recommendations resulting from an assessment are challenged.
  - In such disputes, the opposing parties often seek review of the raw data by experts not involved in the original collection and analyses.
  - The purpose of the review might include actual rescoring raw data or reviewing interpretations of scored data.
  - In this context, test data may refer to any test protocols, transcripts of responses, record forms, scores, and notes regarding an individual’s responses to test items in any medium.

Do I have to give up the raw data?

- HIPAA considers test data in health care records subject to disclosure upon execution of a valid release.
- Forensic cases will almost always trigger a full release when the mental status of the party has been raised as a defense or as a basis for assigning damages.
- Attorneys typically shop for experts out of view of the “other side” in both civil and criminal litigation.
Dr. Sally C. Johnson's Report on Theodore Kaczynski

- "In addition to the clinical interviews, formal review was conducted of previous medical evaluations, as well as previous neuropsychological and psychological testing results. Additional psychological testing administered during this evaluation included the Minnesota Multiphasic Personality Inventory-2 (01/12/98), the Millon Clinical Multiaxial Inventory-II (01/12/98), the Beck Depression Inventory (01/15/98), and the Draw a Person Picking an Apple from a Tree projective drawing (01/15/98). Psychological testing administered during this evaluation was administered by Dr. Johnson. Scoring and interpretation of tests were accomplished with the assistance of psychology staff at FCI Butner."

- [http://www.paulcooijmans.com/psychology/unabomreport.html](http://www.paulcooijmans.com/psychology/unabomreport.html)
- [http://www.med.unc.edu/psych/directories/faculty/sally-c-johnson-md](http://www.med.unc.edu/psych/directories/faculty/sally-c-johnson-md)

Test Security

- Test materials versus test data
- Who’s responsible?
  - Publisher?
  - Clinician?
  - Recipient?
  - Judge Grady proceeded with a point-by-point evaluation of all disputed items on the WISC-R and ruled that all but a few appeared racially neutral—but, all appeared in the record!

The Testing Industry

- Automated Testing Services
  - One key difficulty in the use of automated testing is the aura of validity conveyed by the adjective computerized and its synonyms. Aside from the long-standing debate within psychology about the merits of actuarial versus clinical prediction, there is often a kind of magical faith that numbers and graphs generated by a computer program somehow equate with increased validity of some sort.
Do-It-Yourself Tests

- "IQ" and "Personality Tests" abound
  - One site apparently based at the University of Pennsylvania under the auspices of a former APA president purports to assist participants in determining whether they have "compassionate love" or "authentic happiness," leading to the question of whether inauthentic happiness represents delusional thinking. That site requires a personalized log on and appears intended for data collection and marketing related to
  - Other sites with no clear validity offers a wide range of online testing opportunities, including personality assessment based on color
  - Or one’s possible racial biases
    - http://implicit.harvard.edu/implicit/

High-Stakes Testing

- A single, defined assessment,
- Draws (or used to draw) a clear line between those who pass and those who fail, and
- Has direct consequences for passing or failing (something "at stake").
  - High School graduation
    - Many children left behind...
  - College and grad school admission
    - Use in psychology graduate school admissions

Assessing the Quality of a Psychological Assessment

1. Referral questions and context
2. Current status/behavioral observations
3. Listing of instruments used
4. Reliability and validity
5. Data presentation
6. Summary
7. Recommendations
8. Diagnosis
9. Authentication
10. Feedback
Referral questions and context

- Does the report explain the reason for referral and state the assessment questions?
- Are the questions relevant to the psychological ecology of the client mentioned (e.g., recently divorced, facing criminal charges, candidate for employment)?
- Does the report note that the client or legal guardian was informed about the purpose of and agreed to the assessment?
- If undertaken at the request of a third party (e.g., a court, an employer, or a school), does the examiner note that the client was informed of the limits of confidentiality and obtain a release obtained?

Current status/behavioral observations

- Has the examiner described the client’s behavior like during the interview, especially with respect to any aspects that might relate to the referral questions or the validity of the testing (e.g., mood, ability to form rapport, concentration, mannerisms, medication side effects, language problems, cooperation, phenotype, or physical handicaps)?
- Has the examiner described any deviations from standard testing administration or procedures?

Listing of instruments used

- Is a complete list provided (without jargon or abbreviations) of the tests administered presented, including the dates administered?
- Does the report explain the nature of any unusual instruments or test procedures used?
- If more than one set of norms or test forms exists for any given instrument, does the psychologist indicate which forms or norms were used?
Reliability and validity

- Does the psychologist comment specifically on whether or not the test results in the present circumstances can be regarded as reasonably accurate (e.g., the test administration was valid and the client fully cooperative)?
- If there mediating factors apply, are these discussed in terms of reliability and validity implications?
- Are the tests used valid for assessing the aspects of the client’s abilities in question? This should be a special focus of attention if the instrument used is nonstandard or is being used in a nonstandard manner.

Data presentation

- Are scores presented and explained for each test used? (If an integrated narrative or description is presented, does it report on all the aspects assessed (e.g., intellectual functioning, personality structure, etc.))
- Are the meanings of the test results explained in terms of the referral questions asked?
- Are examples or illustrations included if relevant?
- Are technical terms and jargon avoided?
- Does the report note whether the pattern of scores (e.g., variability in measuring similar attributes across instruments) seems consistent or heterogeneous?
- For IQ testing, are subtest scatter and discrepancy scores mentioned?
- For personality testing, does the psychologist discuss self-esteem, interpersonal relations, emotional reactivity, defensive style, and areas of focal concern?

Summary and Recommendations

- If a summary is presented, does it err by surprising the reader with material not mentioned earlier in the report?
- Is it overly redundant?
- If recommendations are made, do these flow logically from the test results mentioned and discussed earlier?
- Do recommendations mention all relevant points raised as initial referral questions?
Diagnosis and authentication

- If a diagnosis is requested or if differential diagnosis was a referral question, does the report specifically address this point using DSM or ICD terminology?
- Is the report signed by the individual(s) who conducted the evaluation?
- Are the credentials/title of each person noted (e.g., Mary Smith, Ph.D., Staff Psychologist, or John Doe, M.S., Psychology Intern)?
- If the examiner is unlicensed or a trainee, is the report cosigned by a qualified licensed supervisor?

Feedback and follow-up

- Is a copy of the report sent to the person who made the referral?
- Is some mechanism in place for providing feedback to the client, consistent with the context of testing and original agreement with the client?
The EBP Juggernaut

An international effort to base clinical practice on robust, primarily research, evidence

- IOM definition: Evidence-based practice is the integration of best research evidence with clinical expertise and patient values.
- APA definition: Integration of best available research with clinical expertise in the context of patient characteristics, culture, & preferences.

Demands for EBPs are here to stay and will escalate in future.

<table>
<thead>
<tr>
<th>Best Available Research</th>
<th>EBP Decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patient Characteristics, Culture, &amp; Preferences</td>
</tr>
<tr>
<td></td>
<td>Clinical Expertise</td>
</tr>
</tbody>
</table>

### Quack Psychology

- EBPs have provoked enormous controversy, and little consensus exists on either the decision rules to determine effectiveness or the treatments designed as "evidence-based".
- We believe that it will prove as useful and easier to establish what does not work – discredited psychological treatments and tests.
“Why Not Rely on RCTs?”

- because most txs have not (and will not) be subjected to controlled research
- bc of difficulty of "proving" the null hypothesis (no diff between tx and placebo)
- bc there are few bona fide comparisons of alternative txs (most RCTs involve sham comparisons +/-or researcher allegiance)
- bc lack of consensual criteria for discredited or ineffective treatments

Recent Attempts

Pioneering efforts to identify pseudoscientific or "quack" psychotherapies suffer from 2 limitations:

1. None systematically relied on expert consensus. Instead, authors assumed a consensus or selected entries on their own.

2. None provide differentiation between credible & uncredible txs, between unvalidated & validated tests. Demarcation problem leads to crude & dichotomous judgments.

2 Delphi Polls

- Thus, we conducted 2 Delphi polls of mh and addiction experts to secure a consensus and to establish refined characterizations of discredited treatments and tests.

- Inclusion criteria: used during the past 100 years; largely in USA and Western Europe

- Exclusion criteria: controversial theories not directly involved in mental health; txs or tests never advocated by professionals; meds or biochemical substances

- Only rate those txs and tests with which familiar
“But it worked for my...!”

All txs will indeed work for some folks some of the time (due to chance, time, placebo)

2 favorite examples:

- 2005 *Lancet* review of 110 placebo-controlled homeopathic remedies matched with 110 conventional medicine trials
- 2004 *JAMA* RCT comparing magnets to sham magnets for foot pain

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**Defining Discredited**

- **Discredited**: unable to consistently generate tx outcomes or valid assessment data beyond that obtained by the passage of time alone, expectancy, base rates, or credible placebo.
- Can be discredited according to controlled research, clinical practice, and/or professional consensus.
- Use criteria for expert opinions as delineated in Daubert and *Kumho Tire Co.* legal standards. Supreme Court cites such factors as testing, peer review, error rates, and “accept-ability” in the scientific community.

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**Your Nominations**

- Now, you are our panel of experts
- Use our definition of discredited
- Without paging forward in the handouts . . .
- Which treatments do you consider discredited or psychoquackery in mental health and the addictions?
“Top 10” Discredited Treatments

- Angel therapy
- Orgone therapy
- Use of pyramids
- Crystal healing
- Past lives therapy
- Future lives therapy
- Rebirthing therapies
- Color therapy
- Primal scream therapy
- Txs for alien abduction

Those who make you believe absurdities can make you commit atrocities.
- Voltaire

The sleep of reason brings forth monsters.
- Goya

Wilhelm Reich

- Born in 1897 in Austria
- Graduated from the Medical School (University of Vienna) in 1922.
- A student of Freud, he became a psychoanalytic pioneer before beginning investigations of "energy"
- Reich came to the U.S. in 1939 and continued to study the manifestations and laws of orgone energy
Warning! Warning!

"Warning - misuse of the Orgone Accumulator may lead to symptoms of orgone overdose. Leave the vicinity of the accumulator and call the 'Doctor' immediately!"

- Wilhelm Reich

The Quack of Quacks

Some Quack therapies have lead to imitators that go the original Quack one better. Psycho-quackery x2, so to speak.

Actual Examples: If you visit e-Bay and search under orgone, you will discover a plethora of items Wilhelm Reich never dreamed of, based on little more than the term orgone and devoid of any Reichian constructs apart from his name.

Enhanced Orgone Radionics Vortex Accumulator - Pyramid

What is "DOR"?
In your home you have many DOR vibrations intruding in upon you and your family. Computers, ovens, TV's, cell phones and cell phone towers and high voltage lines from outside.

These DOR vibrations are detrimental to your health and the health of your children. The Orgone generator will help clear the DOR (bad energy) from your home.

Orgone generators act very much like trees. Trees convert bad air into oxygen. Orgone generators convert DOR into life force Wilhelm Reich Proved This 40 Years Ago.

- Top Quality Materials Craftsmanship
- Blessed & Consecrated
- Hawk Dragons Blood's Original Design
- Orgonite Fluid Condenser Crystals
- Polar Contradictory Vortex
- Hermetically Sealed
- No Gimmicks
- Measures Approximately 2½ x 2½ x 2½
A new kind of Orgone box?

- These are the bigger Cigar boxes in the pictures. The Orgone boxes come with two Quartz crystals, silver foil, copper and zinc BBs, tiny sea shells, amethyst chips, peat moss and 3 orgone chips, and a DC charger. The Ark of the Covenant was a very expensive Orgone Box. Gold and acacia wood. Think of the possibilities.
- Every Orgone Radionics Box is handmade and unique while the ingredients are the same & backed by our 100% satisfaction guarantee!
- Another adaptation of Orgone for household use!
- This is an adapted technology of Wilhelm Reich’s Orgone accumulators. Reich’s original Orgone accumulators were made from steel wool and wood. Reich could treat people for mental and physical illnesses in the Orgone accumulators.

With Monoatomic Gold
The Orgone Radionics Boxes shown here are samples only.

BLACK ORGONE BEAMER/GENERATOR PENDANT

- 34mm diameter by 12mm thick, the pendant is made completely of Black Coloured Orgone Matrix Material with a Herkimer Diamond and copper coils compressed within the Matrix for extra vibration
- The pendant enable the wearer to manifest (almost) anything the mind desires for it attracts the very life force energy of our existence. You do not need a red one for this and a green one for that or a pretty picture on the front to attract money or a locket to attract a loved one. This pendant attracts the energy we need by the very contents of the pendant, which excite and agitate the life force energy and attracts it to use in which ever way we require or want to manifest. Then it’s up to us as the pendant only gives you the energy although it may be the most powerful energy available.
- No pendant, Talisman or any other object will do the job for you i.e. good health, money, love, etc. We have to play our part in manifesting technique as our thoughts and beliefs create our reality. We are powerful beings capable of great things but we have forgotten most of our abilities, now as the time is quickening our abilities are returning with the use of energy tools to remember our ancient glorious past where all things were possible.
- Also protects against negative energy!

James DeMeo, Ph.D.

He studied the Earth, atmospheric, and environmental/social sciences at Florida International University and the University of Kansas, where he earned his Ph.D. in 1986.
At KU, he openly undertook graduate-level natural scientific research specifically focused upon Wilhelm Reich’s controversial discoveries, subjecting these ideas to rigorous testing with positive verification of the original findings.
He founded the Orgone Biophysical Research Lab and Greenspring Center in rural Ashland, Oregon, holding the post of Director since 1978.
Your Nominations II

➤ Which **tests** do you consider discredited?
➤ That is, which would you give the hook?

“Top 8” Discredited Tests

- Bender-Gestalt for assessment of neuro-psych impairment
- Handwriting analysis (graphology) for personality assessment
- Luscher Color Test for personality assessment
- Szondi test for personality assessment
- Anatomically detailed dolls & puppets to determine child sexual abuse
- Blacky test for assessment of children’s pathology
- Bender-Gestalt for assessment of personality
- Wechsler IQ scale scores for personality assessment

Lipot (Leopold) Szondi

- Born March 11, 1893 in Hungary
- Doctor of Medicine from the University of Budapest in 1919
- 1919-1926: Assistant in experimental psychology at University of Budapest
- 1927-1941: Assistant professor and then professor of biology and psychopathology
- Explored and developed “schicksal (fate) psychology”
- 1941: Fled and settled in Zurich in 1944
**Test Instructions**

“I shall lay before you 8 photographs. Observe all these photographs carefully and from the group give me the first picture toward which you are most sympathetic, then the one toward which you are secondly most sympathetic.”

- *Experientielle Treibdiagnostik*, p. 26

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**The Photographs**

- 48 photographs of individuals with mental disorders chosen in accordance with the principle of genetic relationships.
- All lived in Hungary, Sweden, Austria, and Germany. Actual origins lost when Szondi fled Budapest on a few hours notice.
- The sadists are all Swedish murderers.

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**Szondi’s Diagnostic Categories**

- h = hermaphrodite
- s = sadists
- p = paranoid
- k = catatonic
- e = epileptic
- m = manic
- hy = hysterical
- d = depressed

Szondi writes in the Forward (p. vii-viii)
“We Europeans still pursue an ‘epic’ form of psychology of a kind that we learned from Dostoevski and Freud. The story of the soul of man to us is still a heroic novel that we would like to tell unhurriedly in long sentences. This epic form of presentation is inadequate to the American tempo of thinking.”

Susan Deri writes in her Preface (p. xi)
“…anybody who finds the Rorschach and psychoanalysis ‘worthless and vague’ also will be dissatisfied with the Szondi…I am fully aware of the autistic nature of this reasoning since…I am the only one who received the accumulative evidence of all these individual clinical validations.”

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“Top 10” Discredited Txs for Addictions

- Past life therapy
- Electrical stimulation of the head
- Psychedelic medication
- Electric shock for Etoh dependence
- Scared Straight for prevention
- DARE for prevention
- Ultra-rapid opioid detoxification under anesthesia
- Neuro-Linguistic Programming
- Electrical aversion therapy
- Synanon-style boot camps

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Common Elements of “Successful” Quack Treatments & Tests

- Address a difficult, complex, & refractory problem (*Great and Desperate Cures*)
- Pose a relatively simple solution with apparent face validity
- Reasoning or approach “in sync” with the Zeitgeist
- Often promoted by a charismatic “expert”
10 Features of Pseudoscience

- statements are frequently nonfalsifiable or irrefutable
- absence of controlled research by its founders and disciples
- resistance to controlled research by "outsiders"
- evasion of peer review
- reversed burden of proof (burden placed on skeptics)

Features of Pseudoscience (cont)

- emphasis on confirmation at expense of refutation
- reliance on testimonial & anecdotal evidence
- confusion of the unexplained and the inexplicable
- use of obscure, quasi-scientific language
- designed to influence or sell, not to self-correct


An Ethical Duty?

Actual example: A former patient undergoes a psych evaluation for a handgun permit with a licensed psychologist. The client informs you that the evaluation consisted entirely of clinical interview, 3 Rorschach cards, and the Szondi.

- How do you respond when your client asks about the validity of such an assessment?
- Do you have an ethical duty to contact the evaluating psychologist?
- Do you have an ethical duty to notify the license board?
- Would your answer differ if the client were (a) a current client, (b) denied the handgun permit, or (c) was your child?
More than Discrediting

- We need more than to discredit and ridicule psychoquackery
- A positive, proactive means toward psychological literacy and sophisticated EBP
- A movement in psychological practice that values reasoned pursuit of effective assessments and treatments

Four Final Words

- Let’s Be Encouraged
- Let’s Be Careful
- Let’s Be Humble
- But Let’s Eradicate Patently Discredited Practices

Let’s Be Encouraged

- Psychological science is self-correcting
- Psychology relies on evidence (more than most professions, anyway)
- We are making progress in differentiating science from pseudoscience, evidence-based practices from voodoo practices
Let's Be Careful

- Professional consensus is no epistemic warrant (even experts can be wrong)
- Validity is conditional; usefulness is purpose- and context-specific
- Careful not to threaten innovation and creativity
- Beware our propensity to label and pathologize unusual behavior

Let's Be Humble

- Today's txs and tests may be discredited 30 years from now
- Warn against false pride; science should be ever vigilant and self-correcting
- Debunking should be a staid, sad affair (not gleeful and ridiculing)

But Let's Eradicate Psychoquackery

Use (inclusively defined) EBPs to promote what does work
Avoid (consensually identified) discredited practices to eradicate what does not work