Dan's Talking Points Memo

COUN 231 • H. Dan Smith, EdD, MFT
Wilcoxon, Remley, Gladding, & Huber; Chapter 6
(for discussion on October 22, 2009)

1. On page 138, Green and Hansen have noted the difficulty making ethical decisions due the "general, nonspecific nature of the ethical guidelines provided by professional organizations and bodies." Please understand why these guidelines are deliberately written to be "general and nonspecific."

2. Can you see yourself recommending to a client a web site to augment their treatment? Do you EVER go to a web site to get information on how to guide your personal decisions? What about DIY assessments? Lately, the web has been loaded with advertising banners guiding users to take a Bipolar Disorder questionnaire. Good idea? Take a look at http://www.dbsalliance.org/ and click on "Signs & Symptoms."

3. On page 140, the authors discuss potential problems with Information Management Systems as related privacy issues. How worried are you, personally, about using your computer to prepare client documents or even to store client records? What are you willing to do to protect the security of your personal system?

4. Chat room therapy and email therapy. How do you feel abut these forms of interaction? Will you do it? Will you use either or both to augment your face-to-face interactions?

5. Hey geeks, know the difference between synchronous and asynchronous interactions. (p. 141)

6. A few weeks ago there was a scavenger hunt to find two (2) online therapists. Tonight we'll look at those and discuss. Examine the therapist's credentials, their policies, what they charge and how they get paid, philosophy statement, etc. Does their web presentation engender confidence? Synchronous or asynchronous?

7. Note the study by Day and Schneider, page 141, that found face-to-face and these more "trendy" modes of treatment showed only modest outcome differences. What do you think?

8. Are you moved by the author's concerns about "cultural pitfalls" in use of technology in the delivery of therapy? Actually, I'm not very concerned, but perhaps I should be more concerned. (p. 142)

9. What about this? Electronic therapy modalities may threaten "attention to client welfare" and thus degrade *beneficence* as a guiding principle for therapists. (p. 143)

10. There are worries articulated on pages 143 - 144 on Informed Consent vis-à-vis these modern modes of communication: Knowing your client's identity is compromised. Assurances of confidentiality are murky. Procedures for handling emergencies might be

only wishful thinking. Duty to warn/report/protect situations may be fumbled. Lots of problems articulated here. How do you chart an email session? Just keep the transcript? That sounds pretty good to me. Have I oversimplified the problem?

11. What about Freeny's statement, "computers and confidentiality may be incompatible." Are you impressed with the assertion that the internet is not protected by federal law as is the US Postal Service? (p. 145)

12. Per your text, the National Board for Certified Counselors (NBCC) has developed a beginning Code of Ethics for Internet Counseling (http://nbcc.org/webethics2).

13. Let's talk about those four DSM-IV-TR concerns for MFTs: 1) incompatibility of orientations, 2) the stigma of diagnosis, 3) misrepresentation of diagnoses, and 4) competence to diagnose . . . (beginning p. 146)

14. It is really true that the DSM and MFT are highly incompatible. DSM relates to diagnoses that are almost exclusively individual and relate to the "IP," etc.; MFT generally relates to systemic issues that may not have an individual emphasis at all. Yet, we are expected to utilize this tome to justify our work and diagnose our clients for insurance payment purposes. How do we bridge the abyss? What are the ethics here? (p. 147)

15. What about the stigma of diagnosis? Clients might find family pressures relieved by an accurate mental health diagnosis. Others may use their diagnosis as an excuse to justify their behaviors. (p. 148)

16. Understand what Packer has termed the "insurance diagnosis" (which constitutes "insurance fraud"). I like the inset on pages 149 and 150 that says the health insurance was never intended to pay for non-medical problems such as "floundering marriages" and "trouble raising kids." But, isn't that what we deal with? We have an ethical (and legal) commitment to accurately represent a client's diagnosis.

17. We should chat about Christensen and Miller's notion that we are faced with the dilemma of "fudging on diagnosis at times" in order to resolve diagnostic vs. reimbursement quandaries. (p. 151)

18. Take a look at the entire section on Managed Mental Health Care (MMHC). Note the list of questions by Haas and Cummings for providers who are considering participation in an MMHC program. (p. 151) We will discuss each of the areas in question:

    - Who takes the risk? (p. 152)
    - How much does the MMHC plan intrude into the relationship and the services provided" (p. 152)
    - Are there provisions for exceptions to the rules? Time to learn about capitation! (p. 153)
    - Can clients get help if the client's needs exceed the plan's benefits? (p. 153)
    - Is there training for providers to be more efficient/effective? (per Zimet; "Most clinicians resent having their practices subject to external control.") (p. 154)
    - Do providers get a chance to have input? (p. 155)
    - Are policyholders clearly informed of the limits of their benefit? E.g., Informed consent. (p. 156)

19. Back to Dual Relationships. Consider the authors' observations on dual relationships: 1) [paraphrased] as the difference between the expectations of the therapist and client increases, the potential for problems also increases (see example, page 162), 2) "as the divergence between the obligations imposed by different roles increases, the potential for divided loyalties and loss of objectivity increases" (see example, page 163), and 3) "as the difference in power and prestige increases between the roles of therapist and client, the potential likewise increases for exploitation on the part of the therapist" (see example, page 164).

20. Do you see any problems with Dr. Smith's behavior on page 165? Note that the authors have noticed that the role of "political activist" in the MFT office may be less prevalent than that of "religious activist."

21. Please note study by Kegeles, Catania and Coates on the percentage rates regarding self-report of HIV+ status to current and prior sexual partners. Yikes, this is a worry. (p. 167)

22. Notice the Kimberly, Serovich, and Greene six-step framework for understanding the process an HIV+ client will traverse when deciding whether or not to disclose their status to family members. Actually, this framework could be effectively applied to lots of things. (p. 168)

23. Notice that the authors have likened the HIV status report to the *Tarasoff* case; California law does not acknowledge this linkage; there is no "exception to confidentiality" for HIV reporting, hence it is not an appropriate disclosure for a therapist. This is where supporting the client to "do the right thing" comes into play. (p. 169)

24. What are the obvious differences between *Tarasoff* and HIV status? At least the authors have labeled this disclosure as "the ethical dilemma of *unauthorized* disclosure." I highly recommend you do your best to avoid all incidences of "unauthorized disclosure." (p. 170)

25. At least Schlossberger and Heckler have recognized that one would be wise to consult state law on the matter of these disclosures. Very wise. (p. 171)

26. Beautiful statement by Burkemper: "Relying on personal or therapeutic feelings for the HIV scenario may reflect the lack of an entrenched legal stance, or therapist knowledge or State law, and resulting confusion concerning the violation of confidentiality in the HIV scenario." (p. 171)