Don't Let "Risk Management" Undermine Your Professional Approach

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Recently, I defended a therapist accused by his licensing board of unethical practice. At the administrative hearing, a psychoanalytically oriented board representative aggressively questioned him, berating him for not maintaining a neutral, anonymous therapeutic presence with his client, saying this constituted a transgression of appropriate boundaries. The therapist, said his interrogator, had, in effect, engaged in a "dual relationship" with his client and "harmed the transferential relationship." The board considered the infraction so serious that they sought to revoke the therapist's license for "breaching the therapeutic frame."

What had he done that was such an outrageous affront to therapeutic ethics and professionalism? A cognitive-behaviorist, he'd departed from strict "talk therapy," and accompanied a phobic client to a bank and a supermarket—places the patient had avoided for years. The therapist had conducted a standard cognitive-behavioral form of exposure therapy, an empirically supported intervention, and was operating fully within the professional standard of care. Not to mention that the treatment worked: the client's agoraphobia completely disappeared.

I patiently explained at the board hearing that crossing a boundary from in-office treatment to out-of-office treatment wasn't the same as engaging in a dual or secondary relationship with the client—the relationship remained therapeutic, even though the geography changed. I stated that staying in the office, regardless of the presenting problem, may seem like the only correct methodology to psychoanalysts, risk-management consultants, and many attorneys, but it may not actually help people who suffer from agoraphobia or social phobia. These clients need a therapist who's willing to leave the sanctity of the consulting room and accompany them as they practice mixing with crowds in public spaces. Finally, I tactfully suggested that transference is a strictly psychoanalytic construct, neither applicable nor useful in cognitive-behavioral therapy—an entirely different but just as legitimate approach.

With a certain amount of hemming and hawing, the board dropped all charges—as they often do in such cases—but to save face, members required that the therapist take an ethics class anyway.

In another case, I defended a deaf therapist who worked with a deaf client with whom she'd socialized at a social club for deaf people. The charge, of course, was boundary violation and dual relationship. But as I successfully argued to the board, what other choice did the client or therapist have? Therapists who know sign language don't grow on trees. Furthermore, a boundary crossing—being a part of the same deaf community as the client—isn't the same as a

boundary violation. Would it have yielded a higher level of care to hire an interpreter to sit in on sessions with a therapist who couldn't sign, but was a perfectly anonymous stranger to the client?

I've also testified on behalf of therapists accused of having sexual relationships with their clients. The basis of the accusations? The therapists had been asked about their sexual orientation by gay clients and had answered the question honestly before the first appointment. Such a conversation doesn't suggest a burgeoning sexual relationship, I found myself explaining, but rather fact-finding on the part of a client who's trying to protect him- or herself in a deeply homophobic culture, and a therapist's recognition of that need for self-protection.

Fostering a Culture of Fear

Welcome to the wonderful world of "risk management." Even though cases like these are quite rare, the fact that they can and do happen, and are often based on anachronistic and rigidly legalistic rules, strikes dread into the heart of most therapists. The therapists above were certainly not acting unethically or unprofessionally—quite the opposite—but they were arguably failing to follow what the malpractice insurance industry considers good strategies of risk management, or "healthy defensiveness," as some attorneys call them. *Risk management* is a term referring to the avoidance of certain practices and interventions by therapists—not because they *are* clinically ill-advised, unethical, harmful, or wrong, but because they may *appear* so to judges, juries, licensing boards, or ethics committees. Risk management isn't synonymous with ethical principles and good clinical practice, but, in our increasingly jumpy profession, these concepts are often regarded as synonymous.

In a culture of litigation run amok, therapists aren't the only ones afraid of legal or professional liability. We all know that many obstetricians no longer deliver babies because the threat of malpractice has run their insurance premiums through the roof. Physicians routinely practice "defensive medicine," by ordering large numbers of expensive and probably unnecessary diagnostic tests (wasting an estimated $50 to $100 billion annually), because they don't want to end up defending themselves in court. Playgrounds around the country have been stripped of monkey bars, high slides, and swings because of lawsuits filed by parents whose children were allegedly injured on them. Ministers, teachers, coaches, and youth counselors stringently avoid touching boys, girls, or women for fear of being accused of sexual misconduct and of "abusing" their professional trust.

Currently, the field is so deluged with dire warnings of imminent professional ruin that many therapists practice under a cloud of fear. There's now a huge literature on the subject of risk management, including scores of books with titles like *Fifty Ways to Avoid Malpractice*, by Robert Henley Woody, and *On Your Side: Protecting Your Mental Health Practice from Litigation*, by J. Michael Adams. The insurance industry provides its own, often pricey, version of risk-management workshops. Psychoanalytic literature supports the risk-management view of therapeutic boundaries, but for theoretical reasons, rather than legalistic or financial ones. Newsletters on the subject abound. For example, American Professional Agency, Inc., a professional liability insurance company, regularly publishes a newsletter called *Insight:*

Safeguarding Psychologists Against Liability Risks. At our professional meetings, in the legal columns that are now a regular feature of our journals, and at workshops and seminars, legal professionals, usually without any clinical training whatsoever, are giving their opinions about how we should practice, what we're allowed to do, and what we should never do—and scaring us to death in the process.

The Chilling Effect of Self-Watchfulness

The most frequently uttered words coming from these sources seem to be "don't" and "never." Consider the commandments regularly issued against what these experts consider dangerously risky behaviors. "Don't touch your clients—a handshake is the outer limit!" "Minimize self-disclosure; keep your anonymity intact!" "Never venture outside the office with a client!" "Don't accept gifts from a client!" "Never socialize or share a meal with a client." As Richard Leslie, an attorney specializing in psychotherapy issues and a consultant to the American Association of Marriage and Family Therapy, put it in one all-purpose rule, "If you have to ask, don't do it!"

The problem with these blanket condemnations is that many of the forbidden acts may be among the most powerful therapeutic methods at our disposal. We know that touch is one of the most elementary human ways to relate, and can have a powerful reassuring and healing effect. Self-disclosure can help fearful and defensive clients connect with us, and learn from us through modeling—a proven cognitive-behavioral intervention in itself. Sometimes going to the client, rather than making the client come to us, is the only reasonable way of doing therapy: take, for example, the empirically successful home-based family therapies with juvenile offenders, or therapy with a homebound sick or elderly client. A gift may be an important way for a client to express gratitude; refusing it could be deeply offensive and shaming. Sharing a meal with an anorexic client is often part of an effective, system-based treatment plan. "Dual relationships" with clients are often unavoidable and therapeutically helpful for a therapist who works in a small town or rural setting—your children may go to the same school as your clients' children; you may belong to the same church or synagogue. Conscientious, ethical therapists know all this, but even as we necessarily engage in these "forbidden" activities in the interest of being good therapists, we may feel a shudder of apprehension that we're somehow dangerously flouting rules written in stone.

At workshops, I regularly field questions from experienced therapists who agonize about issues that ought to be far less fraught with ominous implications. Should they accept a gift of home-baked cookies from a client at Christmas? Should they ever give a small gift to a client that they think might serve a therapeutic purpose—a blank-paged book for journaling, for example? Should they go to the recital of a child whom they've coached through paralyzing stage fright? Should they acknowledge a client in a grocery store or at synagogue or at the town's one health club, or slink away at first sighting?

This isn't to deny that most interactions between therapist and client—including touch, self-disclosure, gifts, dual relationships, boundary crossings—require from the clinician solid judgment, sensitivity, awareness of the context, critical thinking, and a certain tolerance for uncertainty, but resources are available to help therapists make decisions about unusual situations. To turn Leslie's advice on its head, "If you have to ask, consult!" Good therapists

should and *do* consult with experts on ambiguous and complex questions of boundaries, confidentiality, and dual relationships all the time, but therapists in today's climate often seem driven by fear that's out of all proportion to the actual risk.

Even more disturbing, therapists sometimes seem on the brink of not doing what they know and feel is good therapy, in the interest of practicing hyperdefensive therapy. Always looking over their shoulders, as it were, fear leads them to commit what Arnold Lazarus called, "the worst professional or ethical violations"—taking care of themselves at the expense of their clients' care.

This extreme self-watchfulness and rigid avoidance of anything resembling a "boundary violation" by a psychoanalytic or risk-management yardstick can do clients real harm. A patient of mine lost her infant son in a drunk-driving accident. Devastated by grief, unable to stop crying, she'd seemed to her terrified family to be on the verge of committing suicide. They insisted on an emergency appointment for her with a psychiatrist. Barely able to walk, she entered the psychiatrist's office and sobbed uncontrollably. In her desperation and isolation, she begged him to hold her. He firmly instructed her to sit down, calmly explained that therapy was about talking—not touching—and cited the importance of maintaining professional boundaries. At the end of the session, he prescribed Valium for her and scheduled a second appointment a few days later.

She never kept the appointment. Instead, she became addicted to alcohol and Valium, divorced, and entered (and failed) two rehab programs. Eight years after seeing the psychiatrist, she began therapy with me. After an intense few months of sessions, we went to her son's grave—the first time she'd ever visited it. We stood there, holding each other and weeping. In the long time we stayed, as she cried, she could finally begin truly mourning her child and grieving for the years lost in drugged denial.

That psychiatrist followed risk-management guidelines to perfection. In his mind, given the way therapists are taught, he was probably also following the highest ethical tradition of "do no harm." But he almost certainly inflicted needless additional suffering on this woman. In his zeal to be perfectly professional, he sacrificed his humanity and, it can be argued, harmed the client by providing substandard care.

You wouldn't know it from this explosion of risk-management advice, but lawsuits and disciplinary actions are actually rare. According to documented reports, less than 2 percent of psychologists faced any licensing complaints between 1996 and 2000. Not all complaints are investigated, and of those that are, 30 percent are determined not to be in violation. All in all, less than 0.4 percent of psychologists have faced any reportable action by licensing boards. The percentage of complaints against counselors and social workers is even lower, and they're less likely to be held liable for malpractice. Accordingly, their insurance premiums are lower.

Why, given how unlikely disciplinary actions or lawsuits are, do we so often succumb to risk-management bugaboos? One possible answer, according to California psychologist, Martin Williams, lies in the human inclination toward phobias: exaggeratedly fearful responses to harmful, but relatively rare, occurrences.

For example, even though flying is much safer than driving, many people fear flying, because of the media's focus on dramatic airplane crashes. This phobia about board investigations didn't arise by accident: it's purposely generated by risk-management gurus with vast stores of horrifying anecdotes involving innocent, well-meaning therapists who, through some careless inattention to the holy writ of risk management, found themselves booted from the profession, sued, broke, and disgraced. One pernicious form of this propaganda involves the "slippery slope" argument, popularized by psychologist Kenneth Pope. According to this logic, nearly all boundary crossings or dual relationships—a therapist patting the hand of a grieving client, sitting on the same school board as a client, accepting a gift from a client—"while not unethical and harmful per se, foster sexual dual relationships." This is a truly breathtaking leap of logic. It seems to assume that most therapists are barely able to control their darker impulses in therapy and require the most stringent self-censorship to keep a comforting touch or passing acquaintanceship outside the consulting room from degenerating into a wild and illicit affair.

Risk Management vs. Standard of Care

This grotesque metastasis of risk management actually emerges from fatal confusions among risk management, psychoanalytic guidelines, and standard of care. Psychotherapists tend to conflate good, ethical, legal therapy with risk-free therapy, which protects practitioners, not clients. Again, there's nothing wrong with attending to professional risks and hazards for our own protection. That's why therapists should keep good records, establish well-articulated treatment plans, and consult clinical, ethical, and legal experts when in doubt. But watching out, primarily, for our own skins isn't the same as fulfilling our obligations to our clients.

What are those obligations? The standard of care that guides psychotherapists is a fluid mix of law, licensing regulations, ethical codes, professional consensus, community norms, and the like. We're required by law, ethics, and good clinical practice not to harm or exploit clients (which includes sexual and financial exploitation), to treat them with respect and dignity, and to protect their privacy and autonomy. We're legally and ethically bound to minimize the risk that mentally ill clients will hurt themselves or others.

The standard of care has traditionally not been driven by risk-management guidelines, which have been geared almost exclusively to reduce the risk of malpractice for therapists so insurance companies can reduce their financial liabilities. Standard of care has never required perfection; it's a minimum standard, based on the average practitioner, someone who achieves what's been called a "C-student standard." Careless mistakes or errors of judgment don't put you below the standard of care; nor does the standard adhere to psychoanalytic or any other particular theoretical orientation: rather, it's guided by a consensus among the practitioners of a particular method or clinical practice—group therapy, humanistic, feminist, family, cognitive-behavioral, whatever. Standard of care isn't determined by outcome: a therapist isn't guilty of substandard care because a client commits suicide, *as long as the therapist has engaged in a coherent and documented process of legal, ethical, and clinically appropriate treatment.* Nor does standard of care exclude what risk managers consider high-risk behaviors: giving gifts, self-disclosure, and boundary crossings (but not boundary violations, like unwanted or sexualized touch) appear rarely, if at all, in ethics codes or state laws, and yet the standard of care has been infiltrated by risk-management principles that, when carried to extreme, can undermine good practice.

The Downside of Risk Management

Even if these risk-management principles are over the top, aren't clients better served by excessive strictness than too much laxity? How does it harm therapy in the long run?

In the first place, an obsession with risk management makes therapists refuse to treat people they could genuinely help, and avoid interventions that are genuinely useful. Some years ago, soon after moving to the small California community where I now live, I got a call from the mother of a child in my daughter's kindergarten class, whose father, a lawyer, was on a basketball league with me. This couple was in a crisis. The woman, already the mother of four children, told me she had an unplanned pregnancy and didn't know what to do. She was inclined toward abortion and her husband, who was pro-life, was against it. For obvious reasons, they had to make a decision within a few days. Could they come see me?

At first, I demurred. I said that, technically, this would constitute a dual relationship and that it would be inadvisable. Her husband then got on the phone and practically yelled at me. "That's *why* we called you! We *know* you—we've seen you with your kids, we've heard you lecture, we've seen you on the basketball court and your wife in the bleachers. We chose you because we knew we wanted to work with you." After telling them I'd get back to them, I consulted a philosopher-psychologist friend, Sam Keen—about as far removed from the risk-management zeitgeist as it's possible to be—who was just as annoyed with me as the father had been. "You come from generations of rabbis, who for thousands of years have counseled people they knew. You've spent time sitting with shamans in Africa, who not only know the people they counsel, but know their ancestors, and the spirits of their ancestors. What's your problem, anyway?"

I called the couple back, made an appointment, and they came to see me at my home for the next five evenings as we thrashed out the issues raised by the pregnancy. In the end, we found a way to resolve the dilemma that they could both live with, and which actually strengthened their relationship. This work was a wake-up call for me, making me realize how out of touch the culture of risk management and emotionally-distanced psychoanalytic principles are with the way real human beings live their lives. Somehow, as a profession, we've created this myth that it's better for people who need help to look in the yellow pages or online directory than to turn to somebody whom they may know and trust.

Risk management makes therapy less attractive to consumers, because, as Williams asserts, it tends to replace what the therapist can offer of warmth, soul, spontaneity, and human connection with a prissy, unattractive defensiveness. One of my clients was a gentle, pleasant older man in his 50’s suffering from chronic paranoid schizophrenia, with whom I worked for many years. As part of therapy, I was continually in touch with his parents, stepparents, children, sisters, landlord, employer, psychiatrist, and everyone else involved in his life. He happened to be a *Starsky and Hutch* junky and it seemed that, with my curly, dark hair, I reminded him of Starsky—in fact, at times, he confused me with the character. He drove a car that reminded him on the signature car of the show.

This car was the “office” or the space where we’d meet. He'd never liked my office—being there made him feel nervous, frightened and withdrawn—but he felt relaxed and engaged, open and

receptive, while tooling around town in his car. During our weekly appointments, we cruised around, checking out the hot spots, all the while talking about his employment, children, medications, fears, girlfriends, or anything else on his mind. Several ethicists, graduate school instructors, and attorneys raised legitimate questions. What would happen if we got into a car accident? How did I bill for it—was there a CPT code for "car therapy"? Some wondered how I managed the transference, while others strongly recommend that I look at my own countertransference issues. After consulting with several experts, I decided my countertransference issues could wait, and that I'd continue this form of therapy because it appealed to him and, most important, it seemed to work well. Besides, the way I looked at it, I was paid to help him, not practice defensive medicine.

As for the issue of gifts, I long ago decided that the meaning and significance of the gift to the client, as well as whether giving or receiving a gift is in the service of the work, should determine whether it's "appropriate" or not. When I come back from a visit to Israel, I regularly bring gifts—rocks from Jerusalem or water from the Jordan River—to certain clients who find them meaningful. One workshop attendee, who's Jewish, once told me that a non-Jewish client, a craftsperson, had made a stained-glass menorah for her. The work itself was nourishing to the woman's spirit and the feeling of gratitude expressed by the gift was an important part of the therapeutic encounter. Not only would it be hurtful and churlish to high-mindedly refuse such gifts, it would be utterly untherapeutic—in its own way a betrayal of good clinical practice.

Paradoxically, excessive risk management tends to increase the rate of complaints about therapists. How can this be? As we've seen, as more and more-risk management practices infiltrate the field, they gradually insinuate themselves into the definition of the standard of care—lengthening the list of behaviors considered inappropriate or downright suspicious. For example, for a long time, risk-management advisors have recommended that therapists carefully bill for all the time that therapy takes—neither underbilling nor overbilling. So, therapists who don't charge for some sessions, bill for hour-long sessions that actually last two hours, or simply forget to send an invoice often find that, according to risk-management principles, their sins are as grave as the usual suspects—self-disclosure, nonsexual touch, gifts, out-of-office treatment, and dual relationships. It's suggested that they're suddenly giving treatment that's below the standard of care.

Even more perverse, rigid risk-management rules can actually contribute to the exploitation of clients. The rules mandating in-office-only treatment and no dual relationships tighten the isolation of the therapeutic encounter, both physically and psychologically—creating a hermetically sealed little world in which the therapist has all the perceived power. As we know, child and spousal abuse usually occurs in isolation, as does the exploitation of people who join cults. Similarly, exploitation by a therapist of a client doesn't happen in the public arena, but in the sacrosanct privacy of the office. Therapists are actually less likely to exploit those with whom they have some kind of connection—through family members and friends or in the community beyond therapy. When implemented with care and integrity, dual relationships with clients and the familiarity that follows are likelier to deter exploitation than invite it.

Finally, when therapists confine themselves to strict risk-management behavior, they also risk blunting their own creativity, spontaneity, and sensitivity to their clients' best interests. It can be

hard even to establish a therapeutic alliance with a client if you're too frightened of what might happen to allow yourself some flexibility. Case in point: I saw a young man, referred to me by his family after a drug-induced, single psychotic episode that landed him in the hospital. When I met him, he neither wanted to be in therapy, nor saw any reason for it. He was unpleasant, sarcastic, uncooperative, and uncommunicative. Working with his parents, uncle, and brothers, I discovered that, like me, he loved to play basketball, so I suggested we meet on the basketball court for our next session. He was taken aback, but regained his swagger and sized me up as if to say, "What can an old man like you do on a basketball court?" At the next session, on the court, after a few minutes of warm-up, we decided to play one on one. Trailing 1–5 in the opening minutes and breathing hard, he turned to me and asked, "How old are you?" To which I responded, "We're here to play, not talk." Eventually, his energy picked up, his game improved, and his connection with me intensified. After a couple more games, at his suggestion, we walked across the street to a coffee shop. Now, he was doing most of the talking. Therapy had begun, and it continues with great progress—on and off the basketball court.

Confusing risk management with a highly ethical and clinically sound standard of care ultimately undermines the latter and does a poor job of protecting the therapist. So, what's a therapist to do who wants to practice good therapy, but not end up on the wrong side of a trial or disciplinary hearing? First, we need to arm ourselves by learning about psychotherapy-outcome research, particularly as it applies to our own methods. Often licensing boards, investigators, and attorneys have little clinical understanding. Second, it should be obvious that we must be knowledgeable about the codes of ethics and state laws that apply to our field—psychology, social work, or counseling. And unlike the advice from the risk-management types cited above, we shouldn't be afraid to consult colleagues and appropriate experts whenever we're uncertain about something, and *keep a record* of the consultation.

This brings us to probably the most important single preemptive defense against getting into trouble: keeping good records. Generally, licensing boards decide whether clinicians have operated within the standard of care not by interviewing them personally, but by sifting through their records. In civil law suits and administrative hearings, it's often the client's word against the clinical records. Not only should clinicians keep good records on diagnosis or presenting problem, assessment, and mental status, but they should also keep notes on relevant biographical background information, treatment planning, crisis interventions, special phone calls, emergencies, and so on. It's particularly important to keep records of boundary crossings, dual relationships, and complex clinical, legal, and ethical issues. Make a note of anything you do that might be defined as a boundary crossing—giving or receiving gifts, extensive touch, exchanging therapy for barter, meeting a client outside the office, seeing somebody in therapy that you know in another context—and explain why you did it. What were the benefits to the client? What might have been the risk had you not accepted that gift? Would therapy have come to a screeching halt if you hadn't taken therapy out of the office? It may be helpful to remember that therapists most often get into trouble not because they did the wrong thing, but because they didn't follow (or didn't document) the right decision-making process.

Life, as every therapist knows, is often messy. Therapy can be messy, too; every day, we run into complex and ambiguous situations not covered in psychology books, much less by the professional guidelines of our profession. Lawyers and insurance functionaries are often paid to

simplify life's complexities, control everything that happens, and make the messes disappear. But that isn't our job. We're here to help our clients accept, deal with, and perhaps do something creative with the messes life inevitably hands them.

Of course, therapists must be aware that some situations—for instance, cases involving custody, repressed memory, and complex PTSD issues or clients who are highly paranoid, aggressive, dissociative, antisocial, or litigious—may present higher levels of risk than others. Additionally, boundary issues should be handled with extra care with clients who have serious personality disorders, such as borderline or narcissistic personality disorder, or those who view themselves inherently as victims.

If we try to combine the role of lawyer and therapist, we'll inevitably make a hash of both. The best and truest kind of "risk management" isn't motivated by fear of taking a wrong step or making a wrong move: it's based on therapeutic competence; knowledge of the laws and codes of ethics; a deep commitment to our clients' welfare; our own maturity, professional development, and common sense; and our ability to think critically, work only within our scope of practice and competence, and carry out an ethical decision-making process. Then, of course, we must bear in mind the importance of informed consent, thorough documentation, and consultations. Without these qualities, we won't be good therapists, no matter how much case law we memorize.

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