

PROFESSIONAL ISSUES

Ethical Practice Issues in Treating Pain

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Human pain and suffering are an integral part of the daily practice of the biofeedback practitioner. Practitioners need to know how to apply basic foundational ethical principles such as nonmaleficence, beneficence, and autonomy with due care and prudence in their daily practice activities. Being competent, doing a conscientious job in obtaining informed consent, and developing a good, integrated set of personal and professional values and ethical beliefs can all be helpful to the practitioner in resolving ethical concerns in a prudent and timely manner while simultaneously reducing personal stress.

Introduction

Physical, mental, or spiritual pain and suffering, whether real or imagined, are integral parts of the daily practice activities of biofeedback practitioners. Practitioners know that clients/patients should not be harmed by the treatment(s) that they receive, and in fact, that clients should benefit from those treatments. In addition, most practitioners know that treatments should be administered with prudence and care to ensure that clients are not harmed. In a practical sense it means that pain, as experienced by the client, should decrease rather than increase. Yet in daily practice, symptoms, including pain, sometimes get worse before they get better. As such, skill is needed in applying the basic ethical principles of nonmaleficence (do no harm) and beneficence (do good). Such ethical principles can help guide the ethical decision-making behavior of practitioners if the practitioner knows how to apply them in the various situations encountered in daily practice (Striefel, 2003).

Prudence and due care along with consideration of many of the foundational ethical principles and their application must be an ongoing part of the intervention process, from the first to the last contact with a client and beyond. For example, client autonomy, the right to choose what does and does not happen to him or herself, generally takes precedence over what the practitioner thinks should happen. A good working relationship, meaningful communication—including an educational component about the client’s problem and treatment options—and an honest and thorough informed consent process are all helpful.

Competence

It is not sufficient for a practitioner to monitor just end of treatment outcomes for evaluating whether harm has occurred and/or for determining if a client has benefited from treatment. Rather, due consideration to potential harms and benefits must be ongoing, and the practitioner must keep the foundational and other ethical principles in mind and apply them at each stage of contact with a client. For example, when a practitioner receives a referral of a client, he or she should ask him or herself several questions.

1. Am I competent to deal with this client’s presenting problem(s) as I understand them from the referral information?
2. Do I need more information before I can decide if I am competent to help this client? How will I get that information?

The additional, needed information might be collected before, during, or after the first session. Sometimes the problem(s) presented in the referral are not what the client actually wants to work on, so additional information needs to be collected and additional questions asked and answered by the practitioner, including, but not limited to:

1. What are the most likely treatments for this client’s problems and what are the risks and benefits of each?
2. What clinical and research evidence, if any, exists to support each of these treatments, especially the one that I am likely to recommend?
3. Which of these treatments am I competent to provide, and which can I legally and ethically deliver?
4. Based on what I know now, can I provide treatment for this client that at least meets the minimal expected standard of care? To do so, do I need supervision and/or consultation? For example, working with a physician who provides pain medication to deal with severe pain might be desirable on the part of the client while he or she acquires some self control skills via biofeedback and other treatments offered by the biofeedback practitioner.

5. Would this client be better served if I referred her or him elsewhere? For example, might this client benefit more from a treatment that I am not competent to provide?

Capacity

Prudence, due care, and a client's right to autonomy, result in various obligations for the practitioner. So a practitioner needs to establish a good working relationship with each client and potential client and with other health care providers in the community, especially the client's primary care physician, so that he or she can meet his or her obligations in a responsible manner (Striefel, 1997, 2005). Included of course, is the client's involvement in all steps of the decision-making process, to the degree that the client has the capacity for making the needed decisions (Striefel, 2004a).

With adult clients a practitioner can generally assume that the client has the capacity to be involved in the decision-making process and "to give informed consent unless there is contrary evidence" (Striefel, 2004a). There are four types of situations in which a practitioner should assess a client's decision-making capacity, or refer the client for such an assessment to another competent practitioner if one does not have the skills to do so (Striefel, 2004a; Tunzi, 2001), including situations in which:

- A client has a rather rapid shift in her or his mental status because of an infection, accident, medication side effect, substance abuse problem, or when the client has a serious psychiatric or neurological problem.
- A client refuses a recommended treatment that has little or no risk, but a strong probability of being beneficial, and the client refuses to discuss his or her reasons for refusing the treatment, or the refusal is based on inaccurate knowledge and information.
- A client consents to treatment quickly without due consideration of possible risks and benefits of treatment, or without consideration of alternative treatments. This issue needs to be carefully considered because the greater the pain and suffering, the more likely it is that a client will agree to any proposed treatment by a health care practitioner.
- A client has a psychiatric or neurological condition known to be associated with impaired decision-making skills (e.g., schizophrenia), a cultural or language barrier exists, the client is under age 18 or over age 85, or the client has a lower level of education or achievement than his or her age would predict.

Each practitioner should develop his or her own approach for assessing a client's capacity for giving informed consent

(assuming the practitioner is allowed to do so based on the licensing laws in that state). Assessing capacity should be an active process that includes a good clinical intake interview with due consideration given to the client's history, education, age, achievement level, mental status, and other relevant factors, including whether the practitioner has the skills needed for assessing the capacity of the specific client (Striefel, 2004a). Specialized assessments might also be used, e.g., The MacArthur Competency Assessment Tool.

The practitioner should pose direct questions to the client about his or her understanding of the proposed treatment, alternative treatments, why a specific treatment might be appropriate for the client's presenting problem, about applying the information received during the informed consent process to his or her specific situation, or about his or her ability to use the information supplied to make needed decisions. In addition the practitioner should present questions to determine the client's ability to express a desire for a specific treatment in his or her own words, including the reasons for that choice. Pursuing these questions can be helpful in assessing capacity and determining whether the client has given meaningful informed consent to treatment (Striefel, 2004a; Tunzi, 2001). Interacting with other health care practitioners who are currently treating the client or who have previously done so (after obtaining the appropriately signed release of information) can allow for a meaningful discussion of the client's capacity to give informed consent for specific treatments and can help the practitioner make his or her own decision about client capacity for giving consent.

The other conditions for legal and ethical informed consent should also be met. See Striefel (2004a, 2004b) for a discussion of all of the components of informed consent, including, knowledge, understanding, capacity, voluntary, actual consent, and documentation.

Validated and Nonvalidated Treatments

When we use the word "experimental" to describe a newer therapy or procedure, we raise another set of concerns about informed consent. The label experimental suggests that the effectiveness of a treatment has not yet been established by research, and that the treatment remains outside the mainstream or controversial in some sense. The treatment has not yet been established as part of the routine standard of care for a specific disorder. There may be some unknown factors for practitioners to consider, and this suggests that there are ethical and standards of care concerns about whether an intervention is validated or nonvalidated.

For example, the Association for Applied Psychophysiology and Biofeedback's (AAPB, 2003) ethical principles specify,

Table. Ethics viewed from an acculturation model.

Personal ethics	High	Low
Professional ethics High	Integrated professionally informed; guided by personal compassion; highly effective practitioner	Separated personal compassion not restrained by professional ethics; may become overinvolved (runaway compassion)
Low	Assimilated adopted professional standards; but lacks compassion; may become rigid and legalistic	Marginalized low professional and personal standards; risks becoming exploitive

“Written informed consent shall be obtained from clients for all non-validated treatment procedures.” The AAPB practice guidelines and standards express similar requirements (Striefel, 2004b). To determine whether a procedure is validated or nonvalidated (experimental) can be difficult. Using the template developed by the Task Force on Validated Procedures (La Vaque et al., 2002; Moss & Gunkelman, 2002; Striefel, 2004a), being familiar with the published literature and commonly used clinical biofeedback interventions, consulting with peers and/or other experts who treat the specific kind of problem the client has, can all be helpful in this decision-making process. See Striefel (2004a) for more information on ways of discerning the validity of specific interventions.

If an expert in a specific area, such as Alan Glaros for temporomandibular pain disorders or Frank Andrasik for head pain, considers a specific biofeedback intervention to be an experimental intervention, a practitioner would be wise to have a very good supported rationale, including published research, before presenting that intervention to a client as a validated (nonexperimental) procedure for the specific kind of pain discussed by the expert. It is always a good idea to ask yourself, “Would my biggest professional competitor (for treating the specific kind of problem this client has) agree that the intervention I am proposing to use is a validated intervention?” If not, how will you avoid or deal with a complaint filed with the licensing board or an ethics committee? Being proactive by having a plan and supporting data in advance can help avoid many problems. I have seen no evidence to indicate that clients will reject a treatment that is considered to be experimental if it has low risk and a reasonable probability of being helpful.

There is a strong, justifiable, motivational bias on the part of practitioners toward making sufficient or good income from one’s clinical practice activities; after all, few

practitioners are in practice purely for altruistic reasons. Care must be taken, however, to not let that motivation override common sense or prudent practice to the detriment of a client. Competent and prudent practitioners know the limitations of their competence and thus do not accept as clients all who are referred. Rather, they accept only those whom they can reasonably expect to help based on their training, experience, and areas of competence. Nor do they bias information during the informed consent process to make a biofeedback intervention appear to be the treatment of choice when it is not. Care is taken to ensure that the information provided is balanced, fair, and accurate. If the evidence available supports a conclusion that a treatment is nonvalidated, the practitioner so informs the client and gives the client realistic information on the probability of an intervention like electromyography biofeedback being helpful, the probable costs in terms of time, money, and pain, and other treatment options that might be more successful at a lesser cost, especially if the client is in severe pain.

Personal and Professional Values

The degree to which a practitioner identifies with his or her personal values and ethical beliefs, as well as his or her professional values and ethical beliefs, and how well integrated the two sets of values and beliefs are, can greatly influence how a practitioner behaves in specific practice situations (Knapp & VandeCreek, 2006). How much a practitioner identifies with either set of values and ethical beliefs can be rated as high or low and in some ways is a measure of how well one is acculturated into his or her profession and/or professional activities (Knapp & VandeCreek, 2006). The Table was adopted from the work of Knapp and VandeCreek (2006), with some very slight modification in the words used to provide a better understanding of how having only one (personal or professional set of values), or no set of values

and ethical beliefs, can result in problems for the practitioner. The best option is for a practitioner to have a well developed set of personal and professional values and ethical beliefs that are congruent and integrated into daily professional decision making.

Clearly, practitioners should strive to develop and maintain both high personal and professional sets of values and ethical standards. Being deficient in either can be problematic and can result in a practitioner having deficits which she or he is not even aware exist (called blind spots). Attending a values clarification workshop and reading about morality, values, and ethics on a personal and professional level can be helpful. A reader can find many good books on ethics, values, and morality by just typing those words into an internet search engine like Google. For more information on moral responsibility and professional socialization and acculturation see Striefel (2006). By stopping to think, by being proactive, and by continuing one's education on values, morality, and ethics, and by practicing with due care and diligence, practitioners can avoid many potential problems in daily practice and can reduce their own level of stress.

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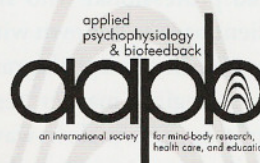
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