

Michael Freeny Associates
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Ethics and Boundary Issues
Michael Freeny, MSW

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This 3 hour home study program is approved for continuing education credits for psychologists, social workers, mental health counselors, and marriage and family therapists.

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Goals

At the end of this program the participant will be able to

- Identify the most common areas of ethical boundary crossings and violations.
- Distinguish between crossings and violations.
- Determine the difference between ethics, rules, and clinical laws.
- Describe the flow and compromises to client clinical information.
- List the limitations of the client's control over personal medical information.
- Identify the purpose and meaning of the HIPAA rules.
- List common ways that therapists are falsely accused of violations.

Boundary and Ethical Issues in Clinical Practice

Michael Freeny, MSW

Ethics have been heatedly argued at least as far back as Socrates and Plato. These debates represent a discussion of how we should behave within certain moral principles. They are also argued by modern day psychotherapy clinicians, about what is proper, effective, and protective clinical behavior. Licensing boards are increasingly requiring that licensees take mandated ethics courses to keep abreast and aware of ethical standards. This course is designed to meet the ethics requirements of psychologists, social workers, mental health counselors, and marriage and family therapists.

Obviously in the course of a three hour program one cannot address all the ethical issues in practice, so the program will be focused on the most prominent issues.

This continuing education program deals with four essential topics.

- Boundary issues - the management of boundary crossing and the avoidance of boundary violations in therapy

- Dual relationships - when a therapist maintains more than one role or relationship with a client.

- Confidentiality - how and why clinical information is desired, used, and manipulated by various entities.

- False complaints - how clinicians can behave ethically and still get in trouble.

It must be noted initially that ethics are often confused with laws and rules. In fact, state laws and rules of clinical behavior often reflect the ethical standards of professional associations, but are stronger and slightly different. For example, if one violates the ethical standards of a professional association the worst that can happen to the individual is that they are expelled from the association. Yet sometimes less than half of practitioners are members of a professional association. However, if a state licensee violates a law he/she can be fined or imprisoned. If a licensing board administrative rule is violated the professional can be fined or lose their license. Thus licensing boards and legislatures, in an effort to enforce clinical standards and protect the public, have used the ethical standards of professional associations to help develop laws and rules.

Dual relationships and sexual contact with a client is considered improper by most mental health professional associations. For example, a therapist having sex with a client is considered an absolute violation of professional ethics regarding dual relationships. The Florida legislature, and many other states, took this even farther and made such an offense a criminal felony under state law. Additionally the Florida psychotherapy licensing boards specifically forbid sexual contact between therapist and client under their psychotherapy rules. Thus the ethical standards of such professional associations as the American Psychological Association and the National Association of Social Workers were used to create and even amplify both administrative rule and criminal law.

In a review of almost 900 NASW ethics complaints filed with NASW, Strom-Gottfried (2002) found the following issues most often addressed

Violating Boundaries	Honesty	Reimbursement
Poor Practice	Confidentiality	Conflicts of Interest
Record Keeping	Informed Consent	Collegial Actions

Yet these are often nebulous standards, like the confidentiality of client information. All psychotherapy professional associations set a standard that client information should not be disclosed to others except when required by law or with the consent of the client. However, the use of third party payers and managed care companies have largely diminished the meaning of this protection. The Privacy Rules of HIPAA (Health Insurance Portability and Accountability Act) have essentially reduced the patient's control over their personal health information, which will be addressed in more detail. Thus confidentiality at the macro level (massive exposure) becomes different than confidentiality at the micro level (personal exposure) and both have grown as significant risks.

Boundary Issues.

These are issues related to the limitations of interaction and involvement between client and therapist. Such interactions should be mostly about the therapeutic process and little about anything else. As mentioned earlier, sex between client and therapist is the ultimate boundary violation, as most would agree. This is based upon the assumption that the power imbalance with the therapist makes it impossible for the client to "consent" to sexual activity. The therapist would have the ability to manipulate the client into sexual activity based upon his or her "status" as a therapist and the pseudo-intimacy that is formed during therapy ("pseudo" in that the client likely knows little about the therapist, but the therapist knows a lot about the client).

It is certainly theoretically possible to draft a scenario where the client "might" benefit from a corrective sexual experience with a caring and responsible therapist. However, such ethical permission would open the floodgates for client exploitation and therapist misjudgement. The public at large and regulatory boards would probably be skeptical that therapists could distinguish the client's needs from their own. So the standard has been set at "no sex with clients." Hence such activity is considered a clear boundary violation.

Unfortunately this standard has expanded into a virtual "don't touch the client" rule. Don't wrap your arm around the shoulder of a teen as an affirmation of good work. Don't offer a hug of support to the wife of a terminally ill husband. Don't hold the hand of a woman who has just miscarried.

There are two important dimensions of boundary issues; crossings and violations. (

Most boundary issues are not as clear as we'd like them to be. For example, there is a distinction between boundary "crossings" and boundary "violations". Crossings involve behavior on the therapist's part that crosses a theoretical boundary of accepted clinical behavior. This is where things get foggy. It includes therapist self disclosure, seeing the client outside of the office, sharing a meal with the client, non-sexual touch, bartering for services, etc. Yet some clinical approaches encourage such actions. Going for a walk with a child or an agoraphobic client may be quite therapeutic. Many people in the substance abuse field disclose their history of chemical dependency. A hug for a distressed client might be helpful and reassuring. The intervention needs to be gauged against the therapeutic value to the client. Touch can say a lot more than words.

Ethics into Laws.

Turning ethics into understandable language is another challenge, and making it law is even more difficult. For example, one standard in Florida is that a therapist, male or female, should not touch the clothed or unclothed breasts of a female client. However, anytime we hug a client that's exactly what we end up doing. Yet therapists and clients often feel this is a very appropriate way to be supportive, affirmative, or celebratory with a client. As one who has contributed to the writing of laws and rules I must state that these are not easy tasks to precisely define in the written word.

Outside of sexual exploitation there are all sorts of ways to cross or violate boundaries, including business arrangements, insider stock tips, employment situations, etc. Which leads to the question, "Who set the standards of the boundaries?" Boundary crossings are defined as doing things with the client that are outside the common realm of psychotherapy practice. They are not necessarily bad, but need to be thoughtfully considered as to the impact on the client. On the other hand, boundary violations are clear violations of professional standards, like helping the client refinance their house so they can afford therapy.

It seems in review that traditional psychoanalytic psychotherapy, with one therapist and one client in the office as the only place of contact, has become the defacto standard. No physical contact. No meetings outside the office. Certainly no house calls or travel together in the same car. In fact the therapist may sit slightly outside of the client's line of sight. But few therapists today practice in such traditions.

For the first 50 years of the 20th Century this was an adequate standard. But with the development of group therapy, humanistic, trauma work, cognitive therapy, in vivo desensitization, etc, the walls between traditional psychoanalytic treatment views and contemporary practice have broken down. Therapists must be much more flexible to work with new models and systems today.

Touching

I recall that as an expert witness for a psychotherapy regulatory board I was asked if it was appropriate for therapist to touch a client to determine the person's level of physiologic tension. Both client and therapist reported that this was not a sexual touch in any way, just a procedure to measure the client's tension in the shoulders and stomach, as a technique during a biofeedback procedure. I agreed that it seemed appropriate for the procedure. I did not believe this was an inappropriate boundary crossing.

This leads to a fascinating discussion of what constitutes appropriate touching in a psychotherapeutic relationship. Additionally, boundary crossing involves more than simply touching the client. As noted earlier, crossings can include the exchange of gifts, self-disclosure, touch, bartering about fees, the length of sessions, and contact outside the office. Many humanistic therapists and addiction professionals feel quite comfortable sharing their experience in their personal life struggles.

The psychoanalytic standard seems to be that anything that occurs therapeutically should happen only in the office and that the therapist should be almost stone-faced about their own history. Yet

with the many new forms of effective therapy this is very limiting. Thus the psychoanalytic standard may not be appropriate for today's world of therapy. In fact, many therapists don't subscribe to the psychoanalytic approach to therapy, especially when compared to the humanistic, cognitive behavioral, existential, or any other of a number of different therapeutic approaches.

Additionally, the venues of psychotherapy delivery have changed dramatically. Clinician's who work with both children and elders often find it helpful to touch or hug to affirm the client's self esteem. Both children and the elderly can be hungry for contact and a touch or a hug can dramatically impact the client's emotional well being. Thus a "boundary crossing" can have therapeutic benefit as long as it keeps the client's welfare in mind. In fact, the mere suggestion that a hug or a pat on the back is a boundary crossing is itself offensive and non-productive.

Clinician and ethicist Ofer Zur, Ph.D. has written extensively on the benefits and even clinical necessity of touch with varied populations. Beginning with the primal needs of Harlow's touched deprived monkeys in 1958 he plots a compelling case for the healing benefits of touch (Zur, 2004) for psychotherapy clients. Of course there are cautions to touch, and the sensitive therapist will attempt to gauge the client's response to non-sexual touch.

There are also tremendous cultural variations in the frequency of non-sexual touch. Zur cites Jourard (1966) who studied the frequency of touching displayed in casual conversations in different cultures. Touching occurred 180 times per hour in Puerto Rico, 110 times per hour in Paris, 0 in London, and 2 for the U.S. citizens.

This author believes non-sexual touch has a deserving place in psychotherapy, as long as it is done for the benefit of the client.

Dual Relationships.

Maintaining a relationship with the client beyond the therapeutic one is a source of great controversy and potential conflict. The more strings that tie the relationship together the more chances of tangles and snares. The most common areas of conflict in dual relationships are bartering, public service, social activities, religious activities, etc. At issue is the complex relationships and dynamics that can develop in these complex interactions. In small communities that are financially close it's easy for the therapist to "barter" clinical services for painting, food, lawn care, house repair, etc. It often becomes the only way to provide the service for a needy client. However, there is no standard for the value of these services and conflicts can easily develop. If the house painting is not up to snuff will the therapist offer inferior psychotherapy? Currency is still the easiest standard by which we judge the value of a service. Therapists are encouraged to remain with that standard. This distracts from the therapeutic process.

Dual relationships also collide with the dynamics of clinical interaction. One of the fundamental elements of therapy is to develop a clinically open and honest relationship, as it flows from client to therapist. If this is compromised by the influences of money, personal influence, social standing, or any other benefit then the relationship may be compromised. Clinical material may be withheld, affect may be dampened, doubts may be raised. This has happened with some frequency with clients who wrote books with their therapists. Again, the more strings that bind one together with their client the more tangled a web we weave.

Jourard, S.E. (1994), *The right touch: Understanding and using the language of physical contact*, Cresskill, NJ : Hampton Press.

Strom-Gottfried, Kimberly (2000) "Ensuring ethical practice: An examination of NASW code violations." *1987-97 Social Work*, 45, 251-262

Zur, Orer, (2004) *To touch or not to Touch: Rethinking the prohibition of touch in psychotherapy. What Ever Happened to Clinical Privacy?*

The war you may have missed.
Michael Freeny, MSW (2007)

In 2005 the University of San Francisco Medical Center received an email from a woman in Pakistan. It essentially said, "Either pay me my \$500 or I'll post the attached medical records to the Internet". The perplexed medical records staff tried to figure out how this woman on the other side of the world was in possession of their medical records. After some research they determined the following sequence of events. The medical center's transcription staff were overwhelmed with work, so the physician's dictation was sent to a firm in Sausalito, which was also overwhelmed, so they sent them to a Florida firm, which was also overwhelmed and sent them to a Texas firm, which was also overwhelmed, and which finally sent them to Pakistan. Someone forgot to pay the Pakistani woman.

Welcome to medical privacy in the 21 century. As distasteful as this story appears, no laws were broken in any of this procedure. Off-shoring data is now a common practice, including psychiatric notes and claims.

The Health Insurance Portability and Accountability Act (HIPAA) has required psychotherapists and all other healthcare providers to dutifully develop privacy disclosure forms for the patient to sign at first meeting. We sign them ourselves when we see our own health care providers. Yet by and large we have no idea what we're doing, what it means, or what the ramifications may be down the road. The purpose of this article is to provide a history of the erosion of confidentiality, what the implications may be, and what we can do about it.

Psychotherapists often think of their offices as protective vaults of personal patient information. Nothing could be further from the truth. This article will explain where clinical information goes, who has access to it, and how it is used. If you want to protect your patients' privacy you must first understand where the leaks are. Additionally, if the client begins to perceive that their information is not protected, they may just stop coming for treatment, or start "grooming" their disclosures so they don't look too bad on paper.

The Hippocratic oath states in part, "That whatsoever you shall see or hear of the lives of men or women which is not fitting to be spoken, you will keep inviolably secret." Most psychotherapy laws and ethics make provision for confidentiality and most practitioners think they are honoring that pledge. But we are not. We are steeped in our own denial even as we fill out Medicaid, Medicare, or insurance forms. Anytime a third party pays, they have a right to know what they are paying for.

President Bush devoted a few paragraphs to the aggressive development of the electronic medical record in his 2006 State of the Union address. He claimed it would streamline care and reduce medical errors, certainly a noble effort. It could save lives, for a patient in a medical or psychiatric emergency out of state could have their entire medical record sent within seconds.

If done properly it would be a great step forward for healthcare providers. It would allow psychotherapists to view a client's entire medical history, including psychotherapy history. That would make our diagnoses and treatment plans much more reliable. However, it would also allow insurers the same rights, as well as a collection of entities called "business partners" (remember the Pakistani woman).

Psychiatric Privacy 101

There are two levels of clinical privacy compromise; the micro and the macro. The micro are the little verbal slips, erroneous faxes, or insufficiently concealed case presentation material that reveals who a client might be to a few people.

Then there are the macro compromises that few of us consider. This is where we disclose information to large bureaucracies that can distribute the patient information to hundreds of thousands of eager recipients.

A show of hands please. How many out there know what the Medical Information Bureau (MIB) is, what it does, and who owns it? This writer was stunned to learn of this about 14 years ago, but more stunned when it became evident that 98% of therapists and physicians also don't know about this entity.

The MIB (MIB.COM) is a central depository of insurance claims owned by around 700 member insurance companies. Its stated purpose is to check for insurance fraud and misrepresentation. They are particularly concerned over claims for heart problems, diabetes, cancer, and any mental health disorder. But in order to check the facts you have to have the facts. Whenever a claim is filed with and member insurance company the diagnosis and CPT codes are forwarded to the MIB. In the case of psychotherapy this establishes for the client 1) that they are seeing a therapist, 2) what their diagnoses are, 3) what mode of treatment they are getting, and 4) from what type of therapist (CAP, Ph.D). This is exactly the information most people don't want others to know.

The MIB also has the right to sell mailing lists and information to members and business partners. A colleague of mine, Debra Peel, MD, an active medical privacy advocate, related a story of a conversation she had with a small business owner. He reported that at insurance renewal time a new vendor dropped into his company, showed him a list of his employees, and said, "If you fire these 3 people who are high insurance users I can give you this great monthly insurance rate." Obviously this health information is very valuable to a great many interested parties.

Formal psychotherapy is a little over a century old. For the first half of the last century the clinician's office was considered sacrosanct. No personal information would leave. But then a slow but steady stream of compromises to this confessional mentality began to invade. First there were insurance companies, as mentioned above. Then there was Tarasoff (1969), the landmark legal decision about a patient who disclosed to a therapist his intent to kill a woman and he actually did kill, which basically gave birth to the disclaimer phrase on our forms "confidentially

except if you are a danger to self, others, or are gravely disabled.”

Then followed the Mondale Child Abuse act of 1976 which mandated a therapist to report the mere suspicion that child abuse may have occurred. It also required that the therapist tell the client of these limitations of confidentiality before therapy commenced, so the client now is increasingly aware of a window into the room where once was a solid wall. We can admire the intent and purpose of these laws, but we must also gauge the impact on our clients perception of their privacy. (A little therapist discretion might be nice).

In 1996 Congress passed the Health Insurance Portability and Accountability Act, or HIPAA. The greatest contribution of this act was to create COBRA, the ability to retain your company's insurance even if you leave. But it also recognized that healthcare was getting ever more complex and run by national insurance companies and hospital chains. Health care laws have always been the province of individual states, which lead to a checkerboard of contradictory laws. Some states had very strong privacy laws, and others had none, particularly for psychotherapy notes.

Another provision of HIPAA was to empower Congress to develop privacy and security standards for medical records. However, Congress missed their own deadline on 1996 and the task fell to Health and Human Services under Donna Shalala of the Clinton administration. The first big piece of the HIPAA puzzle was the privacy rule. It would specify by whom, what, and where clinical data could be viewed. Again, the purpose was to ease and speed the communication between healthcare providers and insurers as well as claims clearing houses across state lines.

HIPAA is actually a set of standards; including privacy, security, claims transactions, provider IDs, and possibly patient IDs standards. The security standards are actually quite good. The provider ID is simply another number, like a Social Security number or Tax Payer ID number. It poses no great threat. It is the privacy rules that have turned healthcare upside down.

This writer researched, contributed to, and lectured on the HIPAA privacy bill for about 3 years. It is some of the thickest bureaucratese one will ever see, with hundreds of cross references (e.g. as defined in section 321.65) and it both giveth and taketh away client rights. In the opinion of this author it doesn't actually protect privacy, it removes it.

One of the first big battles over the privacy rule was the issue of patient consent. Should patient consent be required before any data is sent anywhere? Both hospitals and insurances companies complained that such a provision would be excessively expensive. So HHS removed that requirement in the draft rule, making trade in medical information beyond the client's control, and in some cases beyond their knowledge.

Healthcare providers, patient advocacy groups, professional associations and many others stormed the palace of the White House with protests of the invasion of the doctor patient relationship, the silencing of patients, and the inappropriate use of client data. There has already been a case where a bank loan officer had received information from the local Cancer Society containing the names of patients who had received their help. He quickly determined that a few of them had loans at the bank. Cancer changes one's credit worthiness and he subsequently called in their loans immediately, (Fortunately the media got a hold of the story and the bank backed down).

In 2001, as Bill Clinton was leaving the White House he published the “final” privacy rule and restored the requirement for patient consent. Unfortunately, Mr. Bush immediately retracted the rule for more consideration. In a now classic statement from the White House regarding the issue of informed consent and privacy formally proposed for the new privacy rule, the Bush Administration stated

“We also propose to prohibit covered entities (e.g. healthcare providers) from seeking individual authorization for uses and disclosures for treatment, payment and health care operations unless required by State or other applicable law.

As discussed above in this section, such authorizations could not provide meaningful privacy protections or individual control and could in fact cultivate in individuals erroneous understandings of their rights and protections.” (2002)

Currently, the HIPAA privacy rule does not require patient consent for any data used for treatment, payment, or healthcare operations.

Initially the language of the privacy rule was restricted to “electronic” records. But physicians and providers were so worried about the costs of compliance they said they would just stay with paper records. So HHS expanded the definition of “electronic”, including faxes, letters typed on computers, or if the handwritten claim form was converted to digital format by the insurance company. These actions only had to be committed once for the provider to be required to completely comply with the entire privacy rule. So compliance is basically universally required.

What are the Provisions of the HIPAA Privacy Rule?

One of the things that psychotherapists overlook is how valuable medical information has become. With the rise of computer communication it has also become more accessible. But who would want this data? For starters there are the pharmaceutical companies, medical appliance companies, insurers, bankers, the government, and law enforcement. Recall that Attorney General John Ashcroft requested the records of a hospital while looking for any evidence of late term abortions.

From the provider side, much of compliance is initially just policy and procedure manuals. This writer has helped many a confused therapist pick and chose forms from a CD-Rom, all to be tucked away and never seen again. The one form that everyone sees is the Notice of Privacy Practices, the one we all sign for our doctors and that our clients sign for us.

Few people read it and if they do they don’t understand it. But if Tarasoff was a crack in the door, and the Mondale Act was foot in the door, the HIPAA privacy rule kicks the door open.

There are four basic entities under the HIPAA privacy rule that have access to private medical information; healthcare providers, insurers, health claims clearing houses, and business associates. Business associates are companies or individuals providers contract to provide specific services, like billing, transcriptions, etc.

The privacy provisions of HIPAA are fairly specific. Most privacy forms begin with a statement such as “We are required by law to protect the privacy of your health information (called

Protected Health Information, PHI).without your written permission. However there are some limitations to this protection.

- You can *request* that we limit certain uses and disclosures. But we are under no obligation to honor the request.
- To *request* to see a copy of your information. We may have the right to deny the request.
- You may insert an amendment to your record if you question something but you may not alter the record.
- You may *request* a list of disclosures of your information except for information disclosed to healthcare providers, insurers, or our business associates.
- You may obtain a paper copy of the full notice of privacy practices.

We may use or disclose your medical information without your consent in the following circumstances

- When a disclosure is required to a federal, state, or local law, judicial, or administrative proceeding or law enforcement.
- When communicating with family or friends involved in your care or the payment for your care.
- Food and Drug Administration
- Workers compensation
- Public health and health oversight activities
- Specific government functions, including an audit by HHS.
- Organ or procurement organizations
- Business associates (back to Pakistan)
- Fund-raising
- Correctional Institute
- To avert a serious threat to health or safety.
- Psychiatric information is treated the same as medical information. However, if the raw original notes are kept in a separate folder they will not be readily available, but your diagnosis, treatment, medications, prognosis, dates and types of service will be available for disclosure without your consent.

If President Nixon had this law in place he wouldn't have needed to send burglars to Daniel Ellsberg's psychiatrist's office to steal the records. He could have simply ordered an audit of the clinic.

This is what we are supposed to be communicating to our clients in the interest of informed consent. But few psychotherapists do this for fear it will chase the clients out of the office. Yet down the road there may be trouble. We are entering an age of unforgiving and unforgetting medical databases.

HHS stated that HIPAA doesn't create any databases of healthcare. They don't need to. They already have the MIB, Medicare, and Medicaid databases and full access to them. Why build another?

Additionally, HIPAA strongly admonishes employers who are self insured and may be tempted to look at medical data when considering a promotion are warned in the HIPAA regulations that, "they shouldn't do that," but there is no fine or penalty attached to the statement.

At this point the reader is probably becoming a bit frightened and exasperated, especially since we tend to operate individually or in small groups and feel so powerless against such forces. But there is hope, which will be discussed in a moment.

Financial, Banking, and Insurance Companies

During the Great Depression Franklin D. Roosevelt saw that some of what contributed to the Great Depression were institutions offering multiple services. So he set up a legal structure so that only banks could be banks, financial investment companies could invest money but not lend money, and insurance companies could sell insurance but not loans or investment deals. However, in the last few years these depression era rules have changed. Now banks can sell insurance and investments, financials can act like banks, and insurers can act like banks and financials. So it is fully expected that your medical record may be able to be used to set your mortgage rate and credit card interest (remember the poor cancer victims).

A New Challenge: One man's floor is another man's ceiling.

The HIPAA Privacy Rule was pitched by the Congress and the last two administrations as being simply a "floor" of privacy standards and that stricter state laws would supercede the privacy rule. But that flies in the face of the purpose of HIPAA, making transactions across state lines more streamlined and consistent. The privacy rule was activated in April 2003. To date there has been only two convictions from the millions of entities covered by the HIPAA privacy rule and over 21,000 complaints of privacy violation. This is not about protecting patient privacy.

There is now a bill before the House of Representatives, The Health Information Technology Promotion Act (H.R. 4157), that would allow HHS to set HIPAA as the ceiling of privacy, superceding all state laws, and most likely ethical rules, regarding the sharing of patient information, according to Janis Chester, MD, American Association of Practicing Psychiatrists. This would be consistent with the stated electronic communication goals of HIPAA.

Solutions.

Pushing back this tide of “unprivacy” will take a lot of effort, money, and commitment. However, it’s simple to see that if the public comes to believe that their secrets are not safe with us then that will have a serious impact on psychotherapy’s future. We may be fighting for our professional futures.

Clients who pay cash will have a great advantage because their records will remain in the office. But that’s a very small population. Most people will need to rely on third party payers.

Professional associations need to place this issue on the front burner. Additionally, we need to partner with other professional associations, from all the many psychotherapy associations to the American Psychiatric Association to the American Medical Association, National Association of Social Workers, etc.

The courts provide a great opportunity for smaller advocacy groups to slay Goliath. Jim Pyles <http://www.ppsv.com/members/pyles.htm> is an attorney who has filed many legal briefs on behalf of our cause, but he needs more support. There is also the www.TheNationalCoalition.org, formerly headed by David Byrom.

The simplest objective and focus is to reinstate client consent for the release of medical information. This would upend the applecart and restore us back to those hallowed days of true privacy. We need to block H.R. 4157 and all subsequent bills that will inevitably come forward.

If our clients come to perceive that their secrets are not safe with us then they will not share them.

Hippocrates had a privacy rule correct 2500 years ago. There is no reason to change the privacy principle now as it is every bit as important in 2006.

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**Victimized by “Victims:” A Taxonomy of Antecedents of False Complaints Against
Psychotherapists**

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Abstract

Widespread sympathy for patients who have been victims of abuse perpetrated by predatory psychologists might obscure the possibility that some purported victims fabricate or distort their claims. Civil courts or licensing boards might be used by purported victims to further a variety of personal agendas which involve false claims against psychologists. Anecdotal reports of six antecedents of such claims are presented. It is hoped that this discussion will increase awareness by peers and by those involved with relevant litigation that false, but credible, claims of negligence, predation and malpractice are not only possible but may serve a number of emotional and practical needs on the part of the accuser. Psychologists and those who adjudicate such claims are urged to be wary that the purported victim may be himself or herself the predator.

**Victimized by “Victims:” A Taxonomy of Antecedents of False Complaints Against
Psychotherapists**

When a former psychotherapy patient brings a complaint to a state licensing board, a professional ethics committee or a civil court, one possible precursor is a history of inappropriate conduct by the defendant-psychotherapist. For example, the psychotherapist may have engaged in an inappropriate sexual relationship, a dual relationship involving financial exploitation, a violation of the patient’s privacy, or any other minor or major deviation from the APA Ethical Principles of Psychologists and Code of Conduct (APA, 1992) ¹, state regulations, or the community standard of care. The ethical violations which give rise to legitimate complaints have been described elsewhere (Keith-Spiegel and Koocher, 1985; Koocher and Keith-Spiegel, 1998; Pope, 1994; Pope and Bouhoutsos 1986; Pope and Vasquez 1991).

Not all complaints, however, are based in fact. Some are groundless, but some of these groundless complaints are, nevertheless, credible. The focus of this paper is on the antecedents, dynamics and consequences of groundless complaints against psychotherapists. Because such untrue allegations may be difficult to defend (Goisman and Gutheil, 1992; Gutheil and Gabbard, 1998), it behooves all individuals who may be involved in some aspect of the adjudication

process--attorneys, ethics committee members, state board members, administrative law judges or expert witnesses testifying as to standard of care or damages to the plaintiff--to be aware of the range of conditions which can lead to false, but credible, allegations. It is no less important that one's community of professional peers be aware of the plausibility of claims of innocence on the part of those who are accused, lest the accused find themselves ostracized professionally even prior to adjudication.

This is especially important because the accusers often are portrayed as helpless victims of the psychotherapists who exploited them from positions of power (Rutter, 1989). Emotion can overshadow reason lending inappropriate credibility to complaints. Sympathy for psychotherapists' victims in general, based on emotional arguments by Rutter and others, can distract adjudicators from their task at hand: the determination of the veracity of a specific alleged victim.

A Dearth of Data

Various data points elucidate aspects of the present concern without answering the key question: How many reported complaints are groundless? For example, Parsons and Wincze (1995) were able to detect the inverse phenomenon: the probability of unreported but probably valid complaints. In a survey, they found that Rhode Island therapists had indirectly acknowledged committing 120 boundary violations during a three year period. These included 37 instances of sexual misconduct, yet the Rhode Island Board of Examiners in Psychology had only received a single complaint regarding sexual misconduct. This suggests that valid complaints sometimes go unreported.

Data from the Massachusetts and California psychology boards, published by these agencies on the Internet, point to the possibility that some groundless complaints may be successfully winnowed out. For example, the Massachusetts Board of Registration of Psychologists (<http://www.state.ma.us/reg/boards/py/default.htm>) received 48 complaints in 1997, but these complaints only resulted in 19 informal conferences and nine formal hearings. Assuming that the conferences and hearings were mutually exclusive, this suggests that about 41% of the complaints received were deemed to be either groundless or unsupported by sufficient evidence to necessitate even an informal meeting.

The California Board of Psychology publishes rather thorough enforcement statistics (<http://www.dca.ca.gov/psych/stats.html>) which seem to suggest that many groundless complaints are winnowed out. For example, in the years 1997/1998, 521 complaints were received by the board. Of these, only 141 led to investigations being opened, and of those only 65 cases were sent to the attorney general. Of those, only 20 led to the filing of an accusation. These data are not complete because they do not identify how many investigations led to stipulated agreements or to the voluntary surrender of a license without the need for adjudication or filing of charges. However, certain trends can be seen. All told, during this time period the board took 66 actions that can be considered penalties—either with or without accusations having been formally filed.

Clearly, the majority of complaints resulted in no action being taken. Presumably, this is because the initial complaint was deemed to be either groundless or unsupportable.

When action was taken, the most frequent violation type was “gross negligence/incompetence,” followed by “sexual misconduct,” which was followed by “conviction of a crime” and “mental illness” which ranked equally. Next was “general unprofessional conduct” which was followed by one instance each of “improper supervision,” “dishonesty/fraud” and “probation violation.” These descriptors are rank ordered more or less consistently between 1994 and 1998 ².

Winnowing

Two conceptual dangers arise with respect to the winnowing of complaints: The first is to make the assumption that the winnowing process is valid—that it successfully identifies and neutralizes groundless complaints while allowing valid ones to progress to appropriate degrees of enforcement. The second is to overlook the significant suffering which can befall a psychotherapist during the winnowing process—even if complete and absolute vindication were to be the outcome.

To take the question of the validity of the winnowing process, it must be strongly emphasized that there may be no way to determine, based on data, whether the winnowing process is valid or not and the extent to which it is not. This would hold for licensing actions, ethics committee actions, civil court, or the criminal justice system. There are occasions on which the accused claims innocence to the bitter end, while there are those where the accuser insists that a guilty party has been wrongfully exonerated. There are plea bargains in criminal cases in which the accused denies guilt but asserts that the plea was necessary to avoid the risk of a lengthy and undeserved prison sentence. There are out-of-court settlements in civil cases, made without the admission of liability and with the assertion that the settlement was motivated by a need to avoid the costs of litigation or the risk of an inappropriately high damage award handed down by a jury to a blameless defendant. Similarly, in licensing cases, the respondent sometimes claims to be blameless but accepts a stipulated settlement to avoid the uncertain and costly process of administrative hearings.

What metric would allow us to distinguish between the wrongly accused and the rightfully accused given that both might agree to settlements, or be found liable at a hearing or trial, while denying the accusations with equivalent degrees of vehemence? Presumably, the justice system, whether administrative, civil or criminal, is fallible. However, with the exception of subsequent recantation by the accuser or belated confession by the accused, or a fact pattern that clearly supports only one side or the other and can be reasonably explained in no alternative way, no independent or scientific method may exist for determining if a legitimate failure has occurred—as distinguished from those just outcomes when a failure of justice is disingenuously asserted.

The second conceptual problem in looking at the winnowing process is to presume that the process itself is benign. One ought not make the mistake of viewing the decreasing numbers of complaints that make their way from the initial filing stage to actual litigation or to sanctions as evidence that this process is without harm—even when justice, technically, is done.

The accused may be exonerated after a one month or several year process, but the process itself might leave lasting scars professionally, emotionally and financially. For example, the accused will need to report the fact of a complaint being filed to the managed care companies on which he or she is paneled. This can result in decreased referrals leading in turn to decreased income. The accused will also need to report the complaint to hospital credentialing committees, and this too has possible adverse financial consequences. Further, the accused will need to mount a defense which may be expensive and may not be covered by insurance³. It is noteworthy that the risk of consequences is present to some degree merely because a complaint has been filed—regardless of ultimate exoneration.

The emotional toll on the accused is significant, as the outcome may be unknown for years. One would expect that a great deal of anxiety would be attendant to the possibility of losing one's ability to practice one's chosen profession while simultaneously needing to find a new way to make a living. Even with eventual vindication, one might need to live with the experience of shame, knowing that one's peers may not offer the benefit of doubt, may be spreading rumors and may assume that "where there's smoke, there's fire." Psychotherapy and medical malpractice defense attorneys routinely observe their clients expressing indignation and incredulity that the prosecution of their cases continues, despite these clients' belief that they have provided sufficient documentation to quash any reasonable case against them (e.g., Fler, 1999).

In sum, there may be instances in which vindication of a wrongfully accused psychotherapist could be the end result of a process that is professionally and emotionally damaging. The investigatory and adjudication process itself can be so harmful that endpoint consequences become nearly, if not completely, irrelevant. The financial burden of this process may be exemplified by the case of Don Crowe ("Dispute with California Board Has Cost Psychologist \$400,000," 1998) who faced an accusation by the California Board of Psychology. Dr. Crowe was ultimately allowed to remain in practice following a several year process and the expenditure of several hundred thousand dollars—the cost of several appeals to Superior Court against the Board of Psychology.

If Winnowing Fails—Anecdotal Reports

Six circumstances which may lead to credible false allegations are presented below to point to a phenomenon in need of additional study. They are: malingering and fraud; revenge; psychopathology; "recovered memory;" doctrinaire suggestions from a subsequent therapist; and escape from unwanted treatment.

The frequency of occurrence of the various circumstances is unknown, but these should be considered non-zero phenomena which must be ruled out before a practitioner is found guilty before a licensing board or criminal court, faces licensing or ethics committee sanctions, receives the censure of his or her peers, or is held liable in civil court.

The reader should note that the specific cases to which I make reference may only debatably constitute examples of the phenomena which they are intended to exemplify. Thus, the fact that I have concluded that a plaintiff was dishonest, lied under oath, and fabricated the results of his or her psychological examination may be subject to dispute. In fact, a skeptical reader may argue that I have misread each and every one of the plaintiffs and circumstances discussed below. That notwithstanding, I propose that the possibility exists that similar scenarios occur and involve false allegations against license-holders. Thus, any skepticism regarding the particular examples below should not negate my assertion that each is a member of a class of like phenomena, the existence of which needs to be ruled out in each and every case which is adjudicated.

Malingering and Fraud

Malingering and fraud are well known to play a significant role in the civil justice system (Rogers, 1997). Plaintiffs seeking financial gain may intentionally simulate or exaggerate symptoms of illness in the hope of defrauding an insurance company or other defendant. A plaintiff may fraudulently simulate a specific personal injury scenario for the purpose of winning a financial award or increasing the size of such an award. In many cases, fraud and malingering are difficult to detect because the plaintiff does a convincing job of manifesting credible symptoms. In other cases, damages need not be confirmed for a damage award to be made.

For example, in the realm of therapist-patient sex, a former patient can attempt to defraud the civil justice system by claiming that inappropriate sexual contact has occurred. In some jurisdictions, merely finding the occurrence of inappropriate sexuality leads routinely to the presumption of damages. Consequently, a malingerer might accomplish his or her goal simply by alleging that sex occurred without needing to manifest a credible syndrome of resulting illness. If the allegations are convincing to the finder of fact, damages are presumed, and a sizable settlement or award may automatically follow.

In some instances, a remarkably small factual foundation might convince a jury that sexual boundaries have been crossed. The “slippery-slope” viewpoint holds that once a therapist begins engaging in non-sexual boundary violations, e.g., gift giving or receiving, socializing between sessions or excessive self-disclosure, sexual boundary violations are likely to follow. Articles such as those by Lamb and Catanzaro (1998) or Strasburger et. al. (1992), for example, might be introduced in court to help persuade a jury that sexual boundary violations must have occurred given the undisputed occurrence of non-sexual boundary violations. Williams (1997) has argued that such reasoning can be fallacious and especially harmful to humanistic and behavioral

practitioners for whom non-sexual boundary crossings may be part and parcel of their ethical practice styles.

Case Example: A case in 1996 involved a patient who claimed to have suffered damages resulting from her having been kissed by her psychiatrist. The case was unusual in that the psychiatrist did not contest that the kissing occurred—he acknowledged that he briefly participated in the encounter—but he denied that the brief mistake had resulted in damages. He had expressed his apologies to the patient in a note, hastily composed following the session at issue. The interesting question, since plaintiff and defendant largely agreed about the facts of the transgression, was what the jury would consider an appropriate award for such a circumscribed event in the life of a plaintiff whose prior writings, introduced as evidence, indicated that she was very experienced sexually.

The encounter in question occurred during a treatment session as the psychiatrist was—in an effort to get a taciturn patient to open up—leading the patient to occupy a different chair in the office. The patient suddenly kissed the psychiatrist, and the psychiatrist initially failed to resist. After a brief period of kissing, the psychiatrist testified that he realized that he was making a mistake and stopped the inappropriate behavior. He said he expected to discuss his mistake in subsequent sessions, as well as to explore the meaning of what had occurred for both the patient and the therapy. However, he never got that opportunity, as the patient set in motion a civil law suit within a day of the event. The patient was ultimately awarded nearly \$160,000 by a jury in San Francisco. Because of the rapidity with which the patient went from sex abuse victim to litigant, one might wonder whether indeed the patient had arranged for the entire chain of events to occur in order ultimately to gain the financial reward. Although this scenario can neither be confirmed nor disconfirmed in this case, the case illustrates that such a chain of events might be possible.

Certainly, the psychiatrist was culpable: He could have instantly rebuffed his patient when she attempted to kiss him, but he did not. Despite his obvious culpability, one should also be aware that bunko and con artists often take as their victims individuals who can be persuaded to compromise their morals, making these victims reluctant to go to the authorities because they feel ashamed of what they have done. In this case, the psychiatrist knew he had made a mistake, honestly exposed his mistake to the court, and now finds himself responsible for a large judgment that is not covered by malpractice insurance.

The same case can be used to exemplify malingering. Having readily established that an ethics violation had occurred, the plaintiff needed to counter the defense claim that no meaningful damage had occurred. The plaintiff claimed that she had become significantly depressed for a period of time following the inappropriate contact with her psychiatrist. In support of this claim, the plaintiff testified that she had become unable to continue her regular exercise at her health club. A private investigator hired by the defendant was able to document that the plaintiff had, in fact, continued to exercise at the same health club during the time period in question. This

established that the plaintiff was willing to perjure herself in the hope of financial gain, and it raised serious questions about the degree of alleged depression.

Despite the introduction of this evidence, the jurors found for the plaintiff. Post-verdict interviews with jurors indicated that jurors believed that the plaintiff was entitled to a damage award on the basis of the psychiatrist's admitted transgression, even if the troubled plaintiff had exaggerated her damages. Several jurors also indicated that they held a belief, which unbeknownst to them was untrue, that the award would be paid by a malpractice insurance company. On the basis that the jurors perceived the presence of a mistake in treatment along with the "deep pockets" of an insurance company, they decided to find in the plaintiff's favor.

Although this case involved an undisputed ethics violation, it also raises the possibility that a chain of events, which ultimately results in a damage award, might occur with malicious intent on the part of a plaintiff. The possibility is raised of "setting-up" a psychotherapist by assessing his or her weakness, quickly taking advantage in a moment when the therapist's guard is down, and then obtaining a "confession" which can later be used in court.

The fact that numerous known instances of therapist-patient sexuality are attributable to predatory therapists who prey upon the vulnerability of their patients does not exclude the possibility of the roles being reversed. Predatory patients seeking monetary awards in civil court may also prey upon vulnerable therapists. Because malingering and fraud are presumed to exist in other aspects of civil justice and need to be considered by finders of fact as they adjudicate each case, these phenomena should be considered, too, when the defendant is a psychotherapist.

Revenge

Revenge can serve as motivation for a former patient to file charges against a psychotherapist. The individual who files a complaint based on a wish for vengeance is distinct from the individual who commits fraud for financial gain. While the latter is driven by a wish for compensation that might be unrelated to that plaintiff's relationship with the psychotherapist—the psychotherapist may be little more than an innocent bystander who happens to be harmed by the plaintiff's quest for money—the former files the complaint in reaction to the perception of harm the psychotherapist has done to him, her or a family member. Along these lines, one hears anecdotes about complaints based on revenge following child custody evaluations.

Perhaps there is nothing that transforms ordinary citizens into rabid litigants as quickly as a divorce-related child custody dispute. The warring parties, once husband and wife, may be referred by the divorce court to a psychotherapist for the purpose of obtaining a child custody evaluation. The psychotherapist is asked by the court to carry out an assessment and to offer recommendations regarding the future custody arrangement for the couple's children. While this may be a simple, pro forma evaluation in the case of cooperative soon to be ex-spouses, it may

turn vicious when the two parents are vindictive, abusive towards their children and each other, and desperate to win custody for themselves while depriving their opponent of the contested, but not necessarily loved, children. There is a certain likelihood that whichever angry parent fails to gain the psychotherapist's nod for exclusive custody will find a way to file a complaint against that psychotherapist. Such complaints might run the gamut from the legitimate, e.g., accusing the psychotherapist of failing to properly assess both parents prior to rendering an opinion regarding custody, to the outlandish, accusing a blameless psychotherapist of using the mandated evaluation as an opportunity to sexually molest a minor child.

Case Examples: Former employees of a psychotherapist might also file vengeance complaints. I have consulted regarding two such complaints that were brought to the licensing board by terminated former employees of psychologists. The ex-employees' grudges were based on an obvious circumstance: They believed they had been unfairly terminated. In one case the psychologist was accused of acting in an angry manner toward the employee—this was perfectly true—with the implication that the psychologist was too emotionally disturbed or abusive to be allowed to remain in clinical practice.

In the second case, the former employee, someone with a lengthy drug abuse and criminal career, intentionally set out to ruin the psychologist who had terminated his employment. This former employee was able to influence current and former patients to assist him in “bringing to justice” the psychologist who, he alleged, was engaged in harmful practices and needed to be stopped. Patients, out of a sense of altruism, agreed to talk to investigators, even embellishing their stories. Both psychologists were ultimately exonerated, but only after lengthy and costly struggles, which included prolonged periods of time when their future ability to practice was uncertain.

These vengeance complaints are more likely to find their way to a licensing board than to a civil court for three reasons. First, the plaintiffs are not necessarily financially motivated. This makes civil court a poor venue because all civil court can offer a plaintiff is money. Second, the money that might be paid in civil court is very likely to be paid by an insurance carrier. To the vengeance-seeking litigant, this would be a hollow and pointless victory. If the litigant has the perception that the psychotherapist is well-insured, then a civil verdict would fail to provide the gratification of wreaking personal harm against the psychotherapist. Third, the plaintiff may have a weak case, driven not by actual negligence or malpractice but by the plaintiff's rage. A weak case would be unappealing to an attorney, especially if the plaintiff seeks a contingency fee arrangement.

For these same three reasons, the licensing board might serve as the perfect forum for the complainant to express his or her rage at the psychotherapist. A favorable complainant's verdict would surely do personal harm to the psychotherapist, and there is no need for the complainant to enlist an attorney. Licensing boards exist for the protection of the consumer, so the complaint

filing process is typically consumer-friendly, carried out without an attorney or filing fees. All the complainant needs to do to start the process is make a phone call or complete a questionnaire.

Psychopathology

A variety of emotional disorders can lead a patient to perceive the psychotherapist as his or her tormentor. In some cases the patient will carry such feelings all the way to filing a civil suit or board complaint. Commonplace examples of the sort of psychopathology which could bring about a complaint are schizophrenia, borderline or other personality disorder, paranoia or various types of dementia. The schizophrenic or demented patient, while perhaps inclined to file a complaint, might not pose a credible threat to a psychotherapist, since he or she might impeach the credibility of the complaint by blending whatever could have happened with situations which are very unlikely to have occurred. Such a patient would file the complaint because the psychotherapist had unwittingly entered the patient's delusional system, becoming one more tormentor, generally in a long line.

Case Example: A psychologist had to face a lawsuit filed by a demented patient who alleged that he had been slandered by virtue of material that the psychologist had written into the patient's records. The suit was summarily dismissed in part due to its illogical content—there was no claim that the records had been disclosed to anyone—and in part due to the list of defendants. Other than the psychologist and a handful of physicians, the list included the president of the United States, the governor of California, and several Supreme Court justices.

The borderline, or other personality disordered patient might file a complaint because of a very deteriorated therapeutic relationship based on the characteristic misperceptions and exaggerated emotional reactions which are common to individuals with personality disorders. For example, a narcissistic patient may feel slighted by the therapist's having interrupted sessions to briefly screen a few phone calls or to answer an urgent page and may transform this feeling into a very credible tale of negligent treatment. Similarly such a patient might take offense to a reference made by the therapist to another anonymous patient. The patient might surmise that he or she is being discussed in the same manner with other patients and then file a complaint based on violation of confidentiality.

Case Example: A patient diagnosed with Borderline Personality Disorder presented with marital problems which included a lack of sexual relations with her husband. She also revealed that she was involved in an ongoing extra-martial affair. Inquiries by the therapist into her sexual history with her husband led her to complain to the therapist's supervisor that she had been asked whether she "was good in bed." While this complaint did not pose a significant threat to the therapist, it does illustrate the ability of some patients to transform events that actually do take place in treatment to events that ethically should not have.

One must especially pay attention to any physical contact with such patients—even innocent hugs—as the impact of such contact is very much in the eye of the beholder. A therapist who

routinely hugs all patients may find that one patient finds the hug to be sexually suggestive, groping, “feeling me up,” or otherwise very inappropriate. These complaints can be very difficult to defend when the patient is socially skilled and engaging, is able to make a credible impression, and in no way engenders suspicion on the part of those who will investigate the complaint.

One must be especially cautious in evaluating complaints arising from the patient’s psychopathology. Unlike malingered, vengeful or other fraudulent complaints, this sort of complaint is likely to be sincerely and earnestly believed by the patient. The patient may well make no effort to mangle or exaggerate damages. Thus, unlike some perpetrators of fraud, this sort of patient may not “trip up” during psychological assessment. All that is at issue, often, is an interpretation of an ambiguous situation, with one party describing a warm and caring hug, for example, and the other describing an experience of helplessness and panic during a sexual assault. Unfortunately, finders of fact may be more persuaded by accusations on the part of someone who is emotionally disturbed and feels helpless than denials on the part of someone who appears composed and controlled.

Recovered Memory

Much has been written on the topic of false and planted memories, e.g., Loftus (1995), Pope and Brown (1996). Ordinarily the target of these memories is the parent, but former psychotherapists are also vulnerable.

Case Example: This case involved an accusation against the patient’s former psychologist. The accusation was based on a “memory” which “surfaced” during long term, hypnotic treatment which occurred subsequent to the treatment by the accused psychologist. The patient recalled being straddled during a session, with the male psychologist whispering to the female patient in a provocative and seductive manner. On the basis of this “memory”—either veridical or fabricated—the patient filed a licensing board complaint.

Case Example: In another case, a long term psychotherapy patient became depressed after the tragic death of her therapist. She later named the deceased therapist as a defendant in a sexual abuse malpractice claim. Testimony in the malpractice trial indicated that this woman had a personality disorder, possibly Borderline, and questions were raised about her reality-testing. Following the death of her therapist, she had desperately sought a new therapist who might help her. She tried many but found none of them suitable. Finally, she consulted with a psychiatrist who wondered whether some of her distress—especially her dependency on the deceased—may have been the result of an inappropriate sexual relationship. This question led to her “recalling” and revealing a number of instances of inappropriate sexual contact. The defense argued that her “recall” of the abuse was the result of planted memories, while the plaintiff argued that the memories were veridical, having not previously been revealed because of the patient’s sense of shame along with an effort on her part to protect the deceased. A jury ultimately decided that her claims were not convincing.

Fabricated “recovered” memories might arise for several reasons. Of great concern with regard to the present topic are those caused by the subsequent therapist holding to a sexual trauma theory of psychopathology. Such a therapist may reason backwards—from the present to the past—observing the presenting condition and assuming that such a condition could only have arisen in reaction to a sexual assault. The work of therapy, for such therapists, centers on discovering who it was who assaulted the patient. It would seem that former therapists would be obvious suspects for those with such a theoretical orientation, due if to nothing else, the amount of time the former therapist may have spent with the patient under circumstances when sexual abuse might have taken place without previously having been detected.

No data have been presented attesting to the frequency of “planted memories” leading to licensing board complaints or civil suits. As Pope and Brown (1996) have indicated, any determination of the frequency of real versus false memories—leading to veridical versus fabricated complaints of abuse—is subject to numerous sources of error. The most conservative statement which could be made is that false accusations based on memories which have been planted by a subsequent therapist are not impossible, making this a source of false accusation any trier of fact must consider.

Doctrinaire Suggestions

From A Subsequent Therapist

Psychotherapists have firm opinions regarding what constitutes appropriate and effective treatment, and they disagree with each other. Much of the time, such disagreement is carried out in a context of mutual respect—or at least with a sense that practitioners who see the field in vastly different terms from each another have every right to do so. Sometimes, though, such disagreements become more acrimonious, and they may be couched in terms of ethics. For example, a psychoanalyst may deeply believe that the cognitive-behavior therapist who previously treated a given patient both misdiagnosed the problem and engaged in ineffective treatment that was both superficial and misleading. Similarly, a cognitive-behavior therapist might consider the previously treating psychoanalytic therapist to have been a charlatan who raked in large sums of money while keeping the patient dependent on unnecessarily long-term and unfocused treatment.

When such theoretical disagreements are communicated to the patient, they may give rise to ethics complaints or civil suits. For example, humanistic and behavioral practitioners may view therapeutic “boundaries” differently from their psychoanalytic counterparts (e.g., see Williams, 1997). The humanist who invites patients to his or her home for social events, who carries out weekend marathon group therapy which includes use of a hot tub, and whose treatment involves a strong spiritual component, might be viewed as grossly unethical by more conservative peers. If one of these peers becomes a subsequent provider of psychotherapy to a given patient, that patient may be inculcated with the new provider’s belief system. A given patient may not know that our field is often filled with controversy and that reasonable people might have very strong disagreements with neither side being “correct.” Instead, the patient may come to the conclusion that the previous therapist engaged in practices that were universally held to be unethical if not criminal.

That the patient may serve as the battlefield for such disputes should be obvious from the conflicting expert testimony one often observes in malpractice cases, whether in civil court or before a licensing board. One expert will testify under oath that a given set of treatment procedures is remarkably beneath the standard of care and cannot be in any manner justified. The opposing expert will then testify that the same set of procedures and behaviors was fully appropriate given the defendant's theoretical orientation.

One noteworthy aspect of such doctrinaire differences might involve a “generation gap,” with younger and more recently trained psychotherapists holding to more conservative views on ethics and boundaries than those who are older or less recently trained (e.g., Lamb & Catanzaro, 1998). This may be the result of differences in ethics training, consequences of carrying out psychotherapy for differing numbers of years, or evolving changes in popular theoretical

approaches, with more conservative approaches having become more popular today in contrast to, for example, the widespread use of humanistic-experiential treatments during the 1970's.

Although my anecdotal experience suggests that the subsequent treating psychotherapist often plays a role in the instigation and formulation of a licensing or civil complaint, this remains a matter for further study.

Escape from Unwanted Treatment

A recent case on which I consulted concerned an accusation of sexual assault during a medical examination that was performed by a physician. As with all legal cases, the outcome is not proof one way or the other, but may be legally binding. In this case, the outcome was complete exoneration for the accused physician. Although no one but the two parties involved, the physician and the plaintiff, know exactly what happened, the jury decided that there was not enough evidence to hold the physician liable.

Case Example: The accusation was that during an office visit, the doctor made sexually explicit remarks and then committed a sexual act with the patient's passive participation. The patient was, at the time, a 16 year old high school student who was undergoing treatment for amphetamine abuse. Her psychologist sent her to the physician for prescription of anti-depressant medications. Significantly, the plaintiff had seen other physicians and other psychotherapists, and continued to see others concurrently with the referring psychologist and the accused physician. The referring psychologist and the accused physician were distinguished from the other treaters in this young woman's life by virtue of their cognizance of the plaintiff's severe drug problem. The patient named both the physician and the referring psychologist as defendants in a civil case.

One explanation for this apparent false accusation against the physician was that it was useful in extricating the plaintiff from her previously intended recovery from drug dependence. In fact, the plaintiff may have revealed this motive following the alleged assault: She demanded that she never return again to the accused physician—perfectly reasonable under the circumstances that had been alleged—but she also demanded not to return to the female psychologist who had made the referral. She took this action on the basis that the referring psychologist should have known that the alleged assault might have occurred. While this could be exactly how the plaintiff conceptualized her decision, an alternative explanation was consistent with the jury's decision. The plaintiff, in one fell swoop, terminated her relationship with both parties who were trying to assist her with drug rehabilitation, leaving her only ongoing treatment relationships with another physician and another psychotherapist who had both been kept unaware of her problems with drug abuse and, consequently, posed no threat to her continued drug dependence.

While this account may or not be precisely what happened in this case, it certainly is plausible enough to point out the possibility of false accusations of sexual abuse as a means for a plaintiff to expeditiously terminate any unwanted treatment. Examples of treatments which might be susceptible to false accusations as a means of terminating might include: court ordered treatment,

treatment mandated as a condition of continued employment, or treatment, such as chemical dependency recovery, to which a patient is pressured to submit by a family member or physician.

Conclusion

Our system of jurisprudence is an adversarial one. Psychotherapists must be prepared to face allegations motivated by factors other than a legitimate quest for justice. Greed, vengeance, escape from unwanted treatment, mental illness, false memories and misunderstandings about the procedures of psychotherapy are all factors which can bring about lawsuits, criminal charges or licensing board complaints. Because some of these factors take place independently of any particular acts or omissions done by the psychotherapist, “risk management” methods (e.g., Bennett, Bryant, VandenBos, and Greenwood, 1990 or Goisman and Gutheil, 1992) may have no prophylactic value.

Risk management presupposes that psychotherapists can control their exposure to lawsuits and licensing complaints by altering their behavior thereby eliminating misunderstandings with patients or other factors which lead to an increased likelihood of litigation. In contrast to valid accusations, false accusations may be unaffected by reasonable risk management strategies. As exemplified above, individuals have a variety of motives and predispositions which might lead them to file false complaints. Risk management strategies may alter the nature of the complaints but would not necessarily prevent them. A certain degree of risk is inherent in doing business with the public.

Authors such as Rutter (1989) and Pope and Bouhoutsos (1986) have argued convincingly that a debt is owed to victims of predatory psychotherapists. Although this is doubtless correct in principle, one must be mindful of the fact that some who pose as victims are, in fact, either cunning predators themselves or misguided accusers. To the extent that we, as a profession, fail to guard against harm to ourselves and our peers from such individuals, we can only be considered naive. My belief is that moral outrage against psychotherapists who would exploit their patients has blinded us to the ever present possibility of false accusations. We must realize that sometimes a defendant who is charged with loathsome ethical violations has, in fact, done nothing wrong.

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Footnotes

¹ For the most part, the terms “psychotherapist” and “psychologist” can be used interchangeably. However, reference is made to the APA Ethical Principles of Psychologists and Code of Conduct (APA, 1992) as well as some data that specifically concern psychologists. The term “psychotherapist” will be used throughout unless psychologists specifically are being referenced.

² An effort was made to obtain data from malpractice insurers concerning frequency of civil suits filed against psychotherapists, in terms of type of complaint, likelihood of out-of-court settlement and likelihood of adverse outcome. This proved fruitless, as this information is considered proprietary and is kept confidential by insurance companies, including the company that underwrites policies for the APA Insurance Trust.

³ Malpractice insurance coverage is limited in a variety of ways, and this has a bearing on the defense strategies used by accused psychotherapists. Many policies now offer limited coverage for licensing board defense; this is a recent development within the past few years. For example, the APA Insurance Trust now routinely provides \$5000 of licensing board coverage, with the option to purchase coverage up to \$50,000. The lower coverage amount would pay only a fraction of defense costs should the matter go to a hearing. Lack of sufficient coverage for defense costs would encourage the accused to accept a negotiated settlement. According to the financial contingencies, the accused might accept sanctions even for allegations which are false.

In civil suits, most insurance policies will pay defense costs even for claims of sexual impropriety as long as the defendant denies the allegations. However, if the court finds for the plaintiff, the malpractice policy would not pay the award. Sexual misconduct is not a covered benefit of malpractice policies. This often creates financial quandaries for the accused. For example, a wrongly accused psychotherapist who is confronted with a convincing but false case against him or her, must decide between the following choices: to offer the plaintiff a smaller, out of court settlement which might be covered by the malpractice carrier (as a way for the malpractice carrier to defer litigation costs), or to try to win in court, which entails assuming the risk of bankruptcy

and career-ending loss of employment should the plaintiff's fraudulent or otherwise invalid sexual-abuse case prevail.

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Post Course Quiz

Boundary Issues

1. It must be noted initially that ethics are often confused with laws and rules. In fact, state laws and rules of clinical behavior often reflect the ethical standards of professional associations, but slightly different in that
 - a. to violate the standards of a professional association only risks one's membership.
 - b. it is a misdemeanor violation.
 - c. laws of professional behavior are illegal.
 - d. rules do not have the force of law.

2. Having sex with a client may be considered
 - a. A boundary crossing
 - b. a boundary violation
 - c. either.
 - d. depends upon the circumstances

3. Which of the following is true?
 - a. A boundary crossing is an activity that occurs outside of the normal standards of psychotherapy.
 - b. A boundary violation is something that harms the client.
 - c. Different schools of clinical thought set boundaries differently.
 - d. All of the above are true.

4. According to the author, the limits of clinical boundaries are set within a psychoanalytic model of "nothing outside the office."
 - a. True
 - b. False.

5. Non-sexual touching a client is by definition a boundary violation.
 - A. True
 - B. False

6. A boundary crossing can never have a beneficial effect on the client.
 - A. True
 - B. False.

Clinical Privacy

7. Off-shoring of clinical information to foreign countries has become a common practice.
 - A. True
 - B. False.

8. The author states that if you want to protect you client's privacy you need to
 - a. not file any claims
 - b. get a signed consent
 - c. understand where the leaks of information are.
 - d. refuse to send information to the MIB.

9. The Medical Information Bureau is run by
 - a. the Federal Government
 - b. an independent agency.
 - c. the insurance industry.
 - d. the American Medical Association.

10. One of the benefits of an electronic medical record is that therapists could view their client's full medical history to assist in a diagnosis.
 - A. True
 - B. False.

11. Under the HIPAA privacy rule for most purposes of medical records the patient's consent
 - a. is not required.
 - b. Is required
 - c. Is only required for treatment, payment, or healthcare operations.
 - d. None of the above.

12. Under the HIPAA privacy rule if a patient requests to limit uses and disclosures of medical data the health care provider
 - a. must abide by the request.
 - b. is not required to abide by the request.
 - c. must consult with any third party payer.
 - d. obtain a release from the patient.

Victimized by "Victims"

13. Dr. Williams directs his paper about false complaints to
 - a. Psychotherapists.
 - b. Attorneys
 - c. Ethics Committees
 - d. Regulator Boards.
 - e. All of the above.

14. The Dr. Williams cites a study by Parsons and Wincze which found 120 boundary violations, including 37 involving sexual misconduct by therapists in Rhode Island in a three year period, yet the number of complaints filed with the Board of Examiners was
 - a. 1
 - b. 10
 - c. 25
 - d. 100

15. Dangers in the winnowing process for complaints against psychotherapist include all the following EXCEPT
 - a. It may induce lasting scars on the innocent practitioner.
 - b. It may dismiss valid claims.
 - c. Determining the reliability of the true complaint process is ultimately impossible.
 - d. The use of criminal procedures against a practitioner.

16. The jurors polled in the example case of the psychiatrist kissing a client one time awarded a settlement of \$160,000 because they believed
 - a. The psychiatrist had lied
 - b. The patient had lied
 - c. There was more sexual activity than reported.
 - d. The insurance company would pay for the woman's likely exaggerated claims.

17. Dr. Williams notes which of the following disorders may contribute to a "psychopathology motivated" complaint against a psychotherapist.
 - a. Schizophrenia
 - b. Borderline Personality Disorder
 - c. Paranoia
 - d. Dementia
 - e. All of the above

18. Dr. Williams believes that the moral outrage against psychotherapists who exploit their patients has _____ us to the possibility of false accusations.
 - a. Empowered
 - b. Blinded
 - c. Enabled
 - d. Enlightened

Ethics and Boundaries Issues
Answer Sheet

Name _____ Lic No. _____
Phone _____

Enter correct answer

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.
- 16.
- 17.
- 18.

Signature required to affirm that you are the individual who completed this course.

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