

VICTIMIZED BY VICTIMS

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.