Legalities

Twelve Pitfalls for Psychotherapists

by O. Brandt Caudill, Jr., Esq. – Callahan, McCune & Willis LLP

A question asked of those of us who defend psychotherapists in civil suits and before licensing boards is what are the most common areas where therapists leave themselves vulnerable to attack. The purpose of this article is to identify some of the more common pitfalls that psychotherapists may encounter, in hope that they can be avoided in the future.

Excessive Self Disclosure

Self disclosure is commonly used as a treatment technique, and surveys of MFCCs and psychologists indicate that over 70 percent use self disclosure at least occasionally. [Pope, K.S., Tabachnick, B.G., & Keith-Spiegel, P. (1987) *Ethics of Practice: The beliefs and behaviors of psychologists as therapists.* Vol. 42, pp. 993-1006; "A National Survey of the Ethical Practices and Attitudes of Marriage and Family Therapists," (1998). *AAMFT Ethics Casebook.* p. 175.]

Many licensing board cases and civil suits allege inappropriate or excessive self disclosure. There are two keys as to whether a particular disclosure is ethical: (1) Is it being disclosed for the purposes of the patient or for the purposes of the therapist? and (2) Is it the type of communication that should be disclosed to a patient with that type of mental condition?

As an example, when a patient has a history of child sexual abuse it may be appropriate and ethical to disclose that the therapist has a similar background to establish a degree of empathy. On the other hand, if the patient has no such history and the therapist is disclosing the information because of the therapist's own problems, it would be inappropriate. The question should always be "how does the disclosure aid in the patient's therapy?"

Some disclosures about the therapist's background, family, or sexual identity may be inappropriate given a particular patient's personality and problems. In addition, therapists must be conscious that excessive self disclosure can fuel a patient's perception that he or she is special to the therapist, or that there is a potential for a relationship outside the therapeutic one. The problem becomes more acute when the patient is inquiring as to the therapist's personal life and/or the therapist's relationships with his or her family and/or lovers. At that point, the therapist should ask how this information would serve the patient.

Business Relationships with Patients

There are numerous reported instances where therapists have entered into relationships of a business nature with present or former patients. There are very few reports of successful outcomes of such relationships. In fact, almost every time such a relationship is reported, it is reported in the context of a lawsuit being filed or an administrative action being taken because of the business relationship.

Regardless of how lucrative a potential business opportunity seems to be, a therapist must weigh whether that opportunity is worth the potential destruction of his or her career. The heart of the problem lies in the inherent unequal bargaining power between the parties once the therapeutic relationship has been established. It is almost impossible to establish that an "arms-length" transaction occurred, no matter what legal language is used or what consents are signed. Entering into a business relationship with a present or former patient will be viewed with suspicion by most licensing boards, and the burden will be on the therapist to establish that there was not some form of overreaching. Obviously if the business does not do well, the burden to prove that there was no exploitation is even greater.

Unlike self disclosure, which is a common occurrence, the rule for entering into a business relationship with a present or former patient should be "almost never." Only after obtaining an independent consultation with an ethics expert, preferably one that is well versed in dual relationship theories, should any such relationship even be considered.

Some experts will take the position that when the therapist has a business of selling vitamins, food supplements, educational tapes or books, that the attempt to market these directly to people who are also in psychotherapy constitutes an unprofessional secondary business relationship.

Lack of Training

A recurrent issue over the last 10 to 15 years has been the use by therapists of treatment techniques in which they are not well trained. An example of this is a case from New Hampshire, Hungerford v. Jones 722 A. 2d 478 (1998), where one of the allegations was that a social worker who had limited experience in treating patients with repressed memories, led a patient to believe that she had been sexually abused by her father, when she had not. A key point in the decision of the Supreme Court in New Hampshire allowing the father to sue his daughter's therapist was that the therapist's only training in the area of repressed memories was one lecture on memory retrieval techniques that she attended at a weekend symposium.

Therapists should not use any techniques without being thoroughly trained and experienced in them. It is probably below the standard of care per se to use a technique after being trained in it only one time. It is not uncommon with some treatment approaches such as EMDR or Bioenergetics for therapists to begin using the techniques before completing the entire training. As a practical matter, initiating the use of the technique without completing the training can lead to potential liability and/or licensing board actions.

Using Incorrect Diagnoses

Over the last several years, as managed care has become more a part of a practicing psychotherapist's life, there has also been a rise in allegations that therapists are deliberately reporting inaccurate diagnoses to insurance companies to trigger coverage where it should not exist.

For example, it is not uncommon to have an allegation that a therapist failed to disclose an Axis II diagnosis because of an awareness that a particular insurance carrier in question would not cover any such condition. The general rule is that the diagnosis for treatment and diagnosis for insurance should be the same. The law does not recognize or permit the therapist to have one diagnosis for treatment purposes and one diagnosis for billing or insurance purposes.

In fact, the existence of two such diagnoses offers an opposing attorney a great opportunity to impugn the therapist's credibility. A patient should only be diagnosed with the accurate diagnosis. A typical scenario is for a therapist to report a less severe diagnosis, such as adjustment disorder, rather than a dissociative disorder, or if the patient has a borderline personality disorder. When some dispute arises and the therapist wants to assert that the patient has the more severe diagnosis that was not actually used in reports to insurance companies, the patient's attorney or the attorney for the licensing board will probably contend that the more severe diagnosis was made up after the dispute arose, because no preexisting record can be found.

Avoiding the Medical Model

Faced with the complexities of informed consent, standard of care, note taking, etc., some therapists have tried to opt out of these requirements by simply taking the position that they do not believe in, or endorse the medical model, and therefore they should not be held to it.

This has the same effectiveness as reporting to the Internal Revenue Service that you do not believe that the tax laws are valid, and that you should not have to comply with them. While this may lead to making the acquaintance of interesting criminal defense and bankruptcy lawyers, it will not cause any change in the IRS's view of the applicability of the tax laws. By the same token, for a psychotherapist to assert that he or she should not be subject to the medical model will be ineffective. The medical model will generally be imposed with or without your agreement.

The True Love Exception

Over the years, some therapists have sought to invoke the "true love" exception to actions for damages or by licensing boards arising from sexual relationships with present or former patients. There is no true love exception, there never has been a true love exception, and, in all probability, there never will be a true love exception.

Sexual relationships with existing or former patients are unethical under most associations' ethical principles, illegal in some states (such as California), and have career killing consequences. It is almost axiomatic that what is seen as true love at the time the relationship begins, is seen as mishandling or transference after the relationship ends.

An example of this attitude is a survey of psychiatrists from 1987. The study involved over 1,300 psychiatrists, and approximately 29.6 percent thought that post termination sexual relationships could be appropriate. Approximately 17.4 percent thought the American Psychiatric Association's position permitted such post termination contact. The issue of whether the relationship was due to "true love" was a factor for some of the respondents.

Under no circumstances should a therapist seriously consider a sexual relationship with a present or former patient regardless of how long the interval has been between the termination of the patient and the beginning of the relationship. Generally a therapist who is choosing to engage in such a relationship with a patient is effectively choosing to discard his or her career.

Inadequate Notes

A continuing issue has been the failure of therapists to take accurate notes and, in some cases, any notes at all. While some experts may still say that there is a wide variance in the practice of therapists keeping notes, the practical fact is that notes are essential for survival in this litigious age. Notes should not only be accurate, but should

be meaningful in terms of content. The notes should indicate what was said by the patient, as precisely as possible, and what the therapist did or said about the patient's communication.

It is not necessary that the notes be written in plain English, but the notes should be an accurate picture of what was discussed. A therapist should never agree to not take notes at a patient's request. In fact, such a request from a patient should cause the therapist to seriously questions whether the patient has a secondary agenda.

Failure to Obtain History

An issue related to failing to take notes is failing to obtain an adequate history. It is a common practice for licensing boards and civil plaintiffs to focus on the patient's history in the context of making an accurate diagnosis. The assertion that a therapist failed to obtain an adequate history is a common one, and in some instances is justified.

As a general matter, a history should include the presenting symptoms, prior therapy, history of mental illness in the patient's family of origin, and whether the patient has been involved in litigation. It should also include pertinent physical conditions that might contribute to the presenting symptoms, patient's educational history, patient's marital status, what medications if any the patient is taking, how long the presenting symptoms have lasted, and whether the patient has had any recent physical examination, and/or medical evaluation.

Uncritical Acceptance

An expert in civil litigation and for licensing boards, Dr. Jeffrey Younggren, has commented that therapists, in addition to being required to comply with the standard of care, must utilize common sense in weighing what patients tell them.

The various cases that have dealt with repressed memory issues have articulated what amounts to a duty to utilize common sense or critical judgment, or a duty to be skeptical of a patient's implausible memories. To critically accept implausible memories of sexual abuse has been found to be below the standard of care by the California Board of Psychology.

Inappropriate Use of Syndromes

As early as September of 1989, Dr. Gary Melton and Susan Limber – in the article "Psychologists' Involvement in Cases of Child Maltreatment" (American Psychologist Vol. 44, No. 9, pp. 1225-1233) – commented on the inappropriate use by therapists of syndromes that are not found in the various versions of Diagnosis and Statistical Manual.

There has been a proliferation of such syndromes over the last several years. At this point using syndromes that are not appropriately researched or acknowledged by the profession is below the standard of care. Among the syndromes considered controversial and which should not be accepted as fact in the therapist community are Child Sexual Abuse Accommodation Syndrome, Parental Alienation Syndrome, Wiederholt v. Fischer 169 WIS 2d 524, 45 N.W. 2d 442 (1992), False Memory Syndrome, and Malicious Mother Syndrome.

Out of the Office Contact

As a general rule, unless there is a specific therapeutic purpose for it, patients should only be seen in the therapist's office. While it can be appropriate to see a patient in a setting outside the office for a therapeutic reason, such instances should be extremely rare and should be well documented in the file. If an out-of-office contact is going to occur, the therapist should document in advance what the purpose is and what is hoped to be achieved. Once the out-of-office contact has occurred, the therapist should document what actually took place and how the perceived goals were met or not met. It would be sound practice to obtain a peer consultation prior to an out of the office session.

Failure to Obtain Peer Consultation

One of the most common failings of many psychotherapists is not having a regular peer consultant or consultation group from which to obtain feedback. The progressive isolation of therapists due to economic factors has created the potential for the erosion of clinical judgment. Peer consultation can be the quickest way to avoid a pitfall. Of course, if a therapist obtains a peer consultation and acts in the diametric opposite fashion of what the consultant recommends, there can be potential serious consequences. Whenever consultations are obtained they should, of course, be well documented. One of the areas that is frequently looked at by experts reviewing cases to determine whether a therapist complied with the standard of care, is whether peer consultations were pursued and complied with. ■

O. Brandt Caudill, Jr. Esq. is an attorney at Callahan, McCune & Willis LLP, in Tustin, California and will present at the 2000 AAMFT Annual Conference in Denver, Nov. 2-5.