# Malpractice in Psychotherapy: An Overview

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*Malpractice law as it relates to individual psychotherapy is briefly reviewed. Examples of cases in specific areas of liability are given, and available solutions are discussed. It is suggested that there is a need for consultation plus educational programs designed to enhance our ability to practice within the boundaries the courts have set for us.*

The aim of this overview is to summarize the current state of malpractice law as it relates to the practice of individual psychotherapy by licensed practitioners (primarily psychologists, psychiatrists, clinical and psychiatric social workers) without a legal background. It will examine the circumstances under which civil actions are brought against psychotherapists, describe and present examples of cases in specific areas of liability, discuss the adequacy of available solutions and offer suggestions about preventative measures.

Exactly how extensive the problem of malpractice is for today's mental health professionals is not known; there is no encompassing statistic.[1] There is some evidence, however, that psychotherapists are sued less frequently than most medical specialists. For example, Dr. Bruce Bennett, Chairman of the American Psychological Association's Insurance Trust, claims that the chance of a psychologist being sued is approximately one-half of one percent; that for social workers is even less (personal communication, Nov. 17, 1988). Psychiatrists account for only three-tenths of one percent of all claims filed against physicians, and 1980 statistics show that less than one percent of all psychiatrists covered by APA's Professional Liability Program were sued.[2] Of the cases that do end up in court, it has been estimated that only about 20 percent result in judgments against the defending psychotherapists.[3]

One reason for this relatively low rate of suits against psychotherapists is that negligence by psychotherapists rarely causes physical injury; rather, it will most likely exacerbate a preexisting emotional disorder or lead to further emotional trauma, and "tort law has always been slow to provide remedies for purely emotional injuries"[4] (p. 132). Unless there has been a blatant violation of

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standards of practice, suits for negligent psychotherapy are not likely to succeed. Especially with the multiplicity of schools of psychotherapy, there is no "standard" form of psychotherapy. The absence of a clear mainstream perspective on what constitutes acceptable practice makes it extremely difficult to prove that in any given instance a therapist has been negligent and has engaged in substandard practice.[2,5,6]

Furthermore, because of inadequately defined expectations of the methods and goals of psychotherapy, patients may not recognize the psychotherapist's role in their distress. Also, the frequent contacts involved in psychotherapy often result in an intense patient-therapist rapport, and patients may be reluctant to initiate lawsuits, even if they believe they have been harmed.[7] However, as the goals of therapy become better defined, and because of a growing movement among consumers to expect that professional services as well as products perform satisfactorily, mental health professionals are becoming increasingly vulnerable to malpractice.[2]

As pointed out by VandeCreek, Knapp, and Herzog,[8] over the past 10 years both the number and size of claims has gone up tremendously, with claims of $1 million or more becoming common events. A number of factors may be responsible for this increase. First, as the stigma of being in psychotherapy has declined, so has the reluctance of patients to sue their therapists. Second, it is likely that the fact that clinicians now operate within the behavioral-medicine framework has created a greater malpractice risk than existed within the more traditional framework.[9] Third, the increase in the number of clinicians (there were approximately 5,000 psychologists in 1950 as compared with nearly 60,000 in 1983) has led to their greater visibility. These factors, taken together with the public's increasing demand for professional accountability, appear to have led more patients to seek redress.[10]

It is the purpose of this paper, therefore, to give a capsule review of the major issues on the subject of malpractice for those practitioners of individual psychotherapy who do not have access to, or who do not ordinarily read, journals and bulletins dealing with legal issues as they relate to psychotherapy. It will not present new data or ground-breaking interpretations. The focus will be on outpatient clinical practice of verbal therapy, with or without the use of concomitant antidepressants and/or anxiolytics. Thus, liability involving involuntary commitment, nonreporting of suspected child abuse, ECT, restraint of suicidal and/or violent patients, and injudicious release of such patients from the hospital will not be covered.

## FOUR ELEMENTS OF A MALPRACTICE CLAIM

More than 90 percent of all actions brought against psychotherapists are brought as civil suits based on tort law. In such suits the plaintiff seeks redress for injury sustained as the result of misconduct or improper performance of professional duties by the psychotherapist.[11] This misconduct or improper performance

can be intentional or unintentional. Unintentional torts arise out of the fundamental concept of negligence; that is, failure to take reasonable measures to ensure that others are not harmed by one's actions. Malpractice is a special case of negligence and is the formal term applied to a professional's actions that do not conform to the standards of prudent and reasonable practitioners in a given field.[2] With the exception of committing the torts of breach of confidentiality and invasion of privacy, the majority of malpractice cases in the field of psychotherapy are based on acts of negligence rather than intentional wrongs.

Basically, a psychotherapist or any health care practitioner has a legal duty to provide reasonable care to a patient or client once a therapeutic relationship has been established. If the practitioner fails in this duty by acts of commission or omission and the patient is harmed as a proximate result of this failure, then liability for malpractice may exist. Therefore, there are four essential elements necessary to support a malpractice action.[2,3,6,10,11]

In order to recover damages, the plaintiff must first demonstrate that a legal duty existed between the practitioner and the patient. This is usually self-evident. Second, the plaintiff must show that the practitioner violated that duty by failing to conform to standards of care required by other practitioners in his or her profession. This is usually determined by expert testimony, although the plaintiff may demonstrate negligence through written letters or statements of witnesses.[11] Because of the large range of therapeutic approaches and lack of consensus concerning preferred techniques, this does not mean that the therapist adhered to a particular method of treatment; only that it is one that is subscribed to by at least a "respectable minority" of his/her profession as attested to by expert witnesses.[8]

For a malpractice suit to proceed beyond the stage of legal deposition, the plaintiff's attorney must not only believe that there is evidence to show that the therapist was negligent in not conforming to an accepted standard of care, but must also believe that it can be demonstrated that the patient has been harmed or injured in some way. This is the third essential element necessary to support a suit. The fourth is that it must further be demonstrated that the therapist was the proximate cause of the injury for which damages are sought. The damages sought are usually compensatory; i.e., intended to compensate a patient for harm suffered, which can include lost wages and medical costs, but most often are sought as compensation for emotional pain and suffering.[3]

In recent years malpractice suits against psychotherapists have been brought not only for harm that they negligently caused their patients, but also for injuries that they negligently failed to prevent their patients from causing. As Klein and Glover point out, this distinction is important because ". . . tort law does not generally hold one person legally responsible for the independent acts of another."[4] (p. 132). Now, however, courts have begun to hold therapists liable for patient

suicide and for harm inflicted on third parties by patients. Examples of such suits will be presented in the section concerned with specific areas of liability.

Once a therapist-patient relationship has been established, there are a number of general obligations that the therapist owes the patient. These derive from the nature of the therapeutic relationship itself, which is one in which the patient is dependent on a therapist who must of necessity manage the often powerful emotions that are released in therapy. Furrow[7] lists four such general obligations. First, and perhaps the most important of these general duties is that of neutrality. This means that the therapist must be aware of his own emotional reactions to the patient in order to prevent countertransference problems from arising. These problems are most often manifested in terms of sexual feelings for a patient, but may also become evident in a therapist's growing antipathy or hostility towards a patient. A corollary, therefore, of the duty of neutrality leads to the second obligation: that is, that a psychotherapist consult with a colleague in the event that the therapist becomes aware of unmanageable countertransference feelings.

A third general duty owed to patients is that of nonabandonment. If it can be shown that a patient is harmed, a therapist may be found negligent and liable for abandonment for unilaterally refusing to continue treatment with a patient unless termination has been discussed, and the patient has been given reasonable notice and time to find a new therapist. The therapist is also ethically and legally bound to help the patient find a replacement, although if this is not possible, he is not obligated to treat the patient indefinitely. A "reasonable" length of time naturally varies with the nature of the patient's condition; a week or two is usually considered sufficient. However, when this time runs out, the therapist bears no further responsibility.[3,12,13] In contrast to, and as a corollary of, the duty of nonabandonment is the therapist's fourth obligation; the duty to terminate treatment when it appears uneffective or harmful.[7]

## SPECIFIC AREAS OF LIABILITY

### *Mismanagement of the Therapeutic Relationship*

Of the numerous ways in which psychotherapists can exploit their relationships with patients, for example, by breach of confidentiality, by economic exploitation and abuse of power to persuade, undue intimacy or sexual exploitation has been considered one of the most destructive.[14–16] It has also been ranked as the first cause of professional-liability actions against psychologists on a nationwide basis for the years 1976–1986.[17] While this finding properly applies only to licensed psychologists covered by APA's Insurance Trust, reports of liability patterns for psychiatrists indicate that sexual misconduct accounts for a disproportionate number of claims for this discipline as well.[18]

This situation exists in spite of the fact that intimacy with patients has been prohibited by such varied sources as the Hippocratic Oath, state licensing boards'

regulations, the American Psychological Association,[19] the American Psychiatric Association,[20] and the formal ethical committees of all major health disciplines. There is good reason for this prohibition. Whether or not the therapist is satisfying some of the patient's needs, he is also using the patient to satisfy his own needs. As Karasu has stated ". . . therapist-patient sex may be considered the ultimate expression of the overt misuse and exploitation of the transference relationship"[21] (p. 1508).

Yet in spite of consensus that patient-therapist intimacy is usually destructive to the patient, resulting in damages ranging from inability to trust to severe depressions, hospitalization, and suicide, two recent nationwide surveys, one by psychologists[22] and one by psychiatrists,[18] have found the overall prevalence of therapist-patient sexual contact to be approximately 6.5 percent. This is consistent with the prevalence of patient-therapist sex reported previously for psychologists[23,24] and for psychiatrists.[25,26]

Because of the coercive position of the therapist in relation to the patient, all cases in which the therapist has been shown to have had sex with a patient have resulted in a verdict against the therapist,[7] and juries tend to find not only therapist-patient sexual contact but also transferential exploitation in general prima facie or presumptive evidence of general negligence.

The higher levels of the court system began affirming therapist-patient sexual contact and abuse of the transference relationship as a sound basis for malpractice in 1968 with the case of *Zipkin v. Freeman*.[27] In this case, a psychiatrist was sued by a female patient because he had "mismanaged the patient's transference." She had originally entered treatment with Dr. Freeman for psychosomatic symptoms, which remitted. Subsequently, however, she agreed to continue a rather bizarre treatment plan. This treatment included joining Dr. Freeman at social gatherings, skating parties, traveling with him outside the state, and investing in his business ventures. She also attended "group therapy" swimming parties at which some of those attending, including Dr. Freeman, were nude. As a result of her "treatment," she requested a divorce from her husband, gave up her friends and community commitments, and moved in with Dr. Freeman. Eventually, she brought suit against him.

Despite Dr. Freeman's claims to the contrary, the judge who wrote the majority opinion of the Missouri Supreme Court stated:

> Once Dr. Freeman started to mishandle the transference phenomenon . . . , it was inevitable that trouble was ahead . . . damage would have been done to Mrs. Zipkin even if the trips outside the state were carefully chaperoned, the swimming done with suits on, and if there had been ballroom dancing instead of sexual relations. *Zipkin v. Freeman*[27] (p. 761).

What is crucial about this decision is that the court recognized and affirmed the duty of neutrality owed by a therapist to his patient and that a mishandling of the transference, even in the absence of sexual relations, may constitute malprac-

tice. The court found the defendant liable, and Mrs. Zipkin was awarded $18,029.

*Roy v. Hartogs*[28] is a second important malpractice case involving sexual encounters between a therapist and a patient. Its importance lies in the fact that the court in this case likened the relationship between psychotherapist and patient to that between guardian and ward, inasmuch as a guardian cannot claim a ward is capable of consenting. The defense of patient consent is thus rejected because the patient's transference and general involvement in therapy preclude a voluntary consent. Put succinctly, "A patient cannot consent to a professionally unacceptable form of treatment"[10] (p. 10).

There are, however, some fairly prevalent misconceptions about the ethicality of sexual conduct with a patient that could bias a therapist's judgment. The first, probably resulting from the ambiguous prohibition of therapist-patient sex "during therapy," is that such conduct is acceptable if it occurs outside the therapeutic session. The second misconception is that sexual involvement subsequent to the termination of therapy is neither unethical nor illegal. No state has a regulation that specifies a time limit when therapy ends and a social/sexual relationship can begin. California has recently enacted a law (SB1406) that says, in essence, that there is a cause of action against a psychotherapist for injury caused by sexual contact occurring within two years following termination of therapy. This law clarifies and defines what is illegal. But, two years subsequent to termination of therapy sex between a former patient and a psychotherapist may still be both unethical and illegal.[29] The major issue at stake in determining whether malpractice has occurred is not whether the sexual relations took place "during" or "outside" therapy sessions or the time span between treatment and sexual relations, but rather the extent to which such relations are an exploitation of the therapeutic relationship.[3] In any event, most experts contend the clinician will be on ethically and legally safer ground if he adheres to the motto "once a patient, always a patient."

### *Breach of Confidentiality*

Because of the sensitive and private nature of the information with which the psychotherapist deals, confidentiality is the base upon which the special relationship between psychotherapists and their patients rests.[19] Confidential information about a patient may be released only if the patient authorizes such a release or under proper legal compulsion, and clinical or other materials used in teaching and writing must adequately disguise the patients' identity to preserve their anonymity.

When therapists breach their duty of confidentiality, they have committed an act of invasion of their patients' privacy. For example, in the case of *Doe v. Roe*[30] the Supreme Court of New York found for the plaintiff, a former patient, who brought suit against her analyst to restrain her from publishing a book containing the case history of the patient and her family. It might be noted that recovery for

invasion of privacy generally requires public disclosure of private fact, as opposed to divulging a patient's private affairs to an individual person or small group.[10,13]

Confidentiality may, however, in some limited situations such as comments made on the witness stand in court-ordered evaluations, be breached without liability to the defendant. Such comments have the defense of absolute privilege "because of the great harm which may occur to the truth-seeking process if witnesses are intimidated in their testimony by the fear of a lawsuit"[31] (p. 14). Even in events such as these, however, the therapist may request the right to disclose only such information as is relevant to the legal question under consideration.[20,31]

Absolute privilege and its attending judicial immunity refers only to immunity on the witness stand, not to nonjudicial disclosures. The case of *Schaffer v. Spicer*[32] is illustrative of the prevailing legal opinion. After the defendant psychiatrist had revealed confidential information about his patient to her husband, the couple entered into a child custody battle over their child. The husband's attorney used this information in support of the claim that the plaintiff was unfit to have custody of the child, after which the plaintiff sued the defendant for breach of confidentiality. The defendant had assumed that his patient had waived her privilege, but she had not, and the court held the psychiatrist liable for a tort action. The moral of this tale is that "Psychotherapists . . . need to show caution when communicating to parties antagonistic or adverse to their client's interest"[31] (p. 15).

Another area in which breach of confidentiality is an issue is that of potential harm to third parties. It is becoming increasingly likely that when a psychiatric patient commits a violent act, the victim of this violence will attempt to sue the patient's therapist, even though it is common knowledge that the prediction of dangerousness is quite poor.[33] The plaintiff's argument is that the therapist should have foreseen and prevented his patient's violent behavior. However, because therapists wish to preserve their patients' confidentiality, they are naturally reluctant to be put into the role of informants. The legal issues involved in these cases are quite difficult, and they may lead to very large damage awards. In Klein and Glover's opinion, if more and more courts hold that psychiatrists are responsible for the violent acts of their patients, "This area of liability may ultimately come to present the most serious legal risk that psychiatrists face"[4] (p. 149).

Public policy concerning a therapist's liability for his patient's violent acts began with the well known 1974 case of *Tarasoff v. Regents of the University of California et al.*,[34] which set forth critical limitations on therapist-patient confidentiality when a third party is endangered. It established a legal duty to warn a potential victim, thereby divulging information given in confidence. After much protest from the plaintiffs and institutions involved, the California Supreme Court reheard the case in 1976.[35]

At that time the court established a standard against which the obligations of therapists could be measured, but it did *not* establish a duty to warn. As cited by Gross and his colleagues, this standard states that "when a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs a serious obligation to use reasonable care to protect the intended victim from such danger"[36] (p. 9). What has caused considerable confusion among therapists is the lack of clarity as to how this duty could be discharged. "Reasonable care to protect" is not a rigid standard. It may be discharged by warning the victim and/or the police, but so too by hospitalizing the patient, prescribing medication, or by offering more frequent sessions of psychotherapy. However, Mills, Sullivan, and Eth[37] cite a recent survey[38] that showed that of the 90 percent of psychiatrists who had heard of the Tarasoff case, nearly all believed that the only way to discharge their legal duty was to warn the potential victim. The court made it very clear, however, that warning the threatened party might be too radical a course of action to constitute "reasonable care," while in other cases simply warning the potential victim might not be sufficient action.[36]

The Tarasoff case did not explicitly establish whether therapists would be liable only in situations that involve specific, identifiable victims or whether they would also be liable for nonspecific threats made against nonspecified persons. With the exception of the atypical expansive rule in the duty to protect handed down in the *Lipari v. Sears* case,[39] the trend has been toward a narrow interpretation of the duty as applicable only when a serious threat has been made to a specified individual. Perhaps the most celebrated illustration of how some courts have clearly limited the Tarsoff decision is the case of *Brady et al. v. Hopper.*[40]

In this case, James Scott Brady, former press secretary to President Reagan, and a number of others brought a multimillion dollar suit against Dr. John J. Hopper, the psychiatrist who had treated John W. Hinckley, Jr., the would-be presidential assassin. The plaintiffs alleged that Dr. Hopper was negligent in failing to warn both law enforcement officials and Hinckley's parents of the potentially dangerous situation. The defense argued that Dr. Hopper had neither the right nor the ability to control the conduct of Hinckley and, furthermore, that since Hinckley had made no specific threats against a reasonably identified person, no duty to control could exist. The courts eventually granted the defendant's request for a dismissal, finding the injuries to the plaintiffs were not foreseeable and that no identifiable threat had been made.

In much the same way, a number of courts have refused to extend a psychotherapist's duty to warn when the danger is not foreseeable, when patients have not identified the individuals at risk, and when such individuals are not identifiable to the therapist prior to the violent act.[41-43] With the case of *Mavroudis v. Superior Court of San Mateo,*[44] "imminence of danger" also became

necessary for the Tarasoff duty to exist, and with *Hedlund v. Superior Court of Orange County,*[45] liability for harm to close relatives and associates (foreseeable bystanders) was added. It should be noted, however, that these parameters apply only to the jurisdictions in which they were rendered.

This limited application of Tarasoff has been enacted into law by some individual states. The 1985 white paper published by the American Psychological Association[46] and the American Psychiatric Association's resource document "Duty to Protect" which is reprinted in APA's State Update,[47] both provide model laws through which states can seek a statutory solution to the problems posed by those who would expand the duty to protect. As of January, 1986, liability may be imposed under California law only when a patient has communicated to the therapist an actual threat of physical violence against a reasonably identified victim. In that case, the therapist can fulfill the duty to warn by making reasonable efforts to communicate the threat to the potential victim and to the police. Since then, 10 states besides California have passed such laws. They are Colorado, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Montana, New Hampshire, Ohio, and Utah.[48]

In its decision in the case of *Davis v. Lhim,* concerning the liability of a mental health worker in relation to the duty to warn, the Michigan Supreme Court enumerated several factors that therapists should take into consideration when assessing whether a patient might act on a threat to a third party. These include: the diagnosis of the patient, the context and manner in which the threat is made, whether the patient has the opportunity to act out the threat, the patient's past history of violence, any factors that provoked the threat and whether they are likely to persist, how the patient is responding to treatment, and the implications stemming from the patient's relationship with the potential victim.[49]

Gross et al.[36] present a seven-step response guide for clinicians to apply after hearing a patient make threats. The critical issues facing clinicians include clarity of threat, severity and actuality of danger, identifiability of potential victims, imminence of danger, and classification of potential victims. Options include family therapy, involuntary commitment to an institution, warning the victim, warning relatives of the victim, and calling the police. In any case, Gross et al. stress that "care must be taken to document the actions that are taken, including the rationale for the choices made. The rationale is important because therapists are held to a standard of reasonable care, not to a standard of successful performance"[36] (p. 12).

### *Prevention of Harm to Patients Themselves*

When a psychiatric outpatient commits or attempts suicide, the treating psychotherapist is often faced with malpractice litigation. The plaintiff's usual claim is that if the therapist had provided adequate treatment, or if the spouse (relatives, friends) had been notified they could have prevented the action. The courts have been somewhat more sympathetic to the problem faced by therapists

in predicting danger to self than they have in predicting danger to others. To a certain extent, this is understandable. In making treatment decisions concerning potential suicide, therapists have only to consider the best interests of the patient and, should the decisions prove misguided, they may be judged to be the results of an error of judgment, not of negligence. A simple error of judgment is not malpractice if it is within the standards of acceptable practice.

Nevertheless, in many respects, cases in which a nonhospitalized patient commits suicide are similar to those in which a patient commits a violent act towards a third party. First, they both involve the issue of prediction, and prediction in both these cases is highly uncertain. While prediction of self-harm is probably more accurate than prediction of harm to others,[6,13] studies have repeatedly demonstrated that neither can be accomplished with any degree of certainty. This is particularly true if the prediction covers more than a few days because of therapists' relative lack of control over the patient and their inability to make any confident assessment of the patient's environmental situation.[4]

Second, both types of cases raise the question of whether or not therapists took adequate precautionary measures. There is no way a reliable determination can be made of how a potentially suicidal patient will respond to various treatment options. Therapists may, for example, increase the number of sessions per week and/or focus the therapy on eliminating the suicidal ideation and urges. They may prescribe medication. They may also recommend hospitalization, but unless the risk is great enough to warrant involuntary commitment the patient cannot be forced to accept the recommendation.[4]

Ultimately, then, when an outpatient attempts suicide it must be determined whether or not the defendant was negligent in balancing the risk of suicide against the benefits of increased patient controls. However, the application of Tarasoff to require a warning in the case of a suspected suicide attempt has not been noticeably successful. Furrow,[7] for example, cites one case in which the court ruled that the disclosure requirement was limited only to cases involving danger of violent assault, not to those where the risk is self-inflicted harm. In two other cases, *Brand v. Grubin*[50] and *Runyon v. Reid,*[51] the treating psychiatrists were also not held liable for their patients' suicides.

It appears, then, that the main exception to the overall rule of confidentiality between therapist and patient occurs when a patient is considered a danger to others.

Opinions are, however, divided on how stringently the "duty to warn" should be applied. Some believe that the ultimate impact of strict liability in duty-to-warn cases (the therapist is responsible for any harm inflicted by his/her patients) is likely to be positive overall. Furrow,[7] for example, makes an argument for this position, citing as part of his reasoning that consultation with other professionals when faced with a difficult case is likely to increase. In addition, by putting pressure on therapists to inform themselves of research

findings on dangerousness, prediction of violence directed towards self or others may be improved.

Others point out that even if the duty to warn and the broader duty to protect society from violence are designed to impose liability only on psychotherapists who, through negligence, fail to identify the relatively few patients who are at obvious danger for suicide or violence, "it is very unlikely that juries could adequately distinguish between obvious and non-obvious risks"[4] (p. 155). Therefore, rather than encouraging careful treatment decisions, increased liability laws would probably result in therapists becoming extremely cautious, leading to warnings for any conceivable risk, no matter how small, that patients are dangerous to themselves or others. Even more cautious therapists might decide not to treat patients who are potential risks. Karasu[21] summarizes the viewpoint of those psychotherapists who are antagonistic to expanding the duty-to-warn laws. In addition to compromising their patients' rights to confidentiality, and possibly their treatment if the patients are deterred from disclosing their feelings to the therapist, the therapist becomes liable not only for failure to warn, but also for invasion of privacy or defamation of their patients if the threat of harm does not occur.

### *Failure to Provide Appropriate Treatment*

Stone[52] describes a landmark malpractice suit in which a patient sued a private psychiatric facility for failure to treat him with psychoactive drugs, choosing instead a purely psychodynamic model of treatment. The private hospital contended that the patient was properly diagnosed as a narcissistic personality disorder and that psychoanalytic therapy was the treatment of choice. The patient showed no improvement with this regimen. However, within weeks of his transfer to another hospital and the initiation of treatment with antidepressants, he made a "dramatic" recovery. The patient's psychiatric experts asserted in deposition that "his symptoms were obviously those of a biological depression that should have been treated biologically, as eventually was done"[51] (p. 1386). The patient settled out of court for $250,000.

Therefore, although this action represents neither a binding decision nor a precedent since the case was settled out of court,[53] it raises some questions and should be duly noted by those therapists who rely exclusively on psychosocial treatment models. The "respectable minority rule" has long been accepted in judging whether there has been negligence in the standard of care or whether the therapist is within the boundaries of permissible conduct.[52] This rule, however, which standard legal treatises universally accept at present, came into use before the biological treatment of mental disorders was shown to be efficacious. For example, in a meta-analysis of studies of the treatment of depression published between 1974 and 1984 that contained both psychotherapy and a psychoactive drug, it was found that combined treatments (drugs plus psychotherapy) were

superior to psychotherapy alone, pharmacotherapy alone, or either of these combined with a placebo.[54]

Thus, as knowledge of diagnosis and treatment becomes more certain, the use of any one therapeutic model as the exclusive treatment could be scientifically questioned and viewed as potential grounds for malpractice. Psychotherapists may eventually become liable if they do not at least inform patients what alternative treatments are available and what the possible benefits and risks are, including the possibility of harmful side effects.[3,6]

Even if patients are informed that effective biological treatments are available as either sole treatment or as adjunctive treatment for their symptoms, the possibility of a malpractice suit is not altogether obviated. As has been pointed out,[55] because of the rapidly evolving pharmacologic technologies, neither clinicians nor the courts agree on any one standard approach that, if not followed, could raise the presumption of malpractice. However, it is the opinion of some experts in the field that failure to target therapy specifically to a patient's symptoms and life-style may raise the issue of uncautious practice. For example, although the benzodiazepines have been widely used for the past 30 years, their side effects, including motor dysfunction and potentiation of effects with alcohol, are well known. For most competent patients, therefore, clinicians are obligated to disclose these risks, and this disclosure should indemnify them from liability should harm occur.

## AVAILABLE SOLUTIONS AND POSSIBLE PREVENTATIVE MEASURES

The recent increases in the number of psychotherapy malpractice suits will probably deter certain types of abuses. For example, the media's current focus on therapists who engage in sexual activity with their patients may reduce the extent of such behavior. This is clearly consistent with the underlying purpose of tort law, whose purpose is to deter undesirable conduct and shift the costs of such conduct from the victim to the responsible therapist.

However, merely imposing external sanctions for the correction of harmful therapists' behaviors may not be very effective. Civil action may be taken, but even if the court finds for the plaintiff, it may have little preventative effect. Professional organizations lack the legal expertise and usually have no subpoena power. They also lack funds and time, and the use of peers to judge alleged misconduct makes unbiased and thorough evaluation of complaints difficult.[56] Another possible approach to redress is an appeal to professional boards, which in some states have the power to revoke licenses, but since a therapist is always free to move to another state, this approach is also largely ineffective. Thus the focus may have to be a stronger emphasis on the education of young trainees and the reeducation of older practitioners. "Just as one never outgrows the need for supervision, there should be an ongoing commitment to seek continuing education"[1] (p. 79).

Curricula for training programs should include components that specifically

address ethical misconceptions about the therapeutic relationship. They should also include the importance of being well informed about professional ethics and special guidelines for the delivery of service, and of maintaining accurate, up-to-date records to establish the care taken in thinking issues through and weighing the benefits and risks of options. Of no less importance is the provision of at least minimal training in statutory and case law as they affect the therapist's practice.[1] In addition to improved training programs, higher licensing requirements might help to reduce negligence deriving from lack of knowledge.[8]

It may also be necessary to design specific educational programs, sensitivity training, and consciousness-raising exercises on ethics for already established clinicians. For those individuals who experience chronic transferential difficulties with patients even after sufficient education, personal treatment may be advisable.[10] Whether or not they should continue to practice during this period is an individual matter.

Finally, guidelines should be established to assist psychotherapists in their decisions to seek ethical and clinical consultation from their peers.[2] These guidelines for consultation should be applicable to a wide variety of problems, including those that involve sexual intimacy, breach of confidentiality, potentially suicidal or homicidal patients, modern diagnostic approaches, and the effectiveness of the various treatments and treatment alternatives. Such guidelines for consultation plus educational programs should help to enhance judicial regulation in an effort to promote psychotherapy that is maximally ethical and efficacious and within the boundaries the courts have set for us.

**SUMMARY**

This paper gives a capsule review of the major issues on the subject of malpractice for individual practitioners of psychotherapy. It examines the elements necessary to support a malpractice claim and presents examples of cases in specific areas of liability.

Historically, the field of psychotherapeutic malpractice was largely inactive. However, recent court rulings reveal that psychotherapists are no longer immune to malpractice suits. In decreasing order of the likelihood of the plaintiffs being successful in their suits are cases involving the misuse of the therapeutic relationship, breach of confidentiality, and cases that involve prevention of harm to third parties and to patients themselves. Malpractice suits based on negligence in providing appropriate treatment are beginning to emerge and will probably increase in frequency as the efficacy of biological treatment is demonstrated.

Available solutions to the problems of malpractice are discussed. It is suggested that in addition to the existing external sanctions, there is a need for consultation plus educational programs to enhance our ability to practice within the boundaries that the courts have set for us.

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