Professional Psychology: Research and Practice
1997, Vol. 28, No. 1, 50–57

0735-7028/97/$3.00

Irreconcilable Conflict Between Therapeutic and Forensic Roles

Stuart A. Greenberg
University of Washington

Daniel W. Shuman
Southern Methodist University

Despite being contrary to good patient care and existing clinical and forensic practice guidelines, some therapists nevertheless engage in dual clinical and forensic roles. Perhaps because an injured litigant seeking treatment is required to engage in 2 distinct roles (litigant and patient), care providers may be tempted to meet both sets of that person's needs. Through the presentation of 10 principles that underlie why combining these roles is conflicting and problematical, the authors stress the importance of avoiding such conflicts, avoiding the threat to the efficacy of therapy, avoiding the threat to the accuracy of judicial determinations, and avoiding deception when providing testimony.

With increasing frequency, psychologists, psychiatrists, and other mental health professionals are participating as forensic experts in litigation on behalf of their patients. Factors such as tightened insurance reimbursement rules, a growing market for forensic mental health professionals, and zealous patient advocacy by therapists have combined to induce many therapists, including those who once zealously avoided the judicial system, to appear, often willingly, as forensic expert witnesses on behalf of their patients. Although therapists' concerns for their patients and for their own employment is understandable, this practice constitutes engaging in dual-role relationships and often leads to bad results for patients, courts, and clinicians.

Although there are explicit ethical precepts about psychologists and psychiatrists engaging in these conflicting roles, they have not eliminated this conduct. One important factor contributing to this continued conduct is that psychologists and psychiatrists have not understood why these ethical precepts exist and how they affect the behavior of even the most competent therapists. When the reasons for the ethical precepts are understood, it is clear why no psychologist, psychiatrist, or other mental health professional is immune from the concerns that underlie them.

This article contrasts the role of therapeutic clinician as care provider and the role of forensic evaluator as expert to the court, acknowledges the temptation to engage in these two roles in the same matter, explains the inherent problems and argues strongly against doing so, and discusses the ethical precepts that discourage the undertaking of the dual roles, as well as the legal and professional responses to this dilemma. The specific problem addressed here is that of the psychologist or psychiatrist who provides clinical assessment or therapy to a patient–litigant and who concurrently or subsequently attempts to serve as a forensic expert for that patient in civil litigation.

Expert persons may testify as fact witnesses as well as either of two types of expert witnesses: treating experts and forensic experts. No special expertise beyond the ability to tell the court what is known from first-hand observation is required to be a fact witness. Being an expert person, however, does not preclude one from simply providing to the court first-hand observations in the role of a fact witness. What distinguishes expert witnesses from fact witnesses is that expert witness have relevant specialized knowledge beyond that of the average person that may qualify them to provide opinions, as well as facts, to aid the court in reaching a just conclusion. Psychologists and psychiatrists who provide patient care can usually qualify to testify as treating experts, in that they have the specialized knowledge, not possessed by most individuals, to offer a clinical diagnosis and prognosis. However, a role conflict arises when a treating therapist also attempts to testify as a forensic expert addressing the psycholegal issues in the case (e.g., testamentary capacity, proximate cause of injury, parental capacity).

Although in the preceding description the therapeutic relationship occurs first and the forensic role second, there are parallel concerns with the reverse sequence (i.e., the subsequent provision of therapy by a psychologist or psychiatrist who previously provided a forensic assessment of that litigant). There are also similar concerns about the treating therapist's role in criminal litigation. However, this article will only address civil litigation because the concerns and considerations arising in criminal litigation are somewhat different, such as therapy provided under court order and the provision of therapy and evaluation in forensic hospitals pending criminal responsibility or competency to stand trial determinations.

Role Conflict

In most jurisdictions, a properly qualified therapist testifies as a fact witness for some purposes, as he or she is expected to

STUART A. GREENBERG is a diplomate in forensic psychology, ABPP; is in the full-time private practice of forensic psychology in Seattle, Washington; and is on the adjunct faculty of the University of Washington, Department of Psychiatry and Behavioral Sciences. His private practice specializes in civil forensic psychology, primarily personal injury and employment litigation. He frequently lectures on these topics, on forensic roles and ethics, and on the forensic uses of the Minnesota Multiphasic Personality Inventory.

DANIEL W. SHUMAN is a professor of law at Southern Methodist University School of Law in Dallas, Texas, and an adjunct professor of psychiatry at the University of Texas Health Science Center at Dallas. His work addresses ethical, evidentiary, liability, and mental health law policy issues. His work on this article was supported by a grant from the M.D. Anderson Foundation.

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Stuart A. Greenberg, 720 Olive Way, Suite 605, Seattle, Washington 98101-1853. Electronic mail may be sent via the Internet to stuartg@u.washington.edu.

testify to information learned first hand in therapy, and as an expert witness for some purposes, as he or she is permitted to testify to opinions about mental disorder that a layperson would not be permitted to offer. Thus, a therapist may, if requested to do so by a patient or ordered to do so by a court, properly testify to facts, observations, and clinical opinions for which the therapy process provides a trustworthy basis. This testimony may include the history as provided by a patient; the clinical diagnosis; the care provided to a patient; the patient's response to that treatment; the patient's prognosis; the mood, cognitions, or behavior of the patient at particular times; and any other statements that the patient made in treatment. A therapist may properly testify, for example, that Ms. Jones reported the history of a motor vehicle accident (MVA) 2 weeks prior to the start of therapy and that the therapist observed the patient to be bruised, bandaged, tearful, and extremely anxious. The therapist may properly testify that he or she observed, and that Ms. Jones reported, symptoms that led to a diagnosis of posttraumatic stress disorder (PTSD). The therapist may also describe the particular type of treatment used, the patient's response to that treatment, and her prognosis. The therapist may properly testify that the primary focus for the therapy was the MVA, or the PTSD secondary to the MVA. The therapist may even properly testify that, for treatment purposes, the operating assumption was that the MVA rather than her impending divorce or recent job termination or the death of a family member was what caused the patient's distress.

To be admissible, an expert opinion must be reliable and valid to a reasonable degree of scientific certainty (a metric for scrutinizing the certainty of expert testimony as a condition of its admissibility). It is improper for the therapist to offer an expert opinion that the MVA was the proximate cause of her impairments rather than the divorce, job termination, or bereavement. This is true for two reasons. First, the type and amount of data routinely observed in therapy is rarely adequate to form a proper foundation to determine the psycholegal (as opposed to the clinically assumed) cause of the litigant's impairment, nor is therapy usually adequate to rule out other potential causes. Second, such testimony engages the therapist in conflicting roles with the patient. Common examples of this role conflict occur when a patient's therapist testifies to the psycholegal issues that arise in competency, personal injury, worker's compensation, and custody litigation.

These concerns do not apply when the treating expert witness stays within the boundaries of facts and opinions that can be reliably known by the treating professional. Indeed, the treating therapist can be compelled to testify to information perceived during the therapeutic process and to opinions previously formed for the purpose of therapy but cannot be compelled to do a forensic examination or analysis (Shuman, 1983). Clinical, ethical, and legal concerns arise when the treating expert offers psycholegal assessment—an assessment for which the treating expert does not have adequate professional basis, for which there are inherent role conflicts, and for which there will almost certainly be negative implications for continued therapy.

The temptation to use therapists as forensic experts falls on fertile ground because clinical psychology and psychiatry graduate students often do not receive adequate training in forensic ethics. Although graduate training in ethics has vastly improved in general, most graduate ethics courses teach clinicians in training about the dual roles that most often get therapists in difficulties: mainly, sexual and other nonprofessional relationships with patients. The legal arena is sufficiently foreign to most academicians and their students that ethics training primarily focuses on licensing laws and ethical codes for general practice. For example, few psychologists receive training in the Specialty Guidelines for Forensic Psychologists (Committee on Ethical Guidelines for Forensic Psychologists, 1991) because few see themselves as forensic psychologists. When these clinicians eventually testify in court, they see themselves as benignly telling the court about their patients and perhaps even benevolently testifying on behalf of their patients. Therapists are not typically trained to know that the rules of procedure, rules of evidence, and the standard of proof is different for court room testimony than for clinical practice.

The temptation to use therapists as forensic experts on behalf of patient–litigants exists because of erroneous beliefs about efficiency, candor, neutrality, and expertise. Using a therapist to provide forensic assessment appears efficient because the therapist has already spent time with the patient and knows much about him or her that others are yet to learn and not without substantial expenditures of time and money for an additional evaluation. A therapist appears to gain candid information from a patient–litigant because of the patient's assumed incentive to be candid with the therapist to receive effective treatment. Although litigants may learn much about themselves as a consequence of receiving thorough forensic evaluations (Finn & Tonsager, 1996), the same treatment incentive does not exist in a forensic examination. Thus, the facts forming the basis for a therapist's opinion may initially appear more accurate and complete than the facts that could be gathered in a separate forensic assessment.

In addition, a therapist does not appear to be the attorney's hired gun who came into the case solely to assist in advancing or defeating a legal claim or defense. Thus, a therapist's forensic assessment may appear more neutral and less immediately subject to financial incentives to reach a particular result than does a separate forensic evaluation. And, it is sometimes assumed that if a therapist has the expertise to be trusted to treat the condition for which a patient seeks compensation, surely the therapist has the expertise to testify about it. Indeed, in many ways it would appear from this analysis that one would have to be foolish not to have therapists also testify as forensic experts. Nevertheless, examining the differences between the therapeutic and forensic relationships, process, and expertise reveals that such foolishness is the mirror image of sensibility.

Ten Differences Between Therapeutic and Forensic Relationships

As can be seen from Table 1, the therapeutic and forensic roles demand different and inconsistent orientations and procedures (adapted from Greenberg & Moreland, 1995). The superficial and perilous appeal of using a therapist as a forensic examiner is debunked by examining the conceptual and practical differences between the therapist–patient relationship and the forensic examiner–litigant relationship.

The first and perhaps most crucial difference between the

Table 1
Ten Differences Between Therapeutic and Forensic Relationships

		Care provision	Forensic evaluation
1.	Whose client is patient/litigant?	The mental health practitioner	The attorney
2.	The relational privilege that governs disclosure in each relationship	Therapist–patient privilege	Attorney-client and attorney work-product privilege
3.	The cognitive set and evaluative attitude of each expert	Supportive, accepting, empathic	Neutral, objective, detached
4.	The differing areas of competency of each expert	Therapy techniques for treatment of the impairment	Forensic evaluation techniques relevant to the legal claim
5.	The nature of the hypotheses tested by each expert	Diagnostic criteria for the purpose of therapy	Psycholegal criteria for purpose of legal adjudication
6.	The scrutiny applied to the information utilized in the process and the role of historical truth	Mostly based on information from the person being treated with little scrutiny of that information by the therapist	Litigant information supplemented with that of collateral sources and scrutinized by the evaluator and the court
7.	The amount and control of structure in each relationship	Patient structured and relatively less structured than forensic evaluation	Evaluator structured and relatively more structured than therapy
8.	The nature and degree of "adversarialness" in each relationship	A helping relationship; rarely adversarial	An evaluative relationship; frequently adversarial
9.	The goal of the professional in each relationship	Therapist attempts to benefit the patient by working within the therapeutic relationship	Evaluator advocates for the results and implications of the evaluation for the benefit of the court
10.	The impact on each relationship of critical judgment by the expert	The basis of the relationship is the therapeutic alliance and critical judgment is likely to impair that alliance	The basis of the relationship is evaluative and critical judgment is unlikely to cause serious emotional harm

roles is the identification of whose client the patient–litigant is. As implied by the name, the patient–litigant has two roles, one as therapy patient and another as plaintiff in the legal process. The patient–litigant is the client of the therapist for the purposes of treatment. The patient–litigant is as well the client of the attorney for guidance and representation through the legal system.

The nature of each relationship and the person who chooses to create it differs for therapy and forensic evaluation. The therapist is ultimately answerable to the client, who decides whether to use the services of a particular therapist; the forensic evaluator is ultimately answerable to the attorney, or the court in the case of a court-appointed expert, who decides whether to use the services of a particular forensic evaluator. The patient retains the therapist for treatment. The attorney (or the court) retains the forensic evaluator for litigation. This arrangement allows for the relationship that is most straightforward and free of conflict of interest. It best protects the parties' interests as well as the integrity of the therapist and the forensic evaluator.

Second, the legal protection against compelled disclosure of the contents of a therapist–patient relationship is governed by the therapist–patient privilege and can usually only be waived by the patient or by court order. Society seeks to further the goal of treatment through recognition of a privilege for confidential communications between a therapist and patient in most jurisdictions under a physician, psychiatrist, psychologist, or psychotherapist–patient privilege (Shuman & Weiner, 1987).

Legal protection against compelled disclosure of the contents of the forensic evaluator–litigant relationship is governed by the attorney–client and attorney–work-product privileges. Because the purpose of a forensic relationship is litigation, not treatment nor even diagnosis for the purpose of planning treatment, communications between a forensic examiner and a litigant are not protected under a physician–, psychiatrist–, psychologist–, or psychotherapist–patient privilege. The forensic evaluator, however, having been retained by the attorney, is acting as an agent of the attorney in evaluating the party or parties in the legal matter. This legal agency status puts the forensic evaluator under the umbrella of the attorney–client privilege and usually protects privileged information until such time that the evaluator is declared to be a witness at trial. Until that time, most states, especially in civil matters, allow the attorney to prevent access to that attorney's retained expert by opposing counsel, thus best protecting the party's interest should the evaluator's independent opinion not favor the party of the attorney who has retained him or her. Because it would not be a therapeutic relationship, no such potential protection is available if the forensic evaluator were to be retained directly by the party, thereby creating the onus of one's own expert who was hired to evaluate some potential merit to the case instead being used to discredit the retaining side. Because parties, through their attorneys, need to be able to evaluate the merits of their case candidly without such jeopardy, the attorney–work-product privilege covers such trial-preparation use of experts retained by counsel.

The main practice point to be made here is that the logic, the legal basis, and the rules governing the privilege that applies to care providers are substantially different from those that apply to forensic evaluators. Given this, the duty to inform forensic examinees of the potential lack of privilege and the intended use of the examination product is embodied in case law (*Estelle v. Smith,* 1981) and the Specialty Guidelines for Forensic Psychologists (SGFP) adopted by the American Psychology–Law Society (APA Division 41) and the American Board of Forensic

Psychology in 1991. The Specialty Guidelines state the following:

> Forensic psychologists have an obligation to ensure that prospective clients are informed of their legal rights with respect to the anticipated forensic service, of the purposes of any evaluation, of the nature of procedures to be employed, of the intended uses of any product of their services, and of the party who has employed the forensic psychologist. (Committee on Ethical Guidelines for Forensic Psychologists, 1991, p. 659)

The third difference is evident in the evaluative attitude of each of the experts. The therapist is a care provider and usually supportive, accepting, and empathic; the forensic evaluator is an assessor and usually neutral, objective, and detached as to the forensic issues. A forensic evaluator's task is to gain an empathic understanding of the person but to remain dispassionate as to the psycholegal issues being evaluated. For therapists, empathy and sympathy—generating a desire to help—usually go hand-in-hand. For forensic evaluators, the task is a dispassionate assessment of the psycholegal issues.

Fourth, to perform his or her task, a therapist must be competent in the clinical assessment and treatment of the patient's impairment. In contrast, a forensic evaluator must be competent in forensic evaluation procedures and psycholegal issues relevant to the case. A therapist must be familiar with the literature on diagnoses and treatment interventions, knowing from among which diagnostic categories and treatment interventions the patient's difficulties would be best identified and treated. The forensic evaluator must know the basic law as it relates to the assessment of the particular impairment claimed.

Fifth, a therapist then uses this expertise to test rival diagnostic hypotheses to ascertain which therapeutic intervention is most likely to be effective. For example, a therapeutic diagnostic question might be whether a patient is a better candidate for insight-oriented psychotherapy, systematic desensitization, or psychopharmacologic intervention. A forensic evaluator must know the relevant law and how it relates to a particular psychological assessment. A forensic evaluator then uses this expertise to test a very different set of rival psycholegal hypotheses that are generated by the elements of the law applicable to the legal case being adjudicated. A psycholegal question might be whether an impairment in the plaintiff 's functioning would not have occurred but for the death of the plaintiff 's child that was allegedly caused by the defendant. Another forensic question might be whether the proximate cause of a plaintiff 's impairment is a discriminatory promotional practice, a hostile work environment, quid pro quo sexual harassment, or management retaliation for having filed a complaint.

The sixth difference is the degree of scrutiny to which information from the patient–litigant is subjected. Historical truth plays a different role in each relationship. At least with competent adults, therapy is primarily based on information from the person being treated, information that may be somewhat incomplete, grossly biased, or honestly misperceived. Even when the therapist does seek collateral information from outside of therapy, such as when treating children and incompetent adults, the purpose of the information gathering is to further treatment, not in the pursuit of validating historical truth. In most instances, it is not realistic, nor is it typically the standard of care, to expect a therapist to be an investigator to validate the historical truth of what a patient discusses in therapy. Indeed, trying to do so by contacting family members, friends, or coworkers and by requesting corroborating documentation may frustrate therapy even if the patient has signed a release of information. Further, this corroboration is usually unnecessary. Effective therapy can usually proceed even in the face of substantial historical inaccuracy. For example, a patient's impaired self-esteem, body image, and sexual interest might be effectively treated regardless of the fact that her reported memory of having been sexually abused early in childhood by her maternal uncle was inaccurate and that she was actually abused by her paternal uncle. Similarly, a fear of small places can be effectively treated even if the cause was having been locked in a closet by an angry spouse or parent and not by being trapped in a faulty elevator. Depression from poor work performance, excessive and losing gambling, almost being caught defrauding an employer, and having to resign can be treated even if the reason for the depression conveyed to the therapist by the patient is that he or she was the victim of an incompetent and unfair supervisor.

The more important question for most psychotherapeutic techniques is how a patient perceives or feels about the world—what is real to that patient—not factual or historical truth (Wesson, 1985). Even for those therapeutic techniques that involve confrontation and challenge of a patient's conceptions of events, therapists rarely conduct factual investigations into circumstances surrounding patient claims in therapy. Thus, the historical truth of matters raised during therapy cannot, simply on that basis alone, be considered valid and reliable for legal purposes. This is not a criticism of therapy. This approach to psychotherapy makes sense given its temporal framework. If a patient report or a diagnostic hypothesis is not borne out, it can be revised in later sessions. This approach to therapy, which is informed and educated but still somewhat trial-and-error, typically does no harm unless the patient is in a high-risk situation, such as being suicidal or in an abusive environment.

In contrast, the role of a forensic examiner is, among other things, to offer opinions regarding historical truth and the validity of the psychological aspects of a litigant's claims. The accuracy of this assessment is almost always more critical in a forensic context than it is in psychotherapy. A competent forensic evaluation almost always includes verification of the litigant's accuracy against other information sources about the events in question. These sources may include collateral interviews with coworkers, neighbors, family members, emergency room personnel, or a child's teacher or pediatrician and a review of documents such as police reports, school records, military records, medical records, personnel files, athletic team attendance, credit card bills, check stubs, changes in one's resume, depositions, witness statements, and any other possible sources of information about the litigant's pre- and postincident thoughts, emotions, and behaviors. However, therapists do face a dilemma regarding the historical accuracy of the information provided by the patient, depending on how they or their patients act on that information. This is illustrated by a case in which a therapist was successfully sued for slander by a father who was identified through memories recovered in therapy as allegedly having abused the therapist's patient as a child every Friday evening. The father offered employment records at the thera-

pist's trial that revealed that he had worked for the railroad and had been working out of town every Friday evening in question (Blow, 1995).

Seventh, the need for historical accuracy in forensic evaluations leads to a need for completeness in the information acquired and for structure in the assessment process to accomplish that goal. Therapeutic evaluation, in comparison, is relatively less complete and less structured than a forensic evaluation. Moreover, a patient provides more structure to a therapeutic evaluation than does a litigant to a forensic evaluation. Ideally, a patient and therapist work collaboratively to define the goals of a therapeutic interaction and a time frame within which to realize them. The time frame and goals of a forensic evaluation are defined by the legal rules that govern the proceeding, and once these are determined, the forensic evaluator and litigant are usually constrained to operate within them. To make maximum use of the time available, forensic evaluators usually conduct highly structured assessments using structured interviews supplemented with a battery of psychological tests and forensically oriented history and impairment questionnaires. Certainly the plaintiff is encouraged to describe the events in question, but it is the forensic evaluator's task to establish a preincident baseline of functioning, a complete description of the incidents alleged in the legal complaint, the subsequent areas of resilience and impairment of the plaintiff's functioning, the proximate cause of any impairment, and the likely future functioning of the plaintiff, if necessary, ameliorated or enhanced by any needed therapy.

Eighth, although some patients will resist discussing emotionally laden information, the psychotherapeutic process is rarely adversarial in the attempt to reveal that information. Forensic evaluation, although not necessarily unfriendly or hostile, is nonetheless adversarial in that the forensic evaluator seeks information that both supports and refutes the litigant's legal assertions. This struggle for information is also handled quite differently by each expert: The therapist exercises therapeutic judgment about pressing a patient to discuss troubling material, whereas a forensic evaluator will routinely seek information from other sources if the litigant will not provide it or to corroborate it when the litigant does provide information. In the extreme, when presented with excessive underreporting or overreporting of critical information, the forensic evaluator might even decide that the litigant is dissembling.

Ninth, consider the goals of each of these relationships. Therapy is intended to aid the person being treated. A therapist–patient relationship is predicated on principles of beneficence and nonmaleficence—doing good and avoiding harm. A therapist attempts to intervene in a way that will improve or enhance the quality of the person's life. Effective treatment for a patient is the reason and the principal defining force for the therapeutic relationship. According to the Hippocratic oath, "Into whatever house I enter, I will do so to help the sick, keeping myself free from all intentional wrong-doing and harm. . . ." Similarly, according to the ethical principles of psychologists, "Psychologists seek to contribute to the welfare of those with whom they interact professionally. . . . [They attempt] to perform their roles in a responsible fashion that avoids or minimizes harm" (APA, 1992, p. 1600).

Forensic examiners strive to gather and present objective information that may ultimately aid a trier of fact (i.e., judge or jury) to reach a just solution to a legal conflict. A forensic examiner is obligated to be neutral, independent, and honest, without becoming invested in the legal outcome. A forensic evaluator advocates for the findings of the evaluation, whatever those findings turn out to be. Thus, the results of a forensic examination may well be detrimental to the legal position of an examinee (American Psychiatric Association, 1984) and contrary to basic therapeutic principles.

Tenth, the patient–litigant is likely to feel differently about expert opinions rendered by therapists than those rendered by forensic experts. Consider the role of judgment in therapeutic relationships. There is a robust, positive relationship between the success of the therapist–patient alliance and success in therapy (Horvath & Luborsky, 1993). To develop a positive therapist–patient alliance, a therapist must suspend judgment of the patient so that the therapist can enter and understand the private perceptual world of the patient without doing anything that would substantially threaten that relationship. Indeed, some believe that even a posttherapy disturbance of this therapeutic alliance may cause serious harm to a patient; hence many advocate substantial limitations on personal relationships between former patients and their therapists.

In contrast, the role of a forensic examiner is to assess, to judge, and to report that finding to a third party (attorney, judge, or jury) who will use that information in an adversarial setting. To assess, a forensic examiner must be detached, maybe even skeptical, and must carefully question what the litigant presents. Because a forensic psychologist or psychiatrist has not engaged in a helping relationship with the litigant, it is less likely that his or her judgment-laden testimony would cause serious or lasting emotional harm to the litigant than would that of the psychologist or psychiatrist who has occupied a therapeutic role.

Waiving the Dual-Role Conflict

These role differences are not merely artificial distinctions but are substantial differences that make inherently good sense. Unless these distinctions are respected, not only are both the therapeutic and forensic endeavors jeopardized for the patient–litigant but as well the rights of all parties who are affected by this erroneous and conflictual choice. Unlike some conflicts of interest, this role conflict is not one that the plaintiff can waive, because it is not the exclusive province of the plaintiff's side of the case. The conflict affects not only the plaintiff but also the defense and the court. This conflict not only poses therapeutic risks to the patient–litigant but also risks of inaccuracy and lack of objectivity to the court's process and to all of the litigants.

Existing Professional Guidelines

On the basis of these concerns, both psychological and psychiatric organizations have sought to limit these situations when dual functions are performed by a single psychologist or psychiatrist. In increasing detail and specificity, professional organizations have discouraged psychologists and psychiatrists from engaging in conflicting dual professional roles with patient–litigants. As the Ethical Guidelines for the Practice of Forensic

Psychiatry, adopted by the American Academy of Psychiatry and the Law (AAPL) in 1989, note:

> A treating psychiatrist should generally avoid agreeing to be an expert witness or to perform an evaluation of his patient for legal purposes because a forensic evaluation usually requires that other people be interviewed and testimony may adversely affect the therapeutic relationship.

In a very similar vein, the Specialty Guidelines for Forensic Psychologists indicate the following:

> Forensic psychologists avoid providing professional services to parties in a legal proceeding with whom they have personal or professional relationships that are inconsistent with the anticipated relationship.
>
> When it is necessary to provide both evaluation and treatment services to a party in a legal proceeding (as may be the case in small forensic hospital settings or small communities), the forensic psychologist takes reasonable steps to minimize the potential negative effects of these circumstances on the rights of the party, confidentiality, and the process of treatment and evaluation. (Committee on Ethical Guidelines for Forensic Psychologists, 1991, p. 659)

The Committee on Psychiatry and Law of the Group for the Advancement of Psychiatry (GAP, 1991) concluded in 1991 that "While, in some areas of the country with limited number of mental health practitioners, the therapist may have the role of forensic expert thrust upon him, ordinarily, it is wise to avoid mixing the therapeutic and forensic roles" (p. 44). Similarly, the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association (APA, 1992) admonishes that "In most circumstances, psychologists avoid performing multiple and potentially conflicting roles in forensic matters" (p. 1610). Finally, the most recent and the most specific of these codes, the American Psychological Association's (1994) guidelines for conducting child custody evaluations, concluded the following:

> Psychologists generally avoid conducting a child custody evaluation in a case in which the psychologist served in a therapeutic role for the child or his or her immediate family or has had other involvement that may compromise the psychologist's objectivity. This should not, however, preclude the psychologist from testifying in the case as a fact witness concerning treatment of the child. In addition, during the course of a child custody evaluation, a psychologist does not accept any of the involved participants in the evaluation as a therapy client. Therapeutic contact with the child or involved participants following a child custody evaluation is undertaken with caution.
>
> A psychologist asked to testify regarding a therapy client who is involved in a child custody case is aware of the limitations and possible biases inherent in such a role and the possible impact on the ongoing therapeutic relationship. Although the court may require the psychologist to testify as a fact witness regarding factual information he or she became aware of in a professional relationship with a client, that psychologist should decline the role of an expert witness who gives a professional opinion regarding custody and visitation issues (see Ethical Standard 7.03) unless so ordered by the court. (p. 678)

The Legal Perspective

Although there are explicit ethical precepts addressing this dual role, there are no reported judicial decisions to date that address the exclusion of a forensic assessment by a psychologist or psychiatrist who served as a litigant's therapist. Courts may not see this as an issue of competence or qualification, but instead, at most, as one of weight or credibility. Thus, the therapist would be permitted to testify and the ethical precept could be used to challenge credibility. Some courts may not recognize the role conflicts or not see them as important; other courts may see them but are too concerned with efficiency to give them great weight.

Although even the clear ethical conflict may not yet persuade a court to exclude the testimony of a therapist who offers a forensic assessment, the effect of this departure from professional standards on the perceived credibility of the witness may persuade attorneys to resist this two-for-one strategy. Deviating from the ethical codes or practice guidelines of one's profession is an appropriate and effective basis for impeaching a witness and the explicit ethical and specialty guidelines that address this problem simplify this task for the cross-examining attorney.

Similarly, under both the test of "general acceptance" in the relevant professional community of *Frye v. United States* (1923) and the "good grounds given what is known" test of *Daubert v. Merrell Dow Pharmaceuticals* (1993), forensic assessment by a patient's therapist does not generally provide a reliable basis for a forensic assessment and therefore should be avoided by the ethical psychologist and viewed skeptically by the courts. Expert witnesses are held highly accountable for the accuracy of their opinions through the rules of evidence; the rigors of deposition, voir dire, cross-examination; and the testimony of opposing experts. Courts now scrutinize the admissibility of expert opinion testimony on the basis of the quality of the science that underlies the testimony (Shuman, 1994). The Supreme Court's decision in *Daubert* (1993) requires federal courts to make a "preliminary assessment of whether the reasoning or methodology underlying the testimony is scientifically valid and whether that reasoning properly can be applied to the facts in issue" (p. 592). This decision is part of a trend in both state and federal courts toward a more demanding level of scrutiny requiring scientific support or validation for the assertions made by mental health professionals in forensic settings. This trend (e.g., *State v. Russel,* 1994) is even seen in states that have chosen to apply the "general acceptance in the relevant professional community" test (*Frye,* 1923) instead of the test in *Daubert.* Psychologists and psychiatrists should expect courts to demand evidence of the research that supports their opinions and that supports the data acquisition methods on which opinions are based. A forensic evaluation must be based on information that is more complete and more accurate than that typically obtained as part of therapy.

To date, society has taken a largely laissez-faire, market orientation to psychotherapy. Most successful malpractice claims against mental health professionals have involved sex with patients, drug interactions, failure to warn or protect, and suicide (Smith, 1991). However, engaging in dual roles raises the potential for a lawsuit against a therapist by a patient alleging lack of informed consent. This could be claimed by a disgruntled

patient–litigant who expected the therapist to be as successful and partisan an expert witness as he or she was a therapist. The argument would follow that the therapist should have reasonably known that the patient would be less likely to disclose certain information knowing that a third person would be made aware of, and potentially use, the information to the detriment of the discloser and, therefore, the therapist should have warned the patient of that potential consequence not just before the therapist changed roles but also before therapy (and the disclosures) even began. It is similarly likely that most people would choose to disclose more information with less self-censorship in psychotherapy than in forensic examinations. Once this information has been disclosed in therapy, and the therapy process then becomes the basis for forensic testimony by the therapist, this then places the otherwise innocuous information into a different context and makes it more likely that this disclosure will be used to the detriment of the patient (Shuman & Weiner, 1987).

Where Then Should the Line Be Drawn?

As stated earlier, psychologists and psychiatrists may appropriately testify as treating experts (subject to privilege, confidentiality, and qualifications) without risk of conflict on matters of the reported history as provided by the patient; mental status; the clinical diagnosis; the care provided to the patient and the patient's response to it; the patient's prognosis; the mood, cognitions, or behavior of the patient; and any other relevant statements that the patient made in treatment. These matters, presented in the manner of descriptive "occurrences" and not psycholegal opinions, do not raise issues of judgment, foundation, or historical truth. Therapists do not ordinarily have the requisite database to testify appropriately about psycholegal issues of causation (i.e., the relationship of a specific act to claimant's current condition) or capacity (i.e., the relationship of diagnosis or mental status to legally defined standards of functional capacity). These matters raise problems of judgment, foundation, and historical truth that are problematic for treating experts.

When faced with issues that seem to fall between these guideposts, it is useful to ask whether each opinion is one that could or should have been reached in therapy. Thus, if the legal system did not exist, would therapists be expected to reach these sorts of conclusions on their own? Would doing so ordinarily be considered an aspect of the therapy process? In doing so, would the opinion be considered exploratory, tentative, and speculative, or instead as providing an adequate basis for guiding legal action outside of therapy? Is the therapist generating hypotheses to facilitate treatment or is he or she reasonably scientifically certain that this opinion is accurate? Is it based on something substantially more than, "My patient said so," "My patient would have no reason to lie," or "My patient would not lie to me"?

Conclusion

Psychologists, psychiatrists, and other mental health professionals have given and received criticism about the use of expert witnesses whose partisanship appears to overwhelm their professionalism. Engaging in conflicting therapeutic and forensic relationships exacerbates the danger that experts will be more concerned with case outcome than the accuracy of their testimony. Therapists are usually highly invested in the welfare of their patients and rightfully concerned that publicly offering some candid opinions about their patient's deficits could seriously impair their patient's trust in them. They are often unfamiliar with the relevant law and the psycholegal issues it raises. They are often unaware of much of the factual information in the case, and much of what they know comes solely from the patient and is often uncorroborated. What they do know, they know primarily, if not solely, from their patient's point of view. They are usually sympathetic to their patient's plight, and they usually want their patient to prevail.

By failing to recognize the inherent limitations of their work as therapists, as well as the conflicting therapeutic and forensic roles, psychologists, psychiatrists, and other mental health professionals risk harm to their profession, their patients, and the courts. Although therapists frequently enter the forensic arena in their efforts to help, these efforts may not only put therapists in ethical difficulty but may also neutralize the impact both of their testimony and their work as therapists. Therapists need to acknowledge the limits of what they can accurately and reliably say on the basis of therapeutic relationships. Although it is difficult, when asked psycholegal questions, therapists must be willing to testify "I cannot answer that question given my role in this case," "I do not have an adequate professional basis to answer that question," "I did not conduct the kind of evaluation necessary to reliably answer that question," "I can only tell you what I observed," or "I can only tell you what my patient told me." No matter how laudable their motives might be, therapists who venture beyond these limits and into the arena of psycholegal opinion are deceiving themselves and others. Engaging in an irreconcilable role conflict and lacking an adequate professional basis for their testimony, they can be neither neutral, objective, nor impartial.

References

American Academy of Psychiatry and the Law. (1989). Ethical guidelines for the practice of forensic psychiatry. In *Membership directory of American Academy of Psychiatry and the Law* (pp. x–xiii). Bloomfield, CT: Author.

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47,* 1597–1611.

American Psychological Association. (1994). Guidelines for child custody evaluations in divorce proceedings. *American Psychologist, 49,* 677–680.

American Psychiatric Association. (1984). *Psychiatry in the sentencing process: A report of the task force on the role of psychiatry in the sentencing process.* Washington, DC: Author.

Blow, S. (1995, January 11). Slander case shakes family. *Dallas Morning News,* p. 25a.

Committee on Ethical Guidelines for Forensic Psychologists. (1991). Specialty guidelines for forensic psychologists. *Law and Human Behavior, 15,* 655–665.

Committee on Psychiatry and Law, Group for the Advancement of Psychiatry. (1991). *The mental health professional and the legal system* (Rep. No. 131). New York: Brunner/Mazel.

Daubert v. Merrell Dow Pharmaceuticals, Inc., 405 U.S. 597 (1993).

Estelle v. Smith, 451 U.S. 454 (1981).

Finn, S. E., and Tonsager, M. E. (1996). *Therapeutic assessment: Using*

psychological testing to help clients change. Manuscript in preparation.

Frye v. United States, 293 F. 1013 (D.C. Cir. 1923).

Greenberg, S. A., & Moreland, K. (1995). *Forensic evaluations and forensic applications of the MMPI/MMPI-2.* Unpublished manuscript, University of Minnesota, Department of Continuing Education and Conference Services, Minneapolis, and The American Academy of Forensic Psychology.

Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology, 61,* 561–573.

Shuman, D. W. (1983). Testimonial compulsion: The involuntary medical expert witness. *Journal of Legal Medicine, 4,* 419–446.

Shuman, D. W. (1994). *Psychiatric and psychological evidence* (2nd ed.). Colorado Springs, CO: Shepherds/McGraw-Hill.

Shuman, D. W., & Weiner, M. F. (1987). *The psychotherapist–patient privilege: A critical examination.* Springfield, IL: Thomas.

Smith, S. R. (1991). Mental health malpractice in the 1990's. *Hous. L. Rev., 28,* 209–283.

State v. Russel, 882 P.2d 747 (Wash. 1994).

Wesson, M. (1985). Historical truth, narrative truth, and expert testimony, *Wash. L. Rev., 60,* 331–354.

Received October 2, 1995
Revision received February 22, 1996
Accepted May 20, 1996 ■

Psychotherapy Theory, Research, Practice, Training
2010, Vol. 47, No. 1, 98–110

0033-3204/10/$12.00 DOI: 10.1037/a0018843

AVOIDING THE ROAD TO ETHICAL DISASTER: OVERCOMING VULNERABILITIES AND DEVELOPING RESILIENCE

ALAN C. TJELTVEIT
Muhlenberg College

MICHAEL C. GOTTLIEB
Dallas, Texas

Psychotherapists may, despite their best intentions, find themselves engaging in ethically problematic behaviors that could have been prevented. Drawing on recent research in moral psychology and longstanding community mental health approaches to prevention, we suggest that psychotherapists can reduce the likelihood of committing ethical infractions (and move in the direction of ethical excellence) by attending carefully to 4 general dimensions: the desire to facilitate positive (good) outcomes, the powerful opportunities given to professionals to effect change, personal values, and education. Each dimension can foster enhanced ethical behavior and personal resilience, but each can also contribute to ethical vulnerability. By recognizing and effectively addressing these dimensions, psychotherapists can reduce their vulnerabilities, enhance their resilience, reduce the risk of ethical infractions, and improve the quality of their work.

Keywords: psychotherapy, ethics, prevention, resilience, vulnerabilities

Despite their best intentions, psychotherapists may find themselves in situations where they unwittingly slip into otherwise avoidable unethical behavior. All psychotherapists, we suggest, have vulnerabilities that may increase the likelihood of committing ethical infractions, but they also possess some measure of ethical resilience that can protect against such outcomes. Psychotherapists seldom recognize, however, that the same factors that create vulnerability can, when properly identified and addressed, help develop greater resilience. In this article, we propose that psychotherapists at all developmental stages, from student to seasoned professional, are wise to examine thoroughly these factors and develop effective strategies to address them. Doing so not only reduces the risk of drifting into ethical trouble (as a well-intentioned driver can drift into dangerous somnolence), but also helps move the ethical quality of professional practice from merely adequate to optimal.

Background

The Problem and Efforts at Solutions

In recent years, numerous measures have been taken to improve ethical practice and reduce ethical violations among psychotherapists. The considerably expanded 1992 Ethics Code of the American Psychological Association (APA, 1992) was in part designed as a teaching tool to help students and trainees better understand what was expected of them. Through its Committee on Accreditation, APA made ethics education a requirement in professional preparation programs (APA, 1979). Half of the states now require continuing education in professional ethics for licensure renewal (APA, 2006). Finally, organizations, such as the APA Insurance Trust, offer risk management workshops to

Alan C. Tjeltveit, Department of Psychology, Muhlenberg College; Michael C. Gottlieb, Independent Practice, Dallas, TX.

We thank Mitchell M. Handelsman, Kenneth S. Pope, and Gary R. Schoener for their very helpful comments on a previous version of this article. Versions of this article were presented at the 2002 and 2003 annual meetings of the American Psychological Association.

Correspondence regarding this article should be addressed to Alan C. Tjeltveit, PhD, Department of Psychology, Muhlenberg College, 2400 West Chew Street, Allentown, PA 18104. E-mail: tjelt@muhlenberg.edu

help colleagues understand where the "floor" in ethical behavior lies and how the standard of care is commonly interpreted. Central to many of these efforts is a focus on cognitive learning concerning the current APA (2002) Ethics Code, state regulatory board rules and regulations, relevant state and federal statutes and court decisions, or mastery of a particular ethical decision-making model (e.g., Canadian Psychological Association, 2000; Gottlieb, 1993; Kitchener, 2000; Knapp & VandeCreek, 2006; Knauss, 1997; Koocher & Keith–Spiegel, 2008) that helps psychotherapists generate ethically acceptable solutions.

Unfortunately, several studies have shown that cognitive strategies alone are not sufficient. Many psychologists and trainees can accurately describe their ethical responsibilities, yet they state that they might, in certain situations, act otherwise (e.g., Bernard & Jara, 1986; Bernard, Murphy, & Little, 1987; Branstetter & Handelsman, 2000; Fly, van Bark, Weinman, Kitchener, & Lang, 1997; T. S. Smith, McGuire, Abbott, & Blau, 1991; Wilkins, McGuire, Abbott, & Blau, 1990). For example, Bernard et al. (1987) found that, in response to a hypothetical scenario (a psychologist learns that a male colleague is again sexually involved with a client, despite a previous confrontation about such behavior), 37% of the clinical psychologists in the study reported that they "simply would not do what they [knew] they should do" (p. 491). They stated, for example, that they should report the colleague's violation, but likely would not. Similarly, Pope, Tabachnick, and Keith–Spiegel (1987) found that 80% of their psychologist-respondents thought that "working when too distressed to be effective" (p. 995) is unethical, yet 53% reported doing so themselves, including 4.4% who did so "fairly often" (p. 997). Such research suggests that knowledge per se represents only a portion of what is required for sound ethical practice.

A Broader View

Psychologists studying moral behavior have concluded that a solely cognitive emphasis (e.g., Kohlberg, 1979) should be replaced with more comprehensive and psychologically sophisticated understandings of ethical action (Gibbs, 2003; Haidt, 2007; Rest & Narváez, 1994; Rest, Narváez, Bebeau, & Thoma, 1999). These broader approaches include contextual (Betan & Stanton, 1999), cultural (Turiel, 2002), and emotional factors (Betan & Stanton; Haidt, 2001); evolution (Katz, 2000); gender (Noddings, 2002); identity (Lapsley & Narváez, 2004); interpretation (Betan, 1997); intuition (Cushman, Young, & Hauser, 2006); motivation (Bersoff, 1999); and virtues (Thomas, 1989; Tjeltveit & Fowers, 2003). Taken together, this research suggests that our ethical responses are shaped by multiple factors: the awareness that ethical issues are present, social and cultural influences, habits, emotions, intuitions, identity, virtues and character, multiple or competing motivations, prior decisions, and the executive and organizational skills needed to implement decisions. These factors have the potential to overpower knowledge of ethics codes and rational decision-making models. For instance, we now know that rational models of cognition often fail to capture the reality of human choice and behavior; motives are not always known and judgments are often biased (e.g., Kahneman, 2003; Kahneman & Tversky, 1979). Wilkins et al. (1990) found that whether clinicians reported they *would* do what they believed they *should* do varied by situation and by their closeness to a person exhibiting ethically questionable behavior. Haidt (2001, 2007) summarized considerable empirical evidence indicating that, in at least some circumstances, emotions and social and cultural factors influence moral judgments and behaviors more than does moral reasoning.

We propose that the profession do more to help psychotherapists and students understand the emotions, motivations, and values that underlie and affect their work. The purpose of this article is to draw on work from public health and the psychology of moral development to shed light on some neglected dimensions that can affect—for good or ill—the ethical character of professional practice. By learning to enhance their resilience and minimize their vulnerabilities, psychotherapists can learn to avoid ethical problems and move toward ethical excellence. Before considering those dimensions, we list our assumptions.

Assumptions

First, because personal feelings, motivations, and values so powerfully shape the ethical lives of professionals, we must be cognizant of them. Vulnerability to ethical infractions increases when one's understanding of these basic processes is inadequate or deteriorates. We assume

that prevention of ethical infractions and optimally ethical practice can be enhanced by conscientious forethought and ongoing self-examination regarding one's own feelings, motivations, and values.

Second, many prevention efforts are too narrowly focused. For example, didactic instruction often focuses excessively on rules, regulations, statutes, and procedures, such as knowing the limits of confidentiality, providing adequate informed consent, and, most recently, implementing the Health Insurance Portability and Accountability Act. We do not criticize education surrounding these topics. Rather, we assume that it is necessary but not adequate per se, especially when the goal of ethics education is to create competent ethical psychotherapists capable of dealing with the myriad complex issues professionals will face during the course of their careers. What we consider problematic is the myth that "learning ethical standards, principles, and guidelines, along with examples of how they have been applied, translates into ethical practice" (Pope, Sonne, & Greene, 2006, p. 16).

Third, many training experiences appear to intentionally raise anxiety. Some presenters seem to presume that ample fear will generate abundant caution. Unfortunately, such methods violate the well-established principle that too much anxiety tends to disrupt cognition (Eysenck, Derakshan, Santos, & Calvo, 2007). Indeed, this approach may foster confusion, not clarity.

Fourth, we assume that a positive approach to ethics education will be more effective. Handelsman, Knapp, and Gottlieb (2002, 2009) suggested that doing so helps psychotherapists and students aim toward doing their best and encourages them to think about ethical "ceilings" rather than "floors." When psychotherapists are encouraged to do their best, we assume they will be less likely to fall below the standard of care.

Fifth, the lines between clinical, ethical, and legal issues often blur, making ethical decision making more difficult. Sometimes psychotherapists worry that making a decision in favor of one will occur at the expense of another. We assume the three rarely conflict and, in the main, sound ethical decisions will lead to good clinical practice that complies with the law.

Finally, contemporary psychotherapists work in highly complex and often pressurized environments where the need for ethical decisions can arise very quickly. In light of this reality, it is especially important for psychotherapists to be equipped to address the personal feelings and values that arise in these most difficult situations so they can avoid ethical problems and practice in an optimally ethical manner.

Primary Prevention and Ethical Practice

We believe that the process of building resilience and confronting vulnerabilities in psychotherapists' lives is a form of *primary prevention*, which Albee and Ryan (1998) defined as "doing something now to prevent or forestall something unpleasant or undesirable from happening in the future or doing something now that will increase desirable outcomes" (p. 441). When applied to professional behavior, such actions include addressing the emotions and personal values of individual psychotherapists well in advance of problematic ethical behavior. By drawing on the science of prevention (Coie et al., 1993; Doll, Pfohl, & Yoon, in press; Hage et al., 2007; Nation et al., 2003), we can bolster psychotherapists' protective factors and minimize risks related to ethical behavior. We can enhance protective factors by increasing ethical resilience, minimize risk by decreasing vulnerabilities, attend consciously to prevention, and address both the static and the dynamic dimensions of factors related to ethical behavior.

Resilience

Masten (2001) defined *resilience* as "a class of phenomena characterized by good outcomes in spite of serious threats to adaptation or development" (p. 228; see also Kahn & Juster, 2002; Ryff & Singer, 2003; Schoener, 1999; Skovholt, 2001). Research in this area began with children and adolescents, but it has been extended to early adulthood, midlife (Heckhausen, 2001), and old age (Ryff, Singer, Love, & Essex, 1998). We now know that it is never too late to enhance one's resilience.

By *resilience* we mean four things. First, resilience refers to specific skills that can be marshaled when psychotherapists are faced with difficult situations in which there are strong temptations to transgress. We contend that these skills can be taught, at least to some minimal level of proficiency. Second, resilience refers to those relatively stable personal characteristics

that help us cope with and overcome adversity in optimally ethical ways. This notion of resilience is often related to moral virtues or character (Fowers, 2005; Peterson & Seligman, 2004; Tjeltveit & Fowers, 2003); we are in the early stages of learning how virtues develop (see Burke, Harper, Rudnick, & Kruger, 2007; Snyder & Lopez, 2009). Third, resilience emanates from our social relationships and support networks, including regular contact and consultation with colleagues. Finally, resilience is multidimensional and can mean the ability to respond well to challenging situations by drawing in an integrated fashion on those coping skills, virtues, and social support networks.

Vulnerabilities

Vulnerability refers to the areas of our lives that are not well protected from ethical lapses. There are two types: *general* and *idiosyncratic*. *General vulnerabilities* are those that affect us all. For example, we are all prone to making errors in judgment when fatigued or stressed. If we are unaware or have lost sight of our vulnerabilities, the stressful nature of our work or personal lives can quickly create exposure to ethical risks. *Idiosyncratic vulnerabilities* come from our particular personal histories, personalities, habits, or character structure. They may be created by the ways we suffered childhood maltreatment, victimization, trauma, discrimination, or racism. Vulnerability may also exist for those whose lives have gone so well (in at least some regards) that they find it difficult to understand those who have experienced great difficulties in life. Such empathic failures may predispose them to ethical violations when they make faulty assumptions about clients or the impact of their actions on clients. A different type of vulnerability may exist for those professionals with long histories of successfully manipulating others for personal gain while rationalizing their actions as beneficent. They may exploit others without any awareness of committing ethical violations.

Finally, neither vulnerability nor resilience is a constant in our lives. Each ebbs and flows over time. The qualities that make up our resilience will not necessarily be available when we need them, and our vulnerabilities may lurk within us and emerge unpredictably.

Prevention

Practicing prevention is complicated by the fact that the same characteristics may contribute either to vulnerability or to resilience, depending on the situation. For example, as we discuss below, our desire to help others can be part of a resilience that benefits us and our clients, but it may also become a vulnerability if this desire leads to boundary violations. A key to effective risk management and sound ethical practice lies in how one addresses these issues when ethical vulnerability arises. If psychotherapists can effectively manage the troubling dimensions of their lives, they may reduce vulnerabilities that can result in unethical, or less than ethically optimal, behaviors. In the ideal situation, they convert vulnerabilities into resilience.

Practicing ethical prevention requires intellectual and emotional honesty, flexibility, courage, and a willingness to confront and articulate our vulnerabilities in order to make necessary changes in our personal lives or practices (Pope et al., 2006). As Pope (2001) observed, perhaps it may be helpful to create

> . . . an environment (in the classroom, supervision, or consultation) in which the whole range of emotions that we actually do experience as psychologists [is] explored, acknowledged, and discussed. Even (and especially) those feelings that are hard to own, that don't seem socially acceptable, that are not politically correct, that may seem starkly at odds with our stereotypes of what "good" psychologists feel, and that would—if it became generally known that we had these feelings—dry up any prospects for graduating or finding internship opportunities. (¶3)

Risking such self-disclosure and engaging in such discussions may not only decrease vulnerability but increase long-term resilience as well.

Some vulnerabilities have been conceptualized as stemming from countertransference, the correct management of which (Gelso & Hayes, 2001) is crucial both for therapeutic effectiveness and optimally ethical practice (Gordon, 1993). Although the vulnerabilities we discuss are not necessarily unconscious or about early childhood origins, and require no adherence to a psychodynamic perspective, research and careful reflection on countertransference (e.g., Gelso & Hayes, 2007) may shed light on vulnerabilities and help psychotherapists overcome them. For example, Van Wagoner, Gelso, Hayes, and Diemer (1991) found that clinical psychologists gave to psychotherapists who were considered excellent (across theoretical orientations) higher ratings on quali-

ties thought important in managing countertransference (e.g., psychotherapist self-integration, anxiety management, and self-insight) than they gave to psychotherapists in general.

Static and Dynamic Factors

Resilience and vulnerability can be either *static or dynamic*. For instance, many psychotherapists are resolutely hopeful about the realistic progress their clients can make, and such enduring resilience can be a great asset. Vulnerabilities can also remain within us, however, and represent ongoing risk factors. For example, some psychotherapists always struggle with their tendencies to avoid conflict and anger directed toward them. Failing to confront such unpleasantness in a timely manner can subsequently lead to far more serious ethical problems.

Resilience and vulnerabilities may also be *dynamic*, playing roles that wax and wane over time and circumstance. Otherwise competent psychotherapists who divorce, face financial problems, or experience major medical illnesses may become professionally vulnerable in ways they have never experienced before. Consultation with the right colleague at the right time may produce greater resilience and make all the difference in how a psychotherapist handles an ethically or clinically complex case in which there is great potential for ethical mishap. As a matter of good risk management, resilience and vulnerabilities should be monitored throughout one's career through periodic self-assessment, but especially during times of long-term stress.

In the following section, we discuss four dimensions that may prove useful in preventing some ethical problems. Increased awareness of, and appropriate responses to, key issues within these areas may help psychotherapists stay off the well-paved road that begins with good intentions.

DOVE: Four Factors Affecting Resilience and Vulnerability

Psychotherapists and students wishing to enhance their resilience and minimize their vulnerabilities may benefit from careful reflection about where they stand in relation to the dimensions of Desire, Opportunities, Values, and Education (DOVE). Each represents a valued asset that can foster ethical behavior and personal resilience. At the same time, each may represent vulnerabilities that can lead to ethical breaches.

Each dimension ranges from a resilience factor and protective strength at one end of a continuum to a significant vulnerability and major risk factor at the other. As noted above, placement along these dimensions may vary over time and across situations. Steps toward prevention can follow from an honest assessment of a professional's location along each dimension. We hope that careful consideration of the DOVE factors may contribute significantly to the prevention of ethical problems and to optimally ethical practice.

Finally, we acknowledge that future scholars may propose additional dimensions; we do not claim that these four represent an exhaustive list. Rather, we propose them as a beginning of the discussion. We also concede that problems created by colleagues or students who suffer from personality disorders are beyond the scope of this article.

Desire to Help

Why do people choose to be psychotherapists? Although many factors may be involved (Norcross & Guy, 2007), we think one common answer is straightforward: Psychotherapists want to help others, to be effective in helping clients reach therapeutic (i.e., good; Tjeltveit, 2006) outcomes, or to benefit society. Promoting human welfare (APA, 2002) is a fundamental component of psychology's value system, it is deeply embedded in our professional values and ethical principles, and it is absolutely central to psychotherapists' identities. Many psychotherapists view themselves as good people who have the noble desire to help others and in the process of doing so feel good about themselves.

Desire to help represents a resilience because it can sustain effort even in the face of adversity. Indeed, many contend that beneficence is at the heart of what it means to be a professional, and without it there would be no true professions. Professionals are characterized by "service," contended Raimy (1950, p. 19) in *Training in Clinical Psychology*, his report on the influential Boulder training conference. "The virtue of benevolent service," May (1984) asserted, "is the sine qua non of the professional relationship" (p. 261).

However, desire to help can also create vulnerability. As Behnke (2008) observed, "There's no

one thing that has gotten more psychologists in [ethical] trouble than the desire to be helpful." A typical example is the well-intentioned boundary violation. Under normal circumstances, a good person desiring to be helpful may lend small amounts of money to a friend or accept an invitation to a social function. Students are trained, as a general rule, not to cross such boundaries in professional circumstances because doing so may reduce treatment effectiveness, harm clients, or lead to being manipulated. Learning the skills to properly channel our desire to help others is not easy, especially when emotions, deep value differences, or interpersonal conflicts are involved. Other vulnerabilities that may be created by the desire to help include the following: One may act paternalistically, imposing solutions on clients and violating their autonomy. Out of misguided beneficence, one may allow unpaid bills to accumulate for a client who has fallen on hard times. Finally, out of a misinformed desire for social justice, one may agree to help a client by testifying on his or her behalf even though doing so exceeds the boundaries of one's competence. Although we presume that all four of the dimensions are important, we suggest that the desire to help may represent both psychotherapists' greatest resilience and their most significant vulnerability.

A Powerful Opportunity

Psychotherapists are accorded a role and status in society that create certain opportunities. Psychotherapists have the opportunity to contribute to knowledge, provide clinical services, teach, or advance social policy, and thus the power to foster change in their clients and, at least in some small measure, make the world a better place (e.g., Pope & Vasquez, 2007).

As teachers, researchers, practitioners, and policy advisors, psychotherapists play a fiduciary role in society. As fiduciaries, psychotherapists are given opportunity, power, and responsibilities that exceed those of ordinary citizens. For example, psychologists are expected to teach in an objective manner, produce unbiased research, and (in an appropriately qualified way) put client's needs before their own; failure to adhere to these standards may place others at risk. Because opportunity places psychotherapists in these positions, professions promulgate ethics codes (e.g., APA, 2002) that set minimal standards and provide guidance to their members to help them act in ways that protect the public and enhance trustworthiness.

Opportunity can provide strength and build resilience. If a paper is well received, a client improves, a student does well, or a policy is adopted, the psychotherapist is reinforced by success and may then take on even greater challenges. Psychotherapists generally appreciate their opportunity and guard it carefully. They use their power to establish routines that facilitate high ethical standards (e.g., regularly obtaining both written and verbal informed consent that is tailored to individual clients' cognitive capacities), develop collegial relationships to make ethical consultation easier to obtain and more effective, obtain meaningful continuing education and work to improve their skills, and engage in sufficient self-care to avoid impairment and sustain their effectiveness over the course of a long career. Psychotherapists also have the powerful opportunity to work at becoming more ethical and avoiding potential ethical problems.

But opportunity also can entail vulnerability because of the power psychotherapists have over those who are entrusted to their care. Unfortunately, power can be abused and trust violated. Recent national scandals surrounding clergy sexual misconduct and fraudulent behavior of major business leaders are two obvious examples. Although differences exist across professions, psychotherapists are also vulnerable to abusing their powerful opportunities.

We propose that a central underlying mechanism of vulnerability to abusing one's opportunity is self-deception (e.g., Saradjian & Nobus, 2003) or self-serving bias (Shepperd, Malone, & Sweeny, 2008). When opportunities are exploited and power and trust abused, it may not be because offenders failed to intellectually understand that they had done something wrong. Rather, misbehavior may more often be a function of personal feelings and intuitions that obscure good judgment. These processes interfere with sound decision making because they are not primarily intellectual but emotional (Kahneman, 2003).

Given the opportunity to help, and the sincere desire to do so, we may wish to help a student for whom we feel sympathy by giving a grade he or she did not deserve and fail to see the exception as harmful to academic honesty and fairness. Doing so may also negatively affect the student and others if the higher grade leads them to assume that the student possesses knowledge or

skills that he or she lacks. When such professional boundaries are crossed, it is because we have the opportunity to do so. To make matters worse, the client or student who benefits has no reason to believe we have done anything improper. Remembering that harm can come from an abuse of opportunity may be difficult at times, but it is vital because psychotherapists can harm clients, themselves, their profession, and society.

Vulnerability to abuses of opportunity may be both static and dynamic. For example, it may be wise for some psychotherapists to routinely avoid treating clients who pose personal difficulties for them. When a psychotherapist becomes distressed, however, it may become difficult to focus on asking key questions, concentrate on assessing the person thoroughly, think sufficiently about the implications of accepting the client, or summon the emotional energy to refuse to treat a client and refer them. As a result, some personally problematic clients may slip into a psychotherapist's practice. In these ways, a temporary situation can create a vulnerability that had been relatively well controlled, turning a static resilience into a dynamic vulnerability. The result of this lapse is that the psychotherapist must now deal clinically and ethically with a difficult client at precisely the time when he or she is less capable of doing so.

Values

It is our contention that psychotherapists generally share certain core values that in part also define them as individuals (Handelsman, Gottlieb, & Knapp, 2005). For example, most psychotherapists believe that, in addition to making money, it is important to contribute to society. Other commonly held values include the quest for knowledge, the advancement of science, and striving for social justice. These professional values are tied to personal values that arise from our individual experience, reflections, and value traditions.

These values can be a source of great resilience. They usually lead people in positive directions and help accomplish worthwhile goals. Psychotherapists rely on these values during times of difficulty, assuming they will contribute to prudent judgment. They also promote consistency in work and behavior and enhance one's sense of personal identity. For example, a teacher may refuse to change a student's grade because it would undermine the academic enterprise. A researcher may resist the lure of falsifying data because he or she knows it will harm the openness and trust on which science depends. A psychotherapist may avoid upcoding a client's diagnosis (reporting a more severe diagnosis to insure reimbursement) in order to maintain the integrity of the diagnostic classification system and avoid dishonesty.

How can such values represent vulnerabilities? Situations may arise in which psychotherapists lose sight of the fact that professional values are not always dependable and should not be applied equally in all situations. Consider the following example. Dr. Y, a clinical child psychologist, was invited to the bar mitzvah of one of her clients. She explained to both the client and his parents why it would be inadvisable for her to attend based on her professional value that it was important to maintain fairly rigid boundaries for treatment to be successful. The parents and client understood her concerns clearly and asked her to come nonetheless, arguing that she would not be invited to the reception and that hundreds of people were invited to the ceremony, thus increasing the probability of her anonymity and minimizing the chances of boundary violations or breaches of confidentiality. Furthermore, her client told her that acting as a witness to this rite of passage was very important to him. In sum, they felt that the potential risks were outweighed by the benefit of her being there. Dr. Y became somewhat confused and rigidly adhered to her previous position without adequately taking into account the additional information about benefit and lack of potential harm to her client that she had been given. As a result of her decision, the client and his family were hurt and later terminated treatment.

Problems may also arise when psychotherapists act on their values in misguided, rigid, or self-serving ways. The value of social justice may lead a psychotherapist to push a client who is a leader in a low-income neighborhood to stay there (which would further justice in that community) when the client's best interest (and preference) is to move to a neighborhood offering better opportunities. Another psychotherapist may put pressure on clients from cultural backgrounds valuing relationships to become more autonomous, rigidly adhering to the cardinal value of autonomy and not considering other ways in which clients may become healthy.

Psychotherapists may also confuse personal values with therapeutic ones (Strupp, 1980) or

inappropriately convert a client's values to their own (Tjeltveit, 1986). Psychotherapists who think private schools are much better than public schools and hold the personal value that nothing is more important than a good education may think that parents who care about their children would not send their children to public schools. Using their influence with clients, they may implicitly assert that clients who exhibit the highest levels of mental health and are the best parents will make sure their children attend private schools. However, sending children to private schools may impoverish families, may not represent their values, and may not be the only way for the family to make progress in addressing the problems that brought them to psychotherapy. Conflicts of values, sometimes tied to religion, may lead a religious psychotherapist to woo a client away from his or her own values and adopt the psychotherapist's religious values. Likewise, atheists may woo religious clients away from their religions, and agnostics may woo both atheistic and religious clients to their values.

Education

Psychotherapists are educated people and most value education highly. Education provides psychotherapists with many resources, specialized knowledge, and training that are the central means by which to create knowledge and help others.

Education can serve as a personal resilience if it involves lifelong, multidimensional learning (Gottlieb, Handelsman, & Knapp, 2008; Pope et al., 2006) that improves professional functioning. At a personal level, when loved ones are ill or have problems, psychotherapists use their education and knowledge to help. Finally, as educated citizens, psychotherapists contribute to the community and, in return, draw strength from their participation.

Education is an intellectual exercise, involving learning, memorizing, reasoning, synthesizing, abstracting, and applying information. If education is viewed in strictly cognitive terms and valued only as an intellectual activity, it can leave little room for nurturing emotional intelligence. Although one would hope that colleagues are taught to use, and continue to use, their internal processes to monitor the impact of their behavior on others, not all psychotherapists hold such a broader understanding of education. Accordingly, Pope and Vasquez (2007) discuss "emotional competence," which "involves self-knowledge, self-acceptance, and self-monitoring. Therapists must know their own emotional strengths and weaknesses, their needs and resources, the abilities and limits for doing clinical work" (pp. 49–50; see Pope et al., 2006).

Another crucial form of education pertains to *self-care* (Baker, 2003; Barnett, Baker, Elman, & Schoener, 2007; Norcross & Guy, 2007). Properly understood, self-care refers not merely to avoiding impairment and ethical violations, but also to avoiding ethical mediocrity and moving toward excellence. In response to the "ethical imperative" of self-care, Barnett and Cooper (2009) contended that the profession needs to develop a "culture of self-care" (p. 17), educating and encouraging professionals so they engage in self-sustaining actions.

Not all trainees in professional preparation programs have the opportunity to acquire these skills at an optimal level. Too many professionals complete their training without the emotional education and awareness needed to avoid self-deception and to act in the prudent, considered manner that society expects and that represents professional ethical excellence.

A final way in which education can represent a vulnerability occurs when psychotherapists complacently rely on their graduate training and fail to continue their learning process. New ways of understanding and new solutions may be neglected, as psychotherapists continue to rely on what they once learned, even if now outdated.

Applying the DOVE Factors: An Example

Background

As a child and adolescent, Evangelina Cruz, PhD, had experienced both victimization and discrimination. She developed a desire to help others at a very young age, had been reared with strong values regarding education, and saw becoming a psychotherapist as the way to achieve her goal of helping others and making a difference. She worked hard in school. Despite economic obstacles, she was accepted at a prestigious university, and subsequently a professional preparation program of equal rank, one that had a strong emphasis on multiculturalism and feminism. It was just what she had hoped for. Cruz was an outstanding student and won a coveted internship at a large

urban mental health center that specialized in treating trauma victims and torture survivors. This position allowed her to develop expertise in treatment approaches for women with posttraumatic stress disorder (PTSD). Her scholarly writing and public advocacy won her a number of early career awards and the respect of her colleagues who saw her as a dedicated and self-sacrificing professional who was a strong advocate for her clients. These experiences deepened her personal values and increased her desire to help the disempowered, exactly what her professional education would now provide her the opportunity to do.

The Case

Shortly after entering independent practice, Cruz was consulted by Angie Immel, who presented with moderately severe symptoms of acute anxiety and depression she claimed were the result of sexual harassment by her boss, Alex Morse. She said that Morse began pursuing her from the time she started working for him. When she rejected his initial overtures, she reported, his advances increased, and he began making inappropriate and highly sexualized remarks whenever he could do so in private. Immel said that she tolerated this behavior and had not become symptomatic until Morse began to touch her; then she became afraid.

Immel said she complained to the human resources department on numerous occasions, but nothing had been done because, according to her, Morse was best friends with and the golfing partner of the human resources director. Immel also made oblique references to filing an Equal Employment Opportunity Commission complaint and a subsequent law suit, but Cruz did not fully appreciate what Immel meant by these references. Cruz assumed she would not be involved in the legal process, and she and Immel never discussed it. She saw the legal issues as unrelated to her work and chose to maintain focus on the distress of her client. At the same time, she supported Immel's efforts based on her own belief that a corporate giant had exploited Immel.

Cruz treated Immel with cognitive–behavioral therapy, but she did not respond as well as Cruz expected. In part, Cruz's efforts were frustrated because at every session Immel asked her to document the aversive incidents that occurred during the previous week. Cruz informed Immel that this recording of events was both unnecessary for and interfering with her treatment, but Immel persisted, and Cruz deferred to the wishes of her client. Although the treatment was not going very well, Cruz persevered.

One day, she received a telephone call from Blanca Knox, Immel's attorney, who informed her that she would be calling her to testify as an expert witness in a sexual harassment case against Morse and his company. Cruz first resisted Knox's request because she knew the data she had were limited and that she could not directly address the legal question regarding what caused Immel's condition. But Knox was persistent, telling her that her testimony was vital to the case and that, without it, Immel would surely lose. Eventually, in her desire to advocate for her client, Cruz relented and testified that Immel suffered from PTSD that was the direct result of Morse's behavior.

Shortly after the trial, at which Morse and his company were not held liable, Cruz received notice that a complaint had been filed against her with the state board of psychology for offering testimony that was beyond the boundaries of her competence. Cruz found herself confused, frightened, overwhelmed, and completely unappreciated and misunderstood. She became outraged and came to view the complaint as another example of oppression of the disadvantaged.

Analysis

As a psychotherapist, Cruz brought many strengths to her work. She had a strong *desire* to help others based on her *values* and personal experience, and she acquired the *opportunity* to do so through her *education* and training. Her background motivated her, and her accomplishments reinforced her; she was on course for a successful and rewarding career. By analyzing the DOVE factors, we can see how the resilience produced by those strengths became vulnerabilities when she began treating Immel.

The first vulnerability for her was that, although she may have been well trained clinically, her education regarding the legal system was lacking. Being ignorant of the legal process created a vulnerability for her that could have been easily avoided had she learned even a little about it and the role that experts play in it (see Foote & Goodman-Delahunty, 2005). Her ignorance of the legal system may have been due to deficien-

cies in her training, but it may also have been due in part to her value of helping the disadvantaged. This value may have contributed to her too quickly viewing Immel as a victim who had been exploited by oppressive forces, rather than taking the time to consider alternative hypotheses. A third factor that may have contributed to Cruz's situation was her desire to help. Such feelings may have led her to trust her client and not question her motives. Her desire may have become a more serious vulnerability when Immel did not improve and in fact made what appeared to be unreasonable demands on her. Finally, when Knox called her, Cruz found that she had the opportunity to help Immel in an unanticipated way that could bring her client great benefit. Unfortunately, many dimensions of Cruz's resilience became vulnerabilities in this example. They impelled her forward, caused her to lose control of the treatment process, and became obstacles to the necessary self-examination that could have helped her avoid such an unpleasant outcome.

Recommendations

Ethical transgressions are the final common pathway of a multidetermined process. In our view, the profession has focused too much on logical and quasi-legal reasoning to analyze the development of such transgressions and too little on personal resilience and the ability to address vulnerabilities that form the antecedents of sound preventive ethical practice. The four conceptual dimensions we introduced here represent only a portion of the multiple factors that can either foster optimal clinical practice or lead us down a road that is paved with good intentions but ends in ethical disaster. We hope they raise questions that will help to prevent ethical lapses and lead to optimal practice. To that end, we offer the following recommendations.

1. Students should be made aware of the fluid nature of ethical vulnerabilities and resilience, the importance of prevention, and the role of the DOVE factors during their course work and practicum training and be encouraged to address them on a regular basis with peers, supervisors, and consultants. Students should become accustomed to doing so on a regular basis as a part of their professional responsibilities. However, they cannot be expected to do this on their own. Such behavior should routinely be taught and modeled by faculty and trainers.
2. Emotions and situational factors exert the same powerful influence on the behavior of psychotherapists as they do on people in general. Professionals striving for ethical excellence accordingly need to pay particular attention to their emotional states and to social factors that may influence them. Ongoing awareness of these factors and the development and maintenance of strategies to cope effectively with emotions and situational factors are thus crucial.
3. Faculty and supervisors will ideally develop and employ policies that encourage students, not simply to meet the minimum standards of care, but to go beyond them and strive for their highest ethical goals (Handelsman et al., 2002, 2009). A psychotherapist may use standard therapeutic approaches and obey all applicable ethical standards but fail to see the possibility of, and implement, an innovative psychotherapeutic approach that represents an advance over usual practice. Although aspiring to ethical excellence and actualizing such excellence is by no means easy, especially given the varied ethical perspectives that exist (Tjeltveit, 1999, 2006), careful ethical reflection can be fruitful and foster better working relationships with students, colleagues, and clients, all of whom can assist us in identifying issues and challenge what may be departures from sound practice (e.g., Gottlieb, 1997; Handelsman, 2001; Koocher & Keith–Spiegel, 2008; Norcross, 2000; Pope & Vasquez, 2007). Such increased self-awareness may prevent problems from developing and thus reduce the risk of ethical infractions.
4. Reducing vulnerabilities and enhancing resilience requires a proper balance of care for clients and for oneself. Students, educators, and other psychotherapists thus need to attend to relevant research and engage in behaviors associated with self-care, including physical exercise, self-reflection, spirituality (for some people), friendship, awareness of one's own values, quality leisure time, control over work environment, and the enhancement of emotional competence

(Baker, 2003; Norcross, 2000; Norcross & Guy, 2007; Pope & Vasquez, 2007; P. L. Smith & Moss, 2009; Weiss, 2004). Engaging in good self-care that involves those components is challenging, but both achievable and crucial.

5. Little is taught about personal values in ethics education, much less how they may create resilience or vulnerabilities for us. In part, this may be due to our profession's value of objectivity, the need to cover required material in the curriculum, and realistic time constraints. Such conflicts are understandable, but when we consider the potential for self-deception that can be created by our desire, opportunity, values, and education, further examination of the full range of the ethical dimensions of psychotherapy is vital.

6. Psychotherapists, scholars, and trainers should perform self-assessments on a regular basis throughout their professional careers as a component of general risk management. It may be especially important to reevaluate one's vulnerabilities and resilience more frequently and intensively during times of stress, such as divorce, illness, or major loss. Doing so with a trusted colleague makes the self-assessment process all the more valuable.

7. When vulnerabilities increase too much, some form of intervention may be helpful, or even essential. Psychotherapists need to be open to turning to psychotherapy, structured supervision, or consultation with colleagues (whether formal or informal). What is crucial is that psychotherapists work with someone who can help them honestly face themselves and their vulnerabilities and can help them reduce vulnerabilities and rebuild resilience.

8. More generally, when vulnerabilities are identified, psychotherapists need to take whatever prompt corrective action is necessary to reduce risks for themselves and their clients. Strengths need to be nurtured as well so that they can be drawn on when facing difficult clinical, personal, or ethical challenges.

Conclusion

Psychotherapists want to contribute to human welfare, and the vast majority do. We are, however, fallible human beings. Learning the ethics code and attending risk management workshops are necessary but not sufficient to avoid ethical problems, much less to practice at the highest levels. To do so, we must look more deeply within ourselves and come to a better understanding of our personal feelings and values. The DOVE factors are not exhaustive and even if fully addressed will not prevent all misbehavior. However, we hope that incorporating the issues they raise—into existing ethics education curricula and into psychotherapists' ongoing self-monitoring and strategies for self-improvement—will help psychotherapists not only avoid ethical problems, but move toward ethical excellence.

References

Albee, G. W., & Ryan, K. (1998). An overview of primary prevention. *Journal of Mental Health, 7,* 441–449.

American Psychological Association. (1979). *Criteria for accreditation of doctoral training programs and internships in professional psychology* [Brochure]. Washington, DC: Author.

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47,* 1597–1611.

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57,* 1060–1073.

American Psychological Association. (2006). *Results of State Provincial Mandatory Continuing Education in Psychology (MCEP) requirements survey—2006 results*. Retrieved from http://www.apa.org/ce/mcesurvey03.html

Baker, E. K. (2003). *Caring for ourselves: A therapist's guide to personal and professional well-being.* Washington, DC: American Psychological Association.

Barnett, J. E., Baker, E. K., Elman, N. S., & Schoener, G. R. (2007). In pursuit of wellness: The self-care imperative. *Professional Psychology: Research and Practice, 38,* 603–612.

Barnett, J. E., & Cooper, N. (2009). Creating a culture of self-care. *Clinical Psychology: Science and Practice, 16,* 16–20.

Behnke, S. (2008, August). Discussant. In N. S. Rubin (Chair), *International ethics rounds: Dilemmas and guidance for consultants, clinicians, investigators and educators.* Presented at the annual meeting of the American Psychological Association, Boston.

Bernard, J. L., & Jara, C. S. (1986). The failure of clinical psychology graduate students to apply understood ethical principles. *Professional Psychology: Research and Practice, 17,* 313–315.

Bernard, J. L., Murphy, M., & Little, M. (1987). The

failure of clinical psychologists to apply understood ethical principles. *Professional Psychology: Research and Practice, 18,* 489–491.

BERSOFF, D. M. (1999). Why good people sometimes do bad things: Motivated reasoning and unethical behavior. *Personality and Social Psychology Bulletin, 25,* 28–39.

BETAN, E. J. (1997). Toward a hermeneutic model of ethical decision making in clinical practice. *Ethics & Behavior, 7,* 347–365.

BETAN, E. J., & STANTON, A. L. (1999). Fostering ethical willingness: Integrating emotional and contextual awareness with rational analysis. *Professional Psychology: Research and Practice, 30,* 295–301.

BRANSTETTER, S. A., & HANDELSMAN, M. M. (2000). Graduate teaching assistants: Ethical training, beliefs, and practices. *Ethics & Behavior, 10,* 27–50.

BURKE, A., HARPER, M., RUDNICK, H., & KRUGER, G. (2007). Moving beyond statutory ethical codes: Practitioner ethics as a contextual, character-based enterprise. *South African Journal of Psychology, 37,* 107–120.

Canadian Psychological Association. (2000). *Canadian code of ethics for psychologists* (3rd ed.). Ottawa, Ontario, Canada: Author. Retrieved from http://www.cpa.ca/cpasite/userfiles/Documents/Canadian%20Code%20of%20Ethics%20for%20Psycho.pdf

COIE, J. D., WATT, N. F., WEST, S. G., HAWKINS, J. D., ASARNOW, J. R., MARKMAN, H. J., ET AL. (1993). The science of prevention: A conceptual framework and some directions for a national research program. *American Psychologist, 48,* 1013–1022.

CUSHMAN, F., YOUNG, L., & HAUSER, M. (2006). The role of conscious reasoning and intuition in moral judgment: Testing three principles of harm. *Psychological Science, 17,* 1082–1089.

DOLL, B., PFOHL, W., & YOON, J. (Eds.). (in press). *Handbook of prevention science.* New York: Routledge.

EYSENCK, M., DERAKSHAN, N., SANTOS, R., & CALVO, M. (2007). Anxiety and cognitive performance: Attentional control theory. *Emotion, 7,* 336–353.

FLY, B. J., VAN BARK, W. P., WEINMAN, L., KITCHENER, K. S., & LANG, P. R. (1997). Ethical transgressions of psychology graduate students: Critical incidents with implications for training. *Professional Psychology: Research and Practice, 28,* 492–495.

FOOTE, W. E., & GOODMAN–DELAHUNTY, J. (2005). *Evaluating sexual harassment: Psychological, social, and legal considerations in forensic examinations.* Washington, DC: American Psychological Association.

FOWERS, B. J. (2005). *Virtue and psychology: Pursuing excellence in ordinary practices.* Washington, DC: American Psychological Association.

GELSO, C. J., & HAYES, J. A. (2001). Countertransference management. *Psychotherapy: Theory, Research, Practice, Training, 38,* 418–422.

GELSO, C. J., & HAYES, J. A. (2007). *Countertransference and the therapist's inner experience: Perils and possibilities.* Mahwah, NJ: Erlbaum.

GIBBS, J. C. (2003). *Moral development and reality: Beyond the theories of Kohlberg and Hoffman.* Thousand Oaks, CA: Sage.

GORDON, R. M. (1993). Ethics based on protection of the transference. *Issues in Psychoanalytic Psychology, 15,* 95–106.

GOTTLIEB, M. C. (1993). Avoiding exploitive dual relationships: A decision-making model. *Psychotherapy: Theory, Research, Practice, Training, 30,* 41–48.

GOTTLIEB, M. C. (1997). An ethics policy for family practice management. In D. T. Marsh & R. D. Magee (Eds.), *Ethical and legal issues in professional practice with families* (pp. 257–270). New York: Wiley.

GOTTLIEB, M. C., HANDELSMAN, M. M., & KNAPP, S. (2008). Some principles for ethics education: Implementing the acculturation model. *Training and Education in Professional Psychology, 2,* 123–128.

HAGE, S. M., ROMANO, J. L., CONYNE, R. K., KENNY, M., MATTHEWS, C., SCHWARTZ, J. P., & WALDO, M. (2007). Best practice guidelines on prevention practice, research, training, and social advocacy for psychologists. *Counseling Psychologist, 35,* 493–566.

HAIDT, J. (2001). The emotional dog and its rational tail: A social intuitionist approach to moral judgment. *Psychological Review, 108,* 814–834.

HAIDT, J. (2007, May18). The new synthesis in moral psychology. *Science, 216,* 998–1002.

HANDELSMAN, M. M. (2001). Learning to become ethical. In S. Walfish & A. K. Hess (Eds.), *Succeeding in graduate school: The career guide for psychology students* (pp. 189–202). Mahwah, NJ: Erlbaum.

HANDELSMAN, M. M., GOTTLIEB, M. C., & KNAPP, S. (2005). Acculturation as a framework for training ethical psychologists. *Professional Psychology: Research and Practice, 36,* 59–65.

HANDELSMAN, M. M., KNAPP, S., & GOTTLIEB, M. C. (2002). Positive ethics. In C. R. Snyder & S. Lopez (Eds.), *Handbook of positive psychology* (pp. 731–744). New York: Oxford University Press.

HANDELSMAN, M. M., KNAPP, S., & GOTTLIEB, M. C. (2009). Positive ethics: Themes and variations. In C. R. Snyder & S. J. Lopez (Eds.), *Oxford handbook of positive psychology* (2nd ed., pp. 105–113). New York: Oxford University Press.

HECKHAUSEN, J. (2001). Adaptation and resilience in midlife. In M. E. Lachman (Ed.), *Handbook of midlife development* (pp. 345–394). New York: Wiley.

KAHN, R. L., & JUSTER, F. T. (2002). Well-being: Concepts and measures. *Journal of Social Issues, 58,* 627–644.

KAHNEMAN, D. (2003). A perspective on judgment and choice: Mapping bounded rationality. *American Psychologist, 58,* 697–720.

KAHNEMAN, D., & TVERSKY, A. (1979). Prospect theory: An analysis of decisions under risk. *Econometrica, 47,* 263–291.

KATZ, L. D. (2000). *Evolutionary origins of morality: Cross-disciplinary perspectives.* Thorverton, England: Imprint.

KITCHENER, K. S. (2000). *Foundations of ethical practice, research, and teaching in psychology.* Mahwah, NJ: Erlbaum.

KNAPP, S., & VANDECREEK, L. (2006). *Practical ethics for psychologists: A positive approach.* Washington, DC: American Psychological Association.

KNAUSS, L. K. (1997). Professional training in ethics. In D. T. Marsh & R. D. Magee (Eds.), *Ethical and legal*

issues in professional practice with families (pp. 289–311). New York: Wiley.

KOHLBERG, L. (1979). *The meaning and measurement of moral development.* Worcester, MA: Clark University Press.

KOOCHER, G. P., & KEITH–SPIEGEL, P. (2008). *Ethics in psychology and the mental health professions: Standards and cases* (3rd ed.). New York: Oxford University Press.

LAPSLEY, D. K., & NARVAEZ, D. (Eds.). (2004). *Moral development, self, and identity.* Mahwah, NJ: Erlbaum.

MASTEN, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist, 56,* 227–238.

MAY, W. F. (1984). The virtues in a professional setting. *Soundings, 67,* 245–266.

NATION, M., CRUSTO, C., WANDERSMAN, A., KUMPFER, K. L., SEYBOLT, D., MORRISSEY–KANE, E., ET AL. (2003). What works in prevention: Principles of effective prevention programs. *American Psychologist, 58,* 449–456.

NODDINGS, N. (2002). *Educating moral people: A caring alternative to character education.* New York: Teachers College Press.

NORCROSS, J. C. (2000). Psychotherapist self-care: Practitioner-tested, research-informed strategies. *Professional Psychology: Research and Practice, 31,* 710–713.

NORCROSS, J. C., & GUY, J. D., JR. (2007). *Leaving it at the office: A guide to psychotherapist self-care.* New York: Guilford Press.

PETERSON, C., & SELIGMAN, M. E. P. (2004). *Character strengths and virtues: A handbook and classification.* Washington, DC: American Psychological Association; New York: Oxford University Press.

POPE, K. S. (2001, September 26). Re: Interesting descriptive ethics research. [Electronic mailing list message]. Retrieved from http://listserve.apa.org/cgi-bin/wa.exe?A1=ind0109&L=div24eth

POPE, K. S., SONNE, J. L., & GREEN, B. (2006). *What therapists don't talk about and why: Understanding taboos that hurt us and our clients.* Washington, DC: American Psychological Association.

POPE, K. S., TABACHNICK, B. G., & KEITH–SPIEGEL, P. (1987). Ethics of practice: The beliefs and behaviors of psychologists as therapists. *American Psychologist, 42,* 993–1006.

POPE, K. S., & VASQUEZ, M. J. T. (2007). *Ethics in psychotherapy and counseling: A practical guide* (3rd ed.). San Francisco: Jossey-Bass.

RAIMY, V. C. (1950). *Training in clinical psychology.* New York: Prentice–Hall.

REST, J. R., & NARVAEZ, D. F. (Eds.). (1994). *Moral development in the professions: Psychology and applied ethics.* Hillsdale, NJ: Erlbaum.

REST, J., NARVAEZ, D., BEBEAU, M. J., & THOMA, S. J. (1999). *Postconventional moral thinking: A neo-Kohlbergian approach.* Mahwah, NJ: Erlbaum.

RYFF, C. D., & SINGER, B. (2003). Flourishing under fire: Resilience as a prototype of challenged thriving. In C. L. M. Keyes & J. Haidt (Eds.), *Flourishing: Positive psychology and the life well-lived* (pp. 15–36). Washington, DC: American Psychological Association.

RYFF, C. D., SINGER, B., LOVE, G. D., & ESSEX, M. J. (1998). Resilience in adulthood and later life: Defining features and dynamic processes. In J. Lomranz (Ed.), *Handbook of aging and mental health: An integrative approach* (pp. 69–96). New York: Plenum Press.

SARADJIAN, A., & NOBUS, D. (2003). Cognitive distortions of religious professionals who sexually abuse children. *Journal of Interpersonal Violence, 18,* 905–923.

SCHOENER, G. R. (1999). Preventive and remedial boundaries training for helping professionals and clergy: Successful approaches and useful tools. *Journal of Sex Education and Therapy, 24,* 209–217.

SHEPPERD, J., MALONE, W., & SWEENY, K. (2008). Exploring causes of the self-serving bias. *Social and Personality Psychology Compass, 2,* 895–908.

SKOVHOLT, T. M. (2001). *The resilient practitioner: Burnout prevention and self-care strategies for counselors, therapists, teachers, and health professionals.* Boston: Allyn & Bacon.

SMITH, P. L., & MOSS, S. B. (2009). Psychologist impairment: What is it, how can it be prevented, and what can be done to address it? *Clinical Psychology: Science and Practice, 16,* 1–15.

SMITH, T. S., MCGUIRE, J. M., ABBOTT, D. W., & BLAU, B. I. (1991). Clinical ethical decision making: An investigation of the rationales used to justify doing less than one believes one should. *Professional Psychology: Research and Practice, 22,* 235–239.

SNYDER, C. R., & LOPEZ, S. J. (Eds.). (2009). *Oxford handbook of positive psychology* (2nd ed.). New York: Oxford University Press.

STRUPP, H. H. (1980). Humanism and psychotherapy: A personal statement of the therapist's essential values. *Psychotherapy: Theory, Research, and Practice, 17,* 396–400.

THOMAS, L. (1989). *Living morally: A psychology of moral character.* Philadelphia: Temple University Press.

TJELTVEIT, A. C. (1986). The ethics of value conversion in psychotherapy: Appropriate and inappropriate therapist influence on client values. *Clinical Psychology Review, 6,* 515–537.

TJELTVEIT, A. C. (1999). *Ethics and values in psychotherapy.* London: Routledge.

TJELTVEIT, A. C. (2006). To what ends? Psychotherapy goals and outcomes, the good life, and the principle of beneficence. *Psychotherapy: Theory, Research, Practice, Training, 43,* 186–200.

TJELTVEIT, A. C., & FOWERS, B. F. (Eds.). (2003). Explorations of human excellence in behavioral science: Rediscovering virtue in scholarship, teaching, and practice [Special issue]. *American Behavioral Scientist, 47*(4).

TURIEL, E. (2002). *The culture of morality: Social development, context, and conflict.* Cambridge, England: Cambridge University Press.

VAN WAGONER, S. L., GELSO, C. J., HAYES, J. A., & DIEMER, R. A. (1991). Countertransference and the reputedly excellent therapist. *Psychotherapy: Theory, Research, Practice, Training, 28,* 411–421.

WEISS, L. (2004). *Therapist's guide to self-care.* New York: Brunner–Routledge.

WILKINS, M. A., MCGUIRE, J. M., ABBOTT, D. W., & BLAU, B. I. (1990). Willingness to apply understood ethical principles. *Journal of Clinical Psychology, 46,* 539–547.

Professional Psychology: Research and Practice
2013, Vol. 44, No. 5, 299–306

0735-7028/13/$12.00 DOI: 10.1037/a0033020

Ethical and Legal Considerations for Treatment of Alleged Victims: When Does It Become Witness Tampering?

Tim F. Branaman
Argosy University, Dallas, Texas

Michael C. Gottlieb
Independent Practice, Dallas, Texas

Children who are alleged victims of sexual abuse may require therapy while the alleged perpetrator is awaiting trial. A considerable body of literature addresses the biases that can influence practitioners in ways that may alter children's memories, but little has been written about the risks associated with conducting therapy with an alleged victim during the pendency of a criminal matter. In this article, we review existing professional standards and guidelines and consider the legal implications of their absence for those providing therapy to alleged child victims pending trial of an alleged perpetrator. We conclude with preliminary guidelines for mental health professionals conducting such treatment.

Keywords: child sexual abuse, child witnesses, forensic interviewing, pretrial therapy, child therapy

Kuehnle and Connell (2010) emphasized the importance of establishing and maintaining well-defined professional boundaries for practitioners involved with children who are alleged victims (AVs) of sexual abuse. They distinguished the clinical role from that of a forensic interviewer and noted the risk of the therapeutic role "bleeding" into that of forensic investigator, with the potential for tainting the AV's report. More recently, Quas and Goodman (2012) questioned the effect of involvement in legal proceedings on AVs; they concluded that greater consideration must be given to potential adverse long-term effects of involving AVs in the legal process. Quas and Goodman recognized that when considering policies that facilitate an AV's involvement in legal proceedings, procedural fairness also must be maintained to insure the rights of the accused. More specifically, we are concerned that practitioners may not be sensitive to the importance of maintaining and distinguishing between clinical and forensic roles, and that they not intrude into an area that may alter a child's recollection and subsequent testimony. We contend that the pretrial involvement of AVs in therapy may risk the integrity of the judicial process by influencing the child's testimony, whether they have been victimized or not.

When a child alleges abuse, the standard procedure in nearly all jurisdictions in the United States involves a forensic interview at a Child Advocacy Center (CAC). Such an interview is often not the first one, as a child may already have been questioned by school personnel, parents, and/or a law enforcement officer. Following the forensic interview, best conducted by use of an empirically validated interview protocol (Lamb, Hershkowitz, Orbach, & Esplin, 2008; Lamb, Orbach, Hershkowitz, Esplin, & Horowitz, 2007; Memon, Meissner, & Fraser, 2010), months, if not years, may pass before the child's testimony is required in a criminal proceedings. Due to the misapprehension that all forms of sexual abuse are psychologically traumatic per se (Clancy, 2010; Rind, Tromovitch, & Bauserman, 1998), it is common for children to be seen for psychotherapy during this intervening period. We are concerned about what takes place during such treatment.

Before Treatment Begins

Prior to treatment, we assume that an allegation has arisen and has been investigated by law enforcement, child protective services, and/or the CAC. Based on information derived from the investigation, the district attorney may file charges against the alleged perpetrator (AP). It is during this period of time that the child may be referred for treatment. What the child tells the practitioner during the course of treatment over the ensuing months or years may be introduced at trial through the practitioner's and/or the child's testimony, as evidence of the original and, in some cases, additional allegations.

We question to what degree, if any, it is appropriate for a practitioner to directly inquire and/or process information with an AV about an alleged offense in a pending criminal matter. To what degree can such inquiry, recounting, and/or processing of the

TIM F. BRANAMAN, PhD, is a Professor of Clinical Psychology at The Texas School of Professional Psychology, Argosy University/Dallas and is a forensic psychologist in independent practice in Dallas, Texas. He is board certified (ABPP) in forensic psychology. He presently serves as the appointed presiding officer for the Texas State Board of Examiners of Psychologists. His interests include ethical decision making, assessment of victims and offenders, and the interface of psychology and law.

MICHAEL C. GOTTLIEB, received his PhD in Counseling Psychology from Texas Tech University. He is a forensic and family psychologist in independent practice in Dallas, Texas. He is board certified (ABPP) in family psychology, a fellow of the American Psychological Association (APA), and a clinical professor at the University of Texas Southwestern Medical Center at Dallas. He is a past member of the APA Committee on Professional Practice and Standards and its Ethics Committee. His interests surround ethical decision making and the psychology/law interface.

THE AUTHORS WISH to acknowledge the contributions of our colleagues: Lyn R. Greenberg, Kathryn Kuehnle, Michael E. Lamb, Jon Lasser, and Jodi A. Quas.

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Tim F. Branaman, Department of Clinical Psychology, Argosy University/Dallas, 5001 Lyndon B Johnson Freeway, Farmers Branch, TX 75244. E-mail: tbranaman@argosy.edu

events in question alter the child's recollection of what took place? We contend that after more than 40 years of extensive research regarding the malleability of children's memory (e.g., Gallo, 2006; Loftus, 1979, 2005), accompanied by a number of high profile criminal cases (Ceci & Bruck, 1995), the research has demonstrated the potentially adverse effects of suggestive questioning and recounting of alleged events. This research established the importance of caution not only during investigative interviews but also during subsequent therapy conducted prior to trial testimony (Garven, Wood, & Malpass, 2000; Garven, Wood, Malpass, & Shaw, 1998). The established vulnerability of children's memory to external influences, not to mention internal ones, calls for great caution when working in such contexts, and suggests that boundaries and guidelines should be considered for "postallegation/pretrial" psychotherapy.

Some CACs offer "counseling" to AVs, but their procedures often serve the purpose of gathering additional legally relevant information. The mental health practitioner who conducts such an evaluation plays an inherently investigative role, but the potential for professional role conflict becomes significant when this procedure is portrayed as psychotherapy. Connell (2008) discussed this potential at length in her review of the use of the Extended Forensic Evaluation (EFE), an assessment methodology endorsed by the National Child Advocacy Center (2010) for obtaining information over the course of several sessions in cases of suspected child abuse. She observed that, by its very nature, the EFE incorporates a "hybrid role"—that of "forensic investigator" trying to obtain additional evidence to be used in judicial proceedings, with that of a clinician "assessing the child's functioning for treatment purposes" (Connell, 2008, p. 452). She noted that the conflict of interest inherent in such a dual role compromises the objectivity and accuracy of opinions the "counselor" may offer during testimony. Perhaps more importantly, she observed that not only may the objectivity and accuracy of the clinician be compromised but also the child's memory may be altered as a result of the process. Such alterations can have significant implications for the reliability of the child's account and may result in failure to obtain justice for the child and the accused.

Recently, the National Child Advocacy Center (2010) renamed the EFE; it is now called an Extended Forensic Interview (EFI). In doing so, the Center appears to have recognized the distinction between therapy and investigation and established that the interview, as an investigative process, requires "absolute impartiality" on the part of the interviewer (National Child Advocacy Center, 2011b). It highlighted that "changes have included the removal of the more therapeutic approaches and an emphasis on the key components of a high quality forensic interview" (National Child Advocacy Center, 2010, p. 1). Nevertheless, the National Child Advocacy Center model continues to rely heavily on multiple interviews (from two to five), especially for those who are young preschoolers, have developmental concerns, have experienced extreme trauma, have varying cultural needs, or have had prior forensic interviews (National Child Advocacy Center, 2011a). The National Child Advocacy Center appears to recognize the risk of altering a child's report in the context of multiple interviews, yet the children they view as most appropriate for multiple interviews are precisely those who are the most vulnerable to suggestion. Finally, the qualifications for EFI interviewers are general and require little professional training relevant to the process; no mental health license is required, as it is an investigative process, and as little as 3 days of training may qualify an investigator to conduct these specialized investigative interviews.

Such procedures are very troubling, especially because Sternberg, Lamb, Esplin, Orbach, and Herskowitz (2002) found that even with the use of an empirically supported and structured interview protocol, and knowledge of the effects of leading and suggestive questioning, interviewers continued to ask such troubling questions. As a result, they found that ongoing training was required to effectively implement the protocol.

After an investigative interview, referral to an evaluator/practitioner often follows (National Child Advocacy Center, 2011). The National Child Advocacy Center (2011) model continues to incorporate "trauma assessment" and therapy into its model for those children believed to have experienced "extreme trauma." Yet they provide no guidelines or standards for conducting a "trauma assessment" or therapy in a way that does not risk affecting the child's ability to accurately recount what she or he experienced.

When the Investigation Is Over

We contend that general practice child therapists are unlikely to be aware of the issues we have discussed thus far. Unfortunately, such ignorance can lead to serious problems when AVs are referred to them for treatment.

Ten years ago, Greenberg and her colleagues (Greenberg, Gould, Gould-Saltman, & Stahl, 2003) argued that therapists providing services to children during custody-related matters should have a knowledge base similar to that of forensic evaluators. Similarly, Olesen and Drozd (2012), in writing about "prudent therapy" during high-conflict child custody cases involving allegations of child abuse, observed that therapy is often necessary due to the stressful nature of divorce and custody disputes, but they highlighted the potential consequences of clinicians becoming "part of the problem." They noted that, due to the nature of such affectively laden cases, the potential for practitioner overinvolvement increases, and clinicians may unintentionally take advocacy roles that are unwarranted and lack a substantive basis. Olesen and Drozd emphasized that the clinician is professionally responsible for being aware of such potential biases, maintaining an open mind, and considering all reasonable alternative hypotheses for what a child or parent may be reporting or experiencing. We believe such risks may also arise when AVs are treated by therapists who are not forensically informed.

Guidelines for professionals specializing in forensic evaluations have existed for over 20 years (Committee on Ethical Guidelines for Forensic Psychologists, 1991), and recently they have been revised (American Academy of Psychiatry and the Law, 2005; American Psychological Association, 2011), but these guidelines do not apply to nonforensic clinicians who may work with AVs. This problem has been recognized by courts elsewhere (e.g., United Kingdom; Action for Justice, 2001; Palmer, 2001), but to our knowledge, although recent guidelines have been recommended for court-involved therapists (Association of Family & Conciliation Courts, 2011), it has not been adequately addressed by the mental health professions in the United States.

First, we consider the ethical and empirical basis for the relevance and importance of such standards and guidelines. Second, we review the extant professional standards and guidelines and

consider the legal implications of their absence for those for providing therapy to child victims. Finally, we offer preliminary guidelines for mental health professionals conducting pretrial therapy for sexual abuse victims.

Effects of Questioning, Retelling, and Suggestion on Perceived Personal Experience

A number of years ago, several high-profile cases of bizarre and fantastic allegations of child sexual abuse arose in a number of day care centers across the county. Later, it was learned that the children's reports had been contaminated by incompetent and uninformed interviewing (Ceci & Bruck, 1995). These revelations led to the development of scientifically based interview protocols for evidence gathering, including the eyewitness reports elicited from AVs (Ceci & Bruck, 1995; Walker, 2002). Since then, we have learned that even the solitary process of recollection, combined with imagining, can significantly alter recalled experiences (Gonsalves & Paller, 2000). During this same period, a considerable body of literature arose that addressed the particular heuristics and biases that can influence our thoughts, feelings, behavior and recollections (e.g., Gilovich, Griffin, & Kahneman, 2002; Kahneman, 2003; Kahneman & Tversky, 1979).

These processes operate in all therapeutic settings, but when they arise in the context of treating child witnesses, they play a critical role because they may influence, if not dramatically alter, a child's memory. As Berliner and Barbieri (1984) observed, a child's testimony is likely to be the main, if not the only, evidence presented at the time of trial. Therefore, the possibility that evidence has been tampered with, albeit unwittingly or with the best of intentions, increases the chances of a flawed legal process.

Professional Standards and Legal Considerations

Ethical standards for health care professionals require that they "do no harm" to those with whom they work (Beauchamp & Childress, 2009; American Psychological Association [APA] Ethical Principles and Code of Conduct Principle A, American Psychological Association, 2010a). Although mental health professionals understand that this standard applies to their patients in clinical settings, some appear less cognizant of their responsibility to minimize harm when their child patients are involved in legal matters.

The APA Ethical Principle of Fidelity and Responsibility states that psychologists recognize their responsibility to society at large, conduct themselves in a manner that is consistent with their professional and scientific responsibilities, make clear their professional role and obligations, and recognize and manage conflicts that could result in their professional actions causing harm to others (Principle B; American Psychological Association, 2010a). Professional integrity requires that we "promote accuracy, honesty, and truthfulness" in delivering their services (Principle C; American Psychological Association, 2010a) and seek to insure that our own biases or boundaries of competence do not result in injustice to others (Principle D; American Psychological Association, 2010a). We believe that these foundational principles require that psychologists be more aware of the potential they have for fostering potential injustice for their patient and the accused.

A necessary tension exists among various stakeholders involved with an AV who will testify in a case of child abuse. That tension is the product of an adversarial legal system that brings to bear prosecutorial and defense perspectives combined with standards for the admissibility of evidence. Although a forensic specialist is well aware of and prepared for this situation, a nonforensic, child practitioner is less likely to anticipate these forces, their demands, and what role she or he will play in the legal process. For example, a practitioner may not recognize that by treating an AV, she or he may be called as a witness, without having an appreciation for the distinction between therapeutic and forensic roles (Greenberg & Shuman, 1997, 2007).

In this regard, Shuman and his colleagues observed that existing ethical rules and forensic guidelines were not sufficient to prevent "overzealous patient advocacy by practitioners" and raised the question of whether practitioners should be legally barred from testifying about their patients (Shuman, Shuman, Heilbrun, & Foote, 1998). They suggested that "conflict of interest, lack of foundation, and potential for unfair prejudice" (p. 510) were sufficiently likely to affect the evidence presented that such a rule was warranted. Unfortunately, scant guidance exists to inform mental health professionals regarding how to proceed when providing therapeutic services in this context.

Effective Treatment

The development of an empathic bond, or "therapeutic alliance," is recognized as a foundational element in psychotherapy and is intrinsic to the effective delivery of services (Martin, Garske, & Davis, 2000; Safran & Muran, 2000). More specifically, Jensen et al. (2010) investigated the therapeutic alliance as an essential component of therapy with children who were believed to be sexually abused. They described that alliance as "the joint involvement and emotional relationship between the client and practitioner" (p. 462). In this regard, the therapeutic alliance is consistent with the therapist's ethical obligation of loyalty to the patient and responsibility to advocate for his or her best psychological interest.

At the same time, providing effective therapy means considering all the possible reasons for a child's condition. When practitioners fail to do so, they can become vulnerable to self-serving and/or confirmation bias and lose perspective as a result of trying to "do what's best for my patient" (e.g., Rogerson, Gottlieb, Handelsman, Knapp, & Younggren, 2011). When such processes arise, they may seriously interfere with the legal process and the balance of justice (for further reading and an example, see Tjeltveit & Gottlieb, 2010).

For example, consider the child therapist who inquires about and pursues details of the events in question in order to help her patient "process the trauma so she can work it through," even though the child has not raised it as an issue. Later at trial, the child's testimony is far more detailed and serious than what she disclosed during her forensic interview.

In this case, the therapist may well believe that her treatment was beneficial, but does this mean that she is free to proceed in such a manner without considering the potential cost for the child witness and/or the accused? On one hand, this type of treatment could lead to a loss of credibility for the child witness and a guilty perpetrator freed. On the other, it could mean that the defendant is punished more severely that he otherwise might have been.

The Incompatibility of Therapeutic and Investigative Roles

The potential for conflicting roles arises whenever practitioners become involved in the legal system. Recognition of this potential harm has led various professional associations (e.g., American Academy of Psychiatry and the Law, 2005; American Psychological Association, 2010b, 2011) to distinguish between the roles of practitioner and forensic evaluator and establish guidelines that discourage playing both roles.

We noted that "joint involvement" and an "emotional relationship" are generally necessary for therapeutic progress, but they can be counterproductive and potentially destructive in the forensic context. For example, as early as 1993, Shuman (1993) discussed the ethical ramifications of therapeutic methods in forensic contexts. Later, Greenberg and Shuman (1997) distinguished the roles of health care provider and forensic evaluator, and then reiterated those defining features a decade later (Greenberg & Shuman, 2007). Finally, Greenberg and Gould (2001) discussed the perils and ramifications of practitioners becoming overly engaged with clients involved in family law litigation.

We do not argue that these distinctions should cause practitioners to refuse to treat AVs, as delaying treatment could cause greater harm. Rather, our hope is that practitioners recognize the potential conflicts that may arise in such situations and avoid engaging in harmful dual roles. Unfortunately, even with the development of empirically supported interview protocols, professional guidelines, and a wealth of supporting research, mental health practitioners have been given little guidance regarding the assessment and treatment of children who are to be witnesses in criminal litigation. For example, Heilbrun, DeMateo, Marczyk, and Goldstein (2008) argued for clearer "standards of practice" for forensic mental health assessments that would "inform the operationalization of a standard of care" (p. 1). The basis for their argument was the absence of such a standard and the inconsistency of practice by professionals engaged in specialized forensic assessments. Their concern is well illustrated by Bow, Quinnell, Zaroff, and Assemany (2002), who found that although forensic mental health professionals generally followed established professional guidelines for assessment in child custody cases (e.g., see American Psychological Association, 2010b, *Guidelines for Child Custody Evaluations*), they did not follow an accepted assessment protocol when evaluating allegations of child sexual abuse.

If forensic specialists who we would expect to be cognizant of such issues failed to identify or follow best practices, what can we presume about evaluations and treatment conducted by clinicians in general practice? Clearly, we do not know the answer, but in an effort to avoid such problems, we provide some guidelines below that may be helpful to those who choose to work with child abuse victims.

Guidelines for Pretrial Therapy

We contend that assessment and/or treatment that address an AV's memory for legally relevant events represents a serious concern, as doing so risks substantively altering the victim's subsequent report. We understand that addressing the events in question is unlikely to be legally defined as witness tampering, but we can easily imagine an ethics committee or state regulatory board considering such behavior to be negligent and/or incompetent.

Other countries have recognized the potential detrimental effects of therapy on the reliability of victims' testimony. For example, in 2001, England and Wales published guidelines to aid in determining when therapy for a victim was necessary and appropriate, and to prevent contamination of witness testimony (U.K. Home Office and Department of Health, 2011). Although guidelines for forensic interviewing of children exist in the United States, to our knowledge, no such guidelines exist regarding pretrial therapy. We believe the time for such guidelines has come for two reasons. First, children's memory may be altered so as to increase the seriousness of the charges filed against a defendant and/or the length of punishment given. On the other hand, when AVs have been mistreated, addressing legally relevant matters in therapy may alter their report such that they become less consistent and appear less credible to a jury. In this situation, a guilty defendant may be freed to offend again. In an effort to avoid both of these potential injustices, we propose the following.

The Range of Effects of Sexual Abuse and What to Do About Them

As we have noted, if a referral for therapy of an AV is made, the practitioner should carefully consider whether therapy is indicated in the first place. If the purpose of therapy is to further investigate whether abuse has occurred, one should not proceed (Connell, 2008; Kuehnle, 1996), as such procedures are not therapeutic or intended to benefit the child. If further investigation is warranted, it should be conducted by the proper authorities and not be presented in the guise of treatment.

The practitioner should carefully consider the source, purpose, and context of the referral before accepting an assignment. For example, an initial telephone screening may reveal that, despite the concerns of the referring party, the child is exhibiting no clinical symptoms and may not be in need of treatment at that time. On the other hand, a child may be symptomatic; if so, the need for treatment is best determined on a case-by-case basis by thorough evaluation of the child's current level of functioning (Clancy, 2010; Rind, Tromovitch, & Bauserman, 1998). For example, the symptoms may be transitory or related to parental distress (Paolucci, Genuis, & Violato, 2001; Rind et al., 1998).

Although recent research suggests that delayed disclosure may have a greater adverse effect on long-term functioning (Ahrens, Stansell, & Jennings, 2010; Alaggia, 2010; McElvaney, Greene, & Hogan, 2012), a survey of the literature indicates that body of research is only beginning to consider differential effects of disclosure at various points in a victim's life (Ahrens et al., 2010). Currently, no empirical data suggest that delay of treatment would have either adverse short- or long-term consequences.

The relationship between child maltreatment and subsequent symptoms may range from negligible to traumatic. But symptom severity depends on a number of factors, such as the history of the victim and his or her environment, the relationship of the AP to the AV, the severity and frequency of the alleged abuse, and the length of time over which it occurred (Clancy, 2010; Fortier et al., 2009; Glover et al., 2010; Paolucci et al., 2001; Rind et al., 1998). Because a child's condition is multiply determined, the focus of

treatment may not necessarily be the child but on other variables that may contribute to his or her condition.

Because the risk of altering a child's memory is present during both evaluation and therapy, we suggest that it is preferable to postpone such services whenever it is reasonable to do so. However, some victims may experience distress that requires prompt therapeutic intervention. That distress may or may not be related to the alleged offense or the upcoming trial, but even when the presenting concern is not apparently associated with the legal issues, the potential still exists for issues to emerge that could lead to a discussion of the facts of the case.

We recognize that some victims may want to talk about their experience, even when appropriate limitations regarding pretrial therapy have been established. When this occurs, we contend that the practitioner should allow the child victim to express him or herself while adopting an open, uncritical, and accepting attitude, but should conduct no further discussion. Questions such as "What happened then?" or "How did that make you feel?" are not appropriate, in our judgment. Interpretative and/or suggestive responses such as "That must have made you feel . . ." are even more problematic and are to be avoided. Instead, the child should be gently redirected to the therapeutic goal at hand; treatment should focus on symptom reduction and management.

When therapeutic services are indicated, an appropriate intervention might be a symptom/solution-focused and future-oriented approach. For example, the treatment might address symptoms associated with distress secondary to family disruptions, such as sleep and appetite disturbances, developmental regression, poorer school performance, and/or behavioral problems. In this case, the goal might be to help manage and ameliorate the symptoms through the use of cognitive/behavioral strategies. Doing so could be helpful and avoids discussion of legally relevant material. Alternatively, a child might become symptomatic prior to trial. Here, the goal of treatment might be to prepare the child for courtroom proceedings by teaching relaxation exercises, but discussion of anticipated testimony would not be needed.

When a child is to be evaluated, we believe that the prudent clinician will involve both parents whenever possible, as the child's symptoms may be more a function of the parents' distress surrounding what they believe has happened to their child. Alternatively, the child's symptoms may be more closely associated with the stress of multiple interviews rather than the allegations themselves. Therefore, when the child remains in the care of the biological parent(s), therapeutic intervention may also include educating them regarding reduction strategies and behavior management approaches (Becker, 1971). In some cases, parents may need to be referred for their own treatment.

Familiarity With the Legal System

Mental health professionals who conduct therapy with AVs are well advised to have a basic understanding of the legal system. Such professionals need not be forensic specialists, but they should have a basic familiarity with the operation of the legal system, their role in it, and an appreciation for the potential effect their actions might have on the credibility of an AV's testimony. Practitioners working with such patients understand that their role is that of treatment provider and not investigator or "forensic mental health provider" (American Psychological Association, 2011; Greenberg & Shuman, 1997). They are acutely aware of the danger of asking a child to recount the circumstances associated with alleged crimes. Although practitioners appropriately advocate for the mental health of their patients, it is not appropriate and, arguably, is unethical to advocate for the accuracy or credibility of a victim's reported experience. In this regard, providers of pretrial therapy are mindful of the constructive nature of memory, its vulnerability to suggestion, and the potential effects that repeated questioning and retelling can have upon it (for further reading, see Kuehnle & Connell, 2008, and Walker, 2002). In this regard, practitioners who consider providing psychosexual education, reading material about abuse, or other such services are well-advised to remember that doing so may lead to source monitoring errors. If this occurs, the information provided may later be unwittingly incorporated into the AV's recollection of events (Gathercole, 1998; Laimon & Poole, 2008; Kuehnle, Greenberg, & Gottlieb, 2004).

From the outset, forensically informed providers of pretrial therapy recognize that various individuals may attempt to engage them in an adversarial role. These people may not understand the importance of a practitioner maintaining well-defined professional boundaries between treatment provider and forensic expert. In some cases, expectations can come from the victim him or herself, but they may also come from third parties. For example, prosecutors may seek additional evidence that will bolster their case; parents may have similar desires, and defense lawyers may want to know "if you're going hurt my guy." Forensically informed practitioners are sufficiently familiar with the legal process so that they can anticipate such efforts, establish well-defined boundaries at the outset of therapy, and be prepared to enforce them, if need be.

Establishing Expectations and Limits

As part of standard informed consent, practitioners are well-advised to provide a clear, well-defined description of what the focus of therapy will be and what methods will be used prior to the initiation of treatment. This information also should be provided directly to the AV in an age-appropriate manner, using language she or he can understand, as well as to the parent(s) and/or other involved family members. The nature of what will and will not be done may also be communicated to prosecutors and defense lawyers, should the need arise. The process can be explained to attorneys directly, through the parents, or via written communication.

Practitioners should keep adequate records, just as they would in any other clinical situation. An exception is the need for careful documentation of contacts with those involved in the legal matter, such as telephone calls with attorneys (American Psychological Association, 2007, 2011).

If treatment is to be provided, the prudent practitioner encourages the involvement of all systemically relevant adults. Many child practitioners do not routinely follow this procedure; we do not understand why so many seem to ignore the systemic forces that affect their patients. For example, involving the family may be particularly important when they are upset themselves, as their distress can directly affect the child in a number of ways that may impede treatment and/or alter subsequent testimony. Hence, failing to involve family members risks losing potentially relevant clinical information that could be of direct benefit to the child. Therefore, we recommend that all systemically relevant family members be

involved in the treatment process on a regular basis from the outset whenever it is feasible.

When Therapy Can't Wait

If the welfare of an AV is such that therapeutic intervention is clinically justified during the pretrial process, therapy should be postponed, except in the most extreme circumstances, until all investigative interviews have been completed. Even in such situations, the value and potential consequences of undertaking therapy that focuses on trauma should be weighed with extreme care. If, after careful assessment, a practitioner chooses to proceed, intervention should be symptom-focused, with the goal of stabilizing the patient's condition and providing coping strategies to increase resiliency. In this connection, symptoms arising at this time may appear to be associated with the alleged maltreatment, but they may be due to other factors as well. As a result, methods that focus on providing a sense of safety and security should be employed, and methods that risk altering the alleged victim's recollection of events should be avoided if at all possible.

Managing Symptoms for Victims and Parents Associated With Pretrial Apprehension

If therapy is indicated prior to an impending trial, the focus of the intervention should be future oriented and supportive, and the role of a young child's parents should be recognized. Olesen and Drozd (2012) recommended that practitioners help parents understand their own feelings and beliefs about what they think happened to their child while avoiding supporting any particular presumption. Helping parent(s) understand what their child is experiencing while managing their own stress will serve to reduce their child's as well.

Second, if treatment for the child is indicated, it should focus on symptom management and containment of anxiety so that the child will be able to testify. We realize that there may be exceptions when a discussion of legally relevant events is necessary (Child Sexual Abuse Task Force and Research & Practice Core, 2004), but as a general matter, treatment should not include discussion of what may be asked of the AV during testimony, and it should not involve rehearsal of what their testimony or responses to questions might be. In other words, the practitioner's role is to assist both the child and parent(s) without joining either in their perspectives about what took place or what should happen at the trial.

As we noted, the scope of treatment should be established with the AV and the family members at the outset. Nevertheless, details related to the case may arise from time to time. Should this occur, the practitioner is wise to gently remind the patient and/or the parents that the purpose of treatment during this time period is to help them with symptom management; if it remains necessary to talk about what happened, this material can be addressed after the trial is completed.

Conclusions

No one believes that child sexual abuse is anything but abhorrent and that those who commit such crimes should be punished. At the same time, the justice system retains our support only so long as it lives up to its goal of fairness to both alleged victims and defendants.

We support a robust justice system that is informed by the best science available. In this article, we have raised serious questions about the behavior of some of our colleagues who are unaware that "therapy as usual" may be harmful in the context of pending litigation, and others who ignore well-established scientific data, prefer the role of advocate, and/or fall victim to a variety of cognitive and affective biases that can cause great harm.

We have nothing beyond anecdotal data to support our concerns. On the other hand, both of us have seen numerous cases in which therapeutic interference in a child's report have occurred. Given the small percentage of cases that actually proceed to trial, we can only assume that our experience represents an underestimate of the true incidence of such behavior; if this is the case, the situation may be far more serious.

The harm we have discussed is preventable when practitioners are well informed regarding the malleability of children's memory, the potential dangers that may arise from their own cognitive and emotional biases, and their role in the legal system. When practitioners are well informed regarding these matters, everyone will be better served.

We raised the question of whether making efforts to alter a child's report, even if done so unwittingly, is unethical. Ethics committees and state regulatory boards will carefully judge complaints on a case-by-case basis. We can only wonder what they would do when faced with what appears to be the adoption of an advocacy role and the abandonment of scientific responsibility.

References

American Academy of Psychiatry and the Law. (2005, May). *Ethics guidelines for the practice of forensic psychiatry*. Retrieved from http://www.aapl.org/ethics.htm

Action for Justice. (2001). *Provision of therapy for child witnesses prior to criminal trial: Practice guidance*. London, UK: The Crown Prosecution Service.

Ahrens, C. E., Stansell, J., & Jennings, A. (2010). To tell or not to tell: The impact of disclosure on sexual assault survivors' recovery. *Violence and Victims, 25,* 631–648. doi:10.1891/0886-6708.25.5.631

Alaggia, R. (2010). An ecological analysis of child sexual abuse disclosure: Considerations for child and adolescent mental health. *Journal of Canadian Academy of Child and Adolescent Psychiatry, 19,* 32–39.

American Psychological Association. (2007). Record keeping guidelines. *American Psychologist, 62,* 993–1004. doi:10.1037/0003-066X.62.9.993

American Psychological Association. (2010a). *Ethical principles of psychologists and code of conduct*. Retrieved from http://www.apa.org/ethics/code/index.aspx

American Psychological Association. (2010b). *Guidelines for child custody evaluations in family law proceedings*. Washington, DC: Author.

American Psychological Association. (2011). *Specialty guidelines for forensicpsychology*.Retrievedfromhttp://www.apa.org/practice/guidelines/forensic-psychology.aspx

Association of Family and Conciliation Courts (AFCC). (2011). Guidelines for court-involved therapy. *Family Court Review, 49,* 564–581.

Beauchamp, T. L., & Childress, J. F. (2009). *Principles of biomedical ethics* (6th ed.). New York, NY: Oxford University Press.

Becker, W. C. (1971). *Parents are teachers: A child management program*. Champaign, IL: Research Press.

Berliner, L., & Barbieri, M. K. (1984). The testimony of the child victim of sexual assault. *Journal of Social Issues, 40,* 125–137. doi:10.1111/j.1540-4560.1984.tb01097.x

Bow, J. N., Quinnell, F. A., Zaroff, M., & Assemany, A. (2002). Assessment of sexual abuse allegations in child custody cases. *Professional Psychology: Research and Practice, 33,* 566–575.

Ceci, S. J., & Bruck, M. (1995). *Jeopardy in the courtroom: A scientific analysis of children's testimony*. Washington, DC: American Psychological Association. doi:10.1037/10180-000

Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network. (2004). *How to implement trauma-focused cognitive behavioral therapy*. Durham, NC, and Los Angeles, CA: National Center for Child Traumatic Stress. Retrieved from http://www.nctsnet.org/nctsn_assets/pdfs/TF-CBT_Implementation_Manual.pdf

Clancy, S. A. (2010). *The trauma myth: The truth about the sexual abuse of children and its aftermath*. New York, NY: Basic Books.

Committee on Ethical Guidelines for Forensic Psychologists. (1991). Specialty guidelines for forensic psychologists. *Law and Human Behavior, 15,* 655–665.

Connell, M. (2008). The extended forensic evaluation. In E. K. Kuehnle and M. Connell (Eds.), *The evaluation of child sexual abuse allegations* (pp. 451–490). New York, NY: Wiley.

Fortier, M. A., DiLillo, D., Messman-Moore, T. L., Peugh, J., DeNardi, K. A., & Gaffey, K. J. (2009). Severity of child sexual abuse and revictimization: The mediating role of coping and trauma symptoms. *Psychology of Women Quarterly, 33,* 308–320. doi:10.1111/j.1471-6402.2009.01503.x

Gallo, D. A. (2006). *Associative illusions of memory: False memory research in DRM and related tasks*. New York, NY: Psychology Press.

Garven, S., Wood, J. M., & Malpass, R. S. (2000). Allegations of wrongdoing: The effects of reinforcement on children's mundane and fantastic claims. *Journal of Applied Psychology, 85,* 38–49. doi:10.1037/0021-9010.85.1.38

Garven, S., Wood, J. M., Malpass, R. S., & Shaw, J. S. (1998). More than suggestion: The effect of interviewing techniques from the McMartin preschool case. *Journal of Applied Psychology, 83,* 347–359. doi:10.1037/0021-9010.83.3.347

Gathercole, S. E. (1998). The development of memory. *Journal of Child Psychology and Psychiatry, 39,* 3–27. doi:10.1017/S0021963097001753

Gilovich, T., Griffin, D., & Kahneman, D. (Eds.). (2002). *Heuristics and biases: The psychology of intuitive judgment*. New York, NY: Cambridge University Press. doi:10.1017/CBO9780511808098

Glover, D. A., Loeb, T. B., Carmona, J. V., Sciolla, A., Zhang, M., Myers, H. F., & Wyatt, G. E. (2010). Child sexual abuse severity and disclosure predict PTSD symptoms and biomarkers in ethnic minority women. *Journal of Trauma & Dissociation, 11,* 152–173. doi:10.1080/15299730903502920

Gonsalves, B., & Paller, K. A. (2000). Neural events that underlie remembering events that never happened. *Nature Neuroscience, 3,* 1316–1321.

Greenberg, L. R., & Gould, J. W. (2001). The treating expert: A hybrid role with firm boundaries. *Professional Psychology: Research and Practice, 32,* 469–478. doi:10.1037/0735-7028.32.5.469

Greenberg, L. R., Gould, J. W., Gould-Saltman, D. J., & Stahl, P. M. (2003). Is the child's therapist part of the problem? What judges, attorneys, and mental health professionals need to know about court-related treatment for children. *Family Law Quarterly, 37,* 241–271.

Greenberg, S. A., & Shuman, D. W. (1997). Irreconcilable conflict between therapeutic and forensic roles. *Professional Psychology: Research and Practice, 28,* 50–57. doi:10.1037/0735-7028.28.1.50

Greenberg, S. A., & Shuman, D. W. (2007). When worlds collide: Therapeutic and forensic roles. *Professional Psychology: Research and Practice, 38,* 129–132. doi:10.1037/0735-7028.38.2.129

Heilbrun, K., DeMateo, D., Marczyk, G., & Goldstein, A. M. (2008). Standard of practice and care in forensic mental health assessment: Legal, professional, and principles-based considerations. *Psychology, Public Policy, and Law, 14,* 1–26. doi:10.1037/1076-8971.14.1.1

Jensen, T. K., Haavind, H., Gulbrandsen, W., Mossige, S., Reichelt, S., & Tjersland, O. A. (2010). What constitutes a good working alliance in therapy with children that may have been sexually abused? *Qualitative Social Work, 9,* 461–478.

Kahneman, D. (2003). A perspective on judgment and choice: Mapping bounded rationality. *American Psychologist, 58,* 697–720. doi:10.1037/0003-066X.58.9.697

Kahneman, D., & Tversky, A. (1979). Prospect theory: An analysis of decisions under risk. *Econometrica, 47,* 263–291. doi:10.2307/1914185

Kuehnle, K. (1996). *Assessing allegations of child sexual abuse*. Sarasota, FL: Professional Resource Press.

Kuehnle, K., & Connell, M. (2008). *The evaluation of child sexual abuse allegations*. New York, NY: Wiley.

Kuehnle, K., & Connell, M. (2010). Child sexual abuse suspicions: Treatment considerations during investigation. *Journal of Child Sexual Abuse: Research, Treatment, & Program Innovations for Victims, Survivors, & Offenders, 19,* 554–571. doi:10.1080/10538712.2010.512554

Kuehnle, K., Greenberg, L. R., & Gottlieb, M. C. (2004). Incorporating the principles of scientifically based child interviews into family law cases. *Journal of Child Custody: Research, Issues, and Practices, 1,* 97–114. doi:10.1300/J190v01n01_07

Laimon, R. L., & Poole, D. A. (2008). Adults usually believe young children: The influence of eliciting questions and suggestibility presentations on perceptions of children's disclosures. *Law and Human Behavior, 32,* 489–501. doi:10.1007/s10979-008-9127-y

Lamb, M. E., Hershkowitz, I., Orbach, Y., & Esplin, P. W. (2008). *Tell me what happened: Structured investigative Interviews of child victims and witnesses*. Hoboken, NJ: Wiley. doi:10.1002/9780470773291

Lamb, M. E., Orbach, Y., Hershkowitz, I., Esplin, P. W., & Horowitz, D. (2007). Structured forensic interview protocols improve the quality and informativeness of investigative interviews with children: A Review of research using the NICHD Investigative Interview Protocol. *Child Abuse & Neglect, 31,* 1201–1231. doi:10.1016/j.chiabu.2007.03.021

Loftus, E. F. (1979). The malleability of human memory. *American Scientist, 67,* 312–320.

Loftus, E. F. (2005). Planting misinformation in the human mind: A 30-year investigation of the malleability of memory. *Learning & Memory, 12,* 361–366. doi:10.1101/lm.94705

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68,* 438–450. doi:10.1037/0022-006X.68.3.438

McElvaney, R., Greene, S., & Hogan, D. (2012). Containing the secret of child sexual abuse. *Journal of Interpersonal Violence, 27,* 1155–1175. doi:10.1177/0886260511424503

Memon, A., Meissner, C. A., & Fraser, J. (2010). The cognitive interview: A meta-analytic review and study space analysis of the past 25 years. *Psychology, Public Policy, and Law, 16,* 340–372. doi:10.1037/a0020518

National Child Advocacy Center. (2010, November 15). NCAC renames the extended forensic evaluation protocol. Retrieved from http://www.nationalcac.org/professionals/images/stories/pdfs/final%20%20ncac%20renames%20extended%20forensic%20evaluation%20training.pdf

National Child Advocacy Center. (2011a). *Extended forensic interview protocol referral process*. Retrieved from http://www.nationalcac.org/images/pdfs/Training and Conferences/Online/Webinars/2011–12-13-efioverview/efi%20referral%20flow chart%2010–18-11.pdf

National Child Advocacy Center. (2011b). *Extended forensic interview protocol referral process*. Retrieved from http://www.nationalcac.org/images/pdfs/Training and Conferences/Online/Webinars/2011–12-13-efi overview/efi%20referral%20flow chart%2010–18-11.pdf

Olesen, N. W., & Drozd, L. M. (2012). Prudent therapy in high conflict cases: With and without allegations of intimate partner violence or child abuse. *Journal of Child Custody: Research, Issues, and Practices, 9,* 69–84. doi:10.1080/15379418.2012.652570

Palmer, T. (2001). Pre-trial therapy for children who have been sexually abused. In S. R. Bacon (Ed.), *Creative responses to child sexual abuse: Challenges and dilemmas* (pp. 152–166). Philadelphia, PA: Jessica Kingsley Publishers.

Paolucci, E. O., Genuis, M. L., & Violato, C. (2001). A meta-analysis of the published research on the effects of child sexual abuse. *The Journal of Psychology: Interdisciplinary and Applied, 135,* 17–36. doi:10.1080/00223980109603677

Quas, J. A, & Goodman, G. S. (2012). Consequences of criminal court involvement for child victims. *Psychology, Public Policy, and Law, 18,* 392–414.

Rind, B., Tromovitch, P., & Bauserman, R. (1998). A meta-analytic examination of assumed properties of child sexual abuse using college samples. *Psychological Bulletin, 124,* 22–53. doi:10.1037/0033-2909.124.1.22

Rogerson, M. D., Gottlieb, M. C., Handelsman, M. M., Knapp, S., & Younggren, J. N. (2011). Non-rational processes in ethical decision making. *American Psychologist, 66,* 614–623. doi:10.1037/a0025215

Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York, NY: Guilford Press.

Shuman, D. W. (1993). The use of empathy in forensic examinations. *Ethics & Behavior, 3,* 289–302.

Shuman, D. W., Shuman, S., Heilbrun, K., & Foote, W. E. (1998). An immodest proposal: Should treating mental health professionals be barred from testifying about their patients? *Behavioral Sciences & the Law, 16,* 509–523. doi:10.1002/(SICI)1099-0798(199823)16:4<509::AID-BSL324>3.0.CO;2-Y

Sternberg, K. J., Lamb, M. E., Esplin, P. W., Orbach, Y., & Herskowitz, I. (2002). Using a structured interview protocol to improve the quality of investigative interviews. In M. L. Eisen, J. A. Quas, & G. S. Goodman (Eds.), *Memory and suggestibility in the forensic interview* (pp. 409–436). Mahwah, NJ: Erlbaum.

Tjeltveit, A. C., & Gottlieb, M. C. (2010). Avoiding the road to ethical disaster: Overcoming vulnerabilities and developing resilience. *Psychotherapy: Theory, Research, Practice, Training, 47,* 98–110. doi:10.1037/a0018843

U.K. Home Office and Department of Health. (2011). Achieving best evidence in criminal proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures. Retrieved from http://www.cps.gov.uk/legal/assets/uploads/files/Achieving%20Best%20Evidence%20in%20Criminal%20Proceedings.pdf

Walker, N. E. (2002). Forensic interviews of children: The components of scientific validity and legal admissibility. Retrieved from http://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=1241&context=lcp

Received October 17, 2012
Revision received February 26, 2013
Accepted March 4, 2013 ■