Risk Management: An FAQ Approach

Philip J. Kinsler, Ph.D.

Anyone who uses the web will be familiar with the practice of posting frequently asked questions on web-sites to quickly answer user's common questions. This column will take that approach to some of the questions of risk management in our work with traumatized and dissociative persons.

1. How can I avoid *ever* having to deal with the dreaded complaint letter?

The short answer to this is that you can't. People can and do sue each other, file ethical complaints to licensing boards, bring malpractice cases, for their own internal reasons all the time. The population we work with is often a high demand-high risk population. Relationships and relationship management are complicated and sometimes tricky. Those who work with complex cases can, and do, get suits or complaints. Those with names and reputations, who take public stands about issues such as the tremendous exposure to trauma of children and women, also sometimes become targets. You can reduce but not eliminate risk.

2. What are the most frequent sources of complaints or malpractice suits?

The three top sources of complaints are sexual contact with patients, complaints arising from child custody work, and 'bad therapy' or 'bad relationship management.' This was so when I was Chair of the Licensing Board in NH, and appears to continue to be true from recent literature.

3. Well, I'd never do anything sexual with a patient, so I'm in the clear, right?

Not so fast. By its nature, therapy with seriously traumatized individuals invites deep feelings and a sense of closeness. You sometimes know more about your patient's feelings than you do those of your spouse or partner. You share the best and worst of times. Close feelings *can* be sexy; we are biological animals designed that way. Ken Pope, in his wonderful book Sexual Feelings in Psychotherapy[i], points out that these feelings are very common and are virtually ignored in therapist training. As Board Chair, I sometimes came upon persons who started out well intentioned but slid down the slope. The 'end of session reassuring side hug' moved to the sudden turn and kiss and so on... Of course, this will not happen to everyone or in every case. The best defense against this is acknowledgement of one's deep feelings, and the continual use of professional consultation/mutual supervision with experienced colleagues. I am also a strong advocate of the grandmother rule. If you would be ashamed to discuss the behavior you're pulled towards with your grandmother, don't do it. Get supervision instead.

4. What about this child custody issue? I don't even do custody evaluations...

For those of us who do work even sometimes in family courts—even those of us called as witnesses as treating therapists—this is a high risk area and the second most frequent source of suits and professional misconduct complaints. This is especially so where there is a question about whether one parent or the other may have abused the child sexually. The area is fraught with questions of the validity or malleability of memory, whether the practitioner has been fair to both parties, who has the right to control a child's contact with professionals, and the attempt to tar mothers with the tag of 'parental alienation syndrome.' This could well be the subject of an entire column or article. Some things everyone should know:

a. In a legal sense, if it is not written down, it did not happen. Get in the habit of preparing a 'note to the file' to document contacts with lawyers, court personnel, GAL's, etc. Document what you did and did not agree to do.

b. Stay current with the science. Witnesses sometimes make overly broad statements that can come back to haunt them in a complaint. 'Children never lie about such things.' 'Mr. X does not fit the profile of a sex offender.' 'Memory is extremely malleable and children are highly suggestible.' 'There is no such thing as an incorrect memory of child abuse.'

c. Read the guidelines. The American Psychological Association has guidelines for the conduct of child custody evaluations and for best practices when a professional is involved in child protective actions. There is a thoughtful set of ethical specialty guidelines from the American Academy of Forensic Psychology. Familiarity with these is important.

d. Consult your own attorney. You do *not* have to comply with a subpoena. These can be contested in court and you can wait for a judge to decide what information must and must not be provided. It is generally not considered appropriate to be both the treating therapist and the expert witness for a client. This is seen as mixing an 'objective' evaluator role with an 'involved, less objective' treater role. As a therapist, you are what is called a 'fact witness.' You can talk about your therapy, what your notes said on such and such a date, your treatment plan and diagnosis, etc. You should *not* get into issues such as false memory or parental alienation syndrome here. You should try to be explicit with attorneys calling you about what you can and cannot do. Stick closely to your data.

5. What do you mean bad therapy?

Again, an answer that can and has filled books. Generally, the kinds of bad therapies that have led to complaints in this author's experience have involved poor management of complex relationships, dual relationships, or relatively new therapists failing to read the literature on the type of client they are treating and therefore, in a well-intentioned way, repeating mistakes well known to those with more experience.

a. The most important variable in whether a complaint is likely to be filed, in this author's experience, is clarity about the relationship and what the client can and cannot expect. This does not mean only the written information you are required to hand out by HIPPA; I wonder how much of this any client absorbs. This means:

    i. Being clear about how much contact a client can have and how emergencies will be handled.

    ii. Carefully monitoring the trajectory of the therapy. If the functioning level of the person is going up, you are probably all right. If the functioning level is going down except briefly, perhaps for a few days or week after a powerful abreaction or EMDR processing, you need to stop and ask why.

    iii. Monitoring whether you and the client are building an artificial world where your relationship is the central thing in their life and you are not attending to how they are developing external relationships.

    iv. Thinking that your closeness to the client makes it OK to use their cleaning service, rent them the room over your garage, loan them money etc.

    v. Closeness and boundaries are not incompatible, and in fact both are required for safety in treatment.

    vi. Not taking everything your client says as gospel. Trauma clients are subject to the same distortions, wish fulfillments, confabulations, transference power struggles, vacillations between dependency and distance, and 'showing you how they felt by doing it to you' as every other psychotherapy client. Your stance is as a safe and kind refuge, not as a cheerleader.

b. If the relationship is going well, the therapy is not becoming crisis dominated, the client's functioning overall is on an upward slope, and both

you and the client can visualize them needing less and less of you over time, then the likelihood of a complaint is significantly decreased.

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In a future column, I will touch on the most common mistakes therapists make when responding to complaints, from the 'mea culpa,' I'll just send in my license' to the 'I'm a nationally known scholar, how dare you…'

Philip J. Kinsler, Ph.D.

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[i] Pope, K., Sonne, J., Holroynd, J., Sexual Feelings in Psychotherapy: Explorations for Therapists and Therapists-In-Training, 1993, American Psychological Association, 1993, Washington DC.