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

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0735-7028/97/$3.00

Irreconcilable Conflict Between Therapeutic and Forensic Roles

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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

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estify 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 (1)

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

...hiatry, 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 ..."While, in some areas of the country with limited number ...ental 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.

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