Compatibility of Therapeutic and Forensic Roles

Terence Heltzel
Hillside Rehabilitation Hospital

An article by S. A. Greenberg and D. W. Shuman (1997) has been prominently referenced as an authoritative document making the argument that “explicit ethical precepts” (p. 50) are violated when a therapist provides expert forensic testimony. Greenberg and Shuman (1997) claimed that psychologists attempting to do so are engaging in an “irreconcilable conflict between therapeutic and forensic roles” (p. 50). Their arguments are challenged here and shown to conflict with established ethical standards and guidelines for forensic psychologists. The current author discusses serious potential negative ramifications to the public interest and the profession of psychology if state boards of psychology adopt the position of Greenberg and Shuman as a basis for the discipline of psychologists both treating patients and providing expert testimony.

Keywords: therapeutic and forensic roles, psychotherapy and testimony, ethics and multiple roles

Psychologists are becoming increasingly aware of ethical responsibilities and risks associated with their interactions with the legal system. For instance, an article by Greenberg and Shuman (1997) takes the position that there are irreconcilable role conflicts for therapists attempting to also serve as forensic experts, providing “psycholegal opinions” to the court system regarding their clients and that for psychologists to attempt to do so involves serious ethical hazards. Despite their claims regarding the ethical hazards, Greenberg and Shuman (1997) asserted, “With increasing frequency, psychologists, psychiatrists, and other mental health professionals are participating as forensic experts in litigation on behalf of their patients” (p. 50).

It would thus appear that many mental health professionals are, according to Greenberg and Shuman (1997), violating ethical standards. Their important and influential article was more recently given even more national exposure by its inclusion in the American Psychological Association publication Ethical Conflicts in Psychology (Bersoff, 2003). The alleged ethical conflicts described by Greenberg and Shuman are not of only academic interest. The professional careers of many psychologists being threatened by the application of the concepts they espoused. For instance, the State Board of Psychology of Ohio (2003), hereinafter referred to as the Ohio Board, published the newsletter Alert!, warning psychologists regarding ethical violations when therapists attempt to provide expert testimony. In this publication, the Ohio Board (2003) identified the article by Greenberg and Shuman as one of three specific recommended resources “for the competent psychologist” (p. 2). The clear inference is that the Ohio Board, which adjudicates charges of ethics violations against Ohio psychologists, regards this article as an authoritative reference to be used in their deliberations.

Relying heavily on Greenberg and Shuman (1997), the Ohio Board (2003) stated that the problem with a therapist providing opinions to a court involves “inherent dual roles and bias” (p. 2). Also,

Many reasons why psychotherapy can be so helpful are the same reasons that the psychotherapist cannot meet the standards for rendering opinions to the legal system. It’s about conscious and unconscious risks of taking sides, bias, and a loss of objectivity. Psychologists who attempt this dual role (psychotherapist to the client and expert for the legal system) are in inherent role conflict that can violate administrative rules on negligence, competence, welfare of the client, and impaired objectivity and dual relationships. (Ohio Board, 2003, p. 2)

The Ohio Board (2003) further stated the following: “Prevailing standards essentially demand that you define and remain within one role with a given client” (p. 2). Although the Ohio Board article focused on psychologists providing expert testimony in Domestic Relations Court, its position was not restricted to child custody matters. Greenberg and Shuman certainly did not restrict their concerns to domestic relations issues. They stated: “Common examples of this role conflict occur when a patient’s therapist testifies to the psycholegal issues that arise in competency, personal injury, workers compensation, and custody litigation” (Greenberg & Shuman, 1997, p. 51). Another important judicial venue in which psychologists routinely provide psycholegal opinions on behalf of their patients is the Social Security system. Thus, the positions by Greenberg and Shuman are a direct challenge to the activities of many psychologists who, in the course of providing therapy to their clients, are called on to provide expert opinions to a variety of administrative and legal bodies.

Applicable Ethical Standards

The ethical violations alleged by Greenberg and Shuman (1997) pertain to well-established ethical standards involving multiple
relationships, boundaries of competence, limits of confidentiality, and avoiding harm, according to the American Psychological Association “Ethical Principles of Psychologists and Code of Conduct, 2002” (hereinafter referred to as EPPCC). Also relevant to this discussion is a document by the Committee on Ethical Guidelines for Forensic Psychologists, titled “Specialty Guidelines for Forensic Psychologists” (hereinafter referred to as The Guidelines; Committee on Ethical Guidelines for Forensic Psychologists, 1991). This authoritative document is also prominently mentioned among the resources for the competent psychologist by the Ohio Board (2003, p. 2). The Guidelines are intended to describe “desirable professional practice by psychologists . . . when they are engaged regularly as experts and represent themselves as such, in an activity primarily intended to provide professional psychological expertise to the judicial system” (p. 656). This document further defined forensic psychology as

all forms of professional psychological conduct when acting, with definable foreknowledge, as a psychological expert on explicitly psychosocial issues, in direct assistance to courts, parties to legal proceedings, correctional and forensic mental health facilities, and administrative, judicial, and legislative agencies acting in an adjudicative capacity. (p. 657)

Identification of Client, Roles, and Duties

Application of ethical standards typically first requires determination of the psychologist’s client, as well as the role(s) assumed and duties associated with the role. Also relevant to this discussion is a review of the types of witness roles that may be assumed.

Client identification. The client is normally defined as the individual or agency responsible for paying the psychologist’s fees for the service. The client is also typically the individual or agency that initially contracts with the psychologist, and signs the appropriate fee agreements. Greenberg and Shuman (1997) specifically emphasized the importance of defining the psychologist—client relationship because potentially important privileges related to confidentiality adhere to the psychologist—attorney relationship, privileges that are less strongly protected for the psychologist—patient relationship or psychologist—litigant relationship.

Roles and duties. The Greenberg and Shuman (1997) position is that the duties associated with the therapist’s role and the forensic examiner role are inherently conflicting, with a likelihood of harm to the patient, and that a psychologist engaged in both of these roles is therefore violating the multiple relationship standard. However, to fully evaluate their arguments, it is important to first define the roles and primary duties involved.

1. Diagnostician or evaluator role: Duty is to the examinee (and also to the client, if the examinee is not the client) to competently apply assessment methods and procedures to, with reasonable objectivity, honestly answer questions that are the subject of the exam.

2. Treatment provider or therapist role: Duty is to promote the agreed upon mental health treatment goals of a patient, who is necessarily also the client; seek to do no harm; to maintain patient confidentiality unless specifically court-ordered or given authorization for release of information by the patient; to obtain the patient’s informed consent related to risks associated with treatment; to function within the boundaries of competence.

3. Consultant role: Advise the client regarding subject matter within consultant’s area of expertise, such as forensic issues; duty is to maintain confidentiality regarding the work product until such time as testimony is required, or unless otherwise authorized by the consultant’s client.

4. Witness role: Duty is to the court and society to honestly provide facts or expert opinions that are reliable and valid to a reasonable degree of scientific certainty. The psychologist’s reports and completed forms containing expert opinions should be regarded as expert testimony if they are intended for legal determinations, even if formal testimony at a hearing is not required.

Types of witness. It is helpful to understand the two types of witness that can provide information to a court. A fact witness, as described by Greenberg and Shuman (1997), requires “no special expertise beyond the ability to tell the court what is known from first-hand observation,” whereas an expert witness is required to have “relevant specialized knowledge beyond that of the average person that may qualify them to provide opinions, as well as facts” (p. 50). A psychologist offering testimony will typically provide extensive factual information, such as statements made by the patient, psychosocial history data, or psychometric raw data. In doing so, the psychologist is functioning as a fact witness. However, the courts almost invariably will be more interested in the psychologist’s professional evaluations, including interpretations, mental status observations, diagnoses, prognoses, and related professional opinions. These evaluations give meaning to the facts, are based on the psychologist’s specialized training and the science of psychology, and constitute expert testimony well within the scope of traditional clinical practice. In addition to opinions, the court also may grant the psychologist, as an expert witness, latitude regarding introduction of hearsay evidence (e.g., collateral interviews, reports from other professionals) from individuals not available for direct testimony or cross-examination.

Greenberg and Shuman’s (1997) position relies heavily on a false and misleading additional distinction that they make between a “forensic expert” and a “treatment expert.” It should be noted that The Guidelines make no such distinction, and specifically define treatment as a forensic activity when psychosocial issues are involved. The Guidelines explicitly state forensic psychologists “are obligated to use that knowledge, consistent with accepted clinical and scientific standards, in selecting data collection methods and procedures for an evaluation, treatment [italics added], consultation or scholarly/empirical investigation” (Committee on Ethical Guidelines for Forensic Psychologists, 1991, Section VI, A). Also, “When forensic psychologists conduct an examination or engage in the treatment of a party to a legal proceeding [italics added], with foreknowledge that their professional services will be used in an adjudicative forum, they incur a special responsibility to provide the best documentation possible under the circumstances” (Committee on Ethical Guidelines for Forensic Psychologists, 1991, Section VI, B). Furthermore, “As an expert conducting an evaluation, treatment [italics added], consultation, or scholarly/empirical investigation, the forensic psychologist maintains professional integrity by examining the issue at hand from all reasonable perspectives, actively seeking information that will differentially test plausible rival hypotheses” (Committee on Ethical Guidelines for Forensic Psychologists, 1991, Section VI, C). These statements from The Guidelines clearly contradict Greenberg and Shuman’s (1997) premise that there is a fundamental
distinction between a forensic and treatment expert—a distinction upon which they base their conclusions regarding an “irreconcilable conflict between therapeutic and forensic roles” (p. 50). It is evident that a treatment expert is also a forensic expert. The clear inference is that The Guidelines consider treatment and expert testimony to be compatible roles.

It reasonably follows that as soon as a treating psychologist recognizes that a patient’s mental state may be an issue in a legal proceeding, it is clear that answering psycholegal questions and serving as a witness may be required. With this “definable fore-knowledge,” the psychologist ought to realize that, in addition to the traditional diagnostic and treatment roles, he or she can reasonably anticipate being called upon to provide expert testimony. Anticipating this additional role, the psychologist should conduct himself or herself with the duties of this role in mind. If the psychologist does not have the requisite competence, or the willingness, to assume these duties, then the psychologist should protect the patient’s interests by, in consultation with the patient’s attorney, making an appropriate referral or obtaining a supplemental forensic assessment.

**Multiple Relationships**

With respect to multiple relationships, the EPPCC (2002) states that a multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person. (Standard 3.05)

The EPPCC (2002) standard further states,

A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist’s objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists. (Standard 3.05)

The standard also explicitly states, “Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical” (EPPCC, 2002, Standard 3.05).

As indicated above, multiple relationships are not inherently harmful or unethical. In fact, most professional relationships for a psychologist involve several different professional roles and, without any reasonable expectation of harm or impaired objectivity, are ethical multiple relationships. For instance, therapists almost always initially, and throughout treatment, serve in the role as diagnostician or evaluator. An example of multiple relationships approved of by Greenberg and Shuman (1997) is that of a psychologist who is retained by either the plaintiff’s attorney or the defendant’s attorney and takes on the role of consultant to that attorney, and then also serves as an evaluator of the litigant as well as expert witness to the court.

We can also be informed on the issue of multiple relationships by the work of our professional colleagues in the discipline of psychiatry, who share our ethical obligations. For instance, Weinstock, Leong, and Silva (1994) reported,

> Although controversy still exists, survey results best support a position of multiple agency and multiple responsibility for a forensic psychiatrist. Such multiple responsibility would be true for the forensic psychiatrist and is already required of the treating psychiatrist. . . . Multiple responsibilities have become a part of all psychiatric practice. (p. 11)

Bursztajn (1998) stated that “multiplicity of roles is unavoidable,” and that “[w]hen the potential for unavoidable role conflicts exists, a clinician’s first duty is to engage in an informed consent process. . . . Thus, potential conflicts need to be addressed by dialogue rather than by unilateral fiat” (p. 307). It should therefore be evident that the Ohio Board’s admonition that psychologists should define and remain within one role is neither sensible nor consistent with prevailing standards.

**Boundaries of Competence**

With respect to boundaries of competence, the EPPCC (2002) states, “Psychologists provide service, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.” It continues, “When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing the roles” (Standard 2.01 a,f).

Greenberg and Shuman (1997) argued that one of the primary reasons that the therapist role is incompatible with a forensic expert role is that a therapist is unlikely to conduct an evaluation sufficient to provide a valid and reliable basis for testimony on psycholegal issues—and that the therapist is therefore functioning outside of his or her boundaries of competence when attempting to provide expert opinions regarding psycholegal issues. They stated that the “evaluative attitude” (Greenberg & Shuman, 1997, p. 53) of the typical therapist is insufficiently neutral or objective, and a therapist is not usually as concerned about historical truth as is the forensic expert. However, there is no justifiable reason why a competent psychologist cannot and should not conduct an objective and appropriate evaluation of a patient seeking clinical services as a basis for the treatment. Greenberg and Shuman in effect have erected a straw man with their position that a therapist is an inadequate diagnostician. The contention here is that the therapist must first and foremost be a competent diagnostician and is ethically required to objectively evaluate his or her patient as a basis for both effective treatment and expert testimony. Of course, most therapy patients do not present with pressing legal issues for which a need for testimony would be anticipated. Competent and objective assessment of each patient should be tailored to the needs and issues of that patient. When psycholegal issues are identified as an important aspect of the patient’s presenting complaints and circumstances, the therapist must ensure that the issues are competently addressed. Having conducted an evaluation objectively addressing relevant psycholegal issues, the diagnostician—therapist can appropriately provide expert opinions on these issues.

**Psycholegal issues versus clinical issues.** Greenberg and Shuman (1997) defined psycholegal issues as the province of the forensic expert. However, the purported distinction between psy-
cholegal issues and opinions versus mere clinical issues and opinions was not carefully defined. For instance, they stated that treatment experts can testify regarding such matters as clinical diagnosis and prognosis, but they are not normally able to provide psycholegal opinions such as causation (i.e., the relationship of a specific act to a 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, historical truth that are problematic for treatment experts. (Greenberg & Shuman, 1997, p. 56)

However, the issues which are the subject of a psycholegal opinion are not the exclusive province of the legal system. For instance, a patient’s diagnosis and the etiology of the condition have both psycholegal relevance as well as clinical relevance. The extent of impairment and prognosis have both clinical and psycholegal relevance. A competent and thorough diagnostician—therapist does not find issues of judgment, foundation, and historical truth problematic.

Reasonable degree of scientific certainty. Greenberg and Shuman (1997) reported that “[t]o 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)” (p. 51). Then they asserted that a therapist is unlikely to have the type and amount of data adequate to inform an expert opinion on psycholegal issues meeting this standard. In most legal settings, this standard requires the expert witness to assert that the opinion expressed, on the basis of the accepted standards of the profession, is more likely to be true than false (Imwinkelried, 1980; Jacobs, 1989). This statement of probability as opposed to absolute certainty is the metric typically expected for an expert witness. Although the standard may superficially appear intimidating, in actual practice it would probably be unethical for a competent psychologist to seriously offer any professional opinion—unless clearly labeled as speculative—that falls short of meeting this standard. Why would any competent psychologist render an opinion to a patient that is more likely to be incorrect than correct? The EPPCC (2002) requires that “Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony [italics added], on information and techniques sufficient to substantiate their findings” (Standard 9.01). Furthermore, “Psychologists’ work is based upon established scientific and professional knowledge of the discipline” (2.04). In other words, the standard for reliability of opinions required by the legal system of forensic testimony is normally no higher than that required of general clinical practice.

In the legal environment, these expectations are reflected in the evidentiary standards of the particular court, by which the evaluation procedures and, in particular, the psychometric instruments used must meet court requirements with respect to professional acceptance and reliability (e.g., Daubert v. Merrell Dow Pharmaceuticals, Inc., 1993). A therapist who first evaluates a patient and then determines that potential psycholegal issues are present can and should conduct an evaluation sufficient to properly provide a foundation for testimony.

The adversarial nature of litigation. It is important to note that a forensic expert is not required to have gathered all potentially relevant facts or data. Although the forensic expert (including treatment provider) is ethically obligated to seek information conflicting with the client’s legal argument, no expert is expected to have access to all information, and opinions can only be offered on the basis of information reasonably available to the expert. The typical diagnostic assessment relies heavily on psychosocial history data, usually provided primarily by the patient, often supplemented by information from other sources (family members, referring doctors, attorneys, etc.). An expectation of the adversarial system is that each party to a conflict is motivated to seek and present information favorable to its position, and factual errors or distortions in the psychosocial history may be readily identified. The vigorous scrutiny given by each side of a dispute to the evidence presented by the other side generally assists the trier-of-fact to discern the truth of the given situation, permitting a just conclusion.

In an adversarial system, neutrality or independence of expert testimony is not required. Honesty is required. For instance, the plaintiff’s attorney and the defendant’s attorney can each retain an expert to evaluate the plaintiff, and each expert can then offer an honest opinion, and yet these honest opinions by the experts can differ (perhaps on the basis of different facts, observations, or weight given to variables and reasoning), and it is up to the trier-of-fact to weigh the value and credibility of each opinion. Likewise, the treatment expert can also offer a psycholegal opinion, the weight and credibility of which is up to the trier-of-fact to determine. If either the plaintiff’s evaluator—therapist or the defendant’s consultant—evaluator selectively presents only favorable or distorted facts, or makes a weak argument, this will usually become evident to the trier-of-fact. The legal system does not assume unbiased or neutral testimony. It should be up to the court, not a preemptive state board position, to assess the extent and importance of any bias in expert testimony.

Prevailing standard of care. When a psychologist’s activities are judged with respect to competency, they are normally compared with the prevailing standard of care. The Greenberg and Shuman (1997) article has been the focus of this discussion because it has been prominently identified nationally and as required reading for Ohio psychologists who wish to be determined competent. Although their article clearly articulates their own view, Greenberg and Shuman did not provide much evidence regarding prevailing standards of care. Other than a few references to “Existing Professional Guidelines” (p. 54) which only tangentially address the issue, Greenberg and Shuman (1997) provided very little information beyond their own writings regarding professional acceptance of their position. Several articles (e.g., Berger, 2004; Strasburger, Gutheil, & Brodsky, 1997) have been identified which were theoretical discussions in agreement with Greenberg and Shuman. Strasburger et al. (1997) was noteworthy because they at least made an effort to determine prevailing opinions regarding the ethics related to a therapist providing testimony. What is especially instructive is that the survey evidence they referenced indicated that only a small minority of forensic psychiatrists agree with the position that it is a significant ethical problem for a therapist to provide expert testimony regarding a patient (Weinstock, 1986, 1989; Weinstock, Leong, & Silva, 1991). The survey results dramatically support a finding that there is no violation of a prevailing standard of care for a therapist providing expert witness testimony.

Greenberg and Shuman (1997), as indicated above, make reference to “Existing Professional Guidelines;” that might be regarded as including recommended standards of care. None of the refer-
enced guidelines provide a coherent prohibition against a therapist providing expert testimony, other than in child custody or visitation cases. The reference to a single statement in the Ethical Guidelines for the Practice of Forensic Psychiatry (American Academy of Psychiatry and the Law, 1989, as cited in Greenberg & Shuman, 1997) comes closest: “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.” The reasons given for avoiding the dual roles have been discredited here: To the extent that interviewing others is necessary to form an expert opinion, then a treating psychologist can and should do so, and the potential for testimony to adversely affect the therapeutic relationship is remote and is ethically addressed with appropriate informed consent, as discussed in detail below.

Several of the referenced guidelines caution against combining the evaluation and treatment roles when legal issues are involved, but offer no reasons for the caution and indicate that it is permissible to combine the roles when necessary. It is also noteworthy that reference was made to the 1992 Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association: “In most circumstances, psychologists avoid performing multiple and potentially conflicting roles in forensic matters” (p. 1610). However, EPPCC has since dropped this guideline.

**Limits of Confidentiality**

Issues related to limits of confidentiality are important to Greenberg and Shuman’s (1997) position that there are irreconcilable conflicts between the therapeutic role of a treatment provider and the role of the expert witness answering psychological questions. They argue that a psychologist evaluating a patient with respect to forensic issues sacrifices the privilege of confidential communication between a therapist and patient. They claim that, by inquiring regarding psycholegal issues, the psychologist establishes “a forensic relationship” and “communications between a forensic examiner and litigant are not protected (Greenberg & Shuman, 1997, p. 52). However, the competent and thorough evaluation recommended here, encompassing forensic and clinical issues, and to be used as a basis for treatment and anticipated forensic testimony, surely would enjoy traditional psychologist—patient privileges. In any case, it is well-known that a patient filing a legal claim involving his or her mental state waives the privilege of confidentiality. Furthermore, there are probably circumstances in which the patient’s mental state becomes an issue before a court, regardless of whether the patient initiates a claim, and it is certainly conceivable that the patient’s therapist may be required to offer testimony due to circumstances beyond either the patient’s or therapist’s control.

Therefore, it should be clear that the ideal of complete confidentiality as a feature of the therapeutic relationship is simply not capable of being guaranteed and that all therapy carries inherent risks to confidentiality because of legal requirements. It follows that the risks related to limits of confidentiality cannot reasonably render treatment an unethical professional activity, EPPCC simply requires that recipients of psychological services be informed and give consent regarding these limits to confidentiality.

**Avoiding Harm**

Regarding avoiding harm, the EPPCC (2002) states, “Psychologists take reasonable steps to avoid harming their clients/patients, . . . and others with whom they work, and to minimize harm where it is foreseeable and unavoidable” (Standard 3.04). Greenberg and Shuman (1997) asserted that harm occurs when a therapist provides forensic testimony because the therapist’s duty of beneficence and nonmaleficence to the patient conflicts with the forensic expert’s duty to testify truthfully, regardless of effect on the patient’s legal position—thus potentially causing harm. They stated, “A forensic evaluator advocates for the findings of the evaluation, whatever those findings turn out to be. Thus, the results of a forensic evaluation may well be detrimental to the legal position of an examinee . . . and contrary to basic therapeutic principles” (Greenberg & Shuman, 1997, p. 54).

The competent diagnostician—therapist can best limit the risk of testimony damaging to the patient’s legal position by conducting a thorough and objective evaluation. The psychologist is ethically obligated to carefully assess and probe for circumstances and issues which would harm the patient’s legal position, and openly discuss any evident problems with the patient. It is clearly in the patient’s best interest to be advised of any weaknesses of his or her legal position before he or she decides to file a claim. If, after conducting a thorough, competent evaluation, and determining that the facts and clinical data support rendering opinions favorable to a claim, the psychologist can confidently proceed without reasonable anticipation of having to provide damaging testimony.

The harm described by Greenberg and Shuman (1997) is also relatively infrequent because the patient normally has the option of whether to file a claim leading to the psychologist’s expert testimony. This decision is based on the patient and his or her attorney first having the opportunity to review the treating psychologist’s evaluation report. It is reasonable to presume that a claim will not be filed unless the evaluation supports the patient’s legal position. If the diagnostician—therapist’s evaluation report does not support a claim, the patient is not harmed because the findings may persuade the patient not to pursue a claim of doubtful validity. Or, the patient, with the advantage of legal counsel, can search for a diagnostician—therapist whose evaluation may be more favorable. In any event, a properly informed patient should never be surprised by unfavorable forensic testimony from his or her therapist.

If, in the course of treatment, the psychologist’s opinions evolve unfavorably to the patient’s legal position, this patient must be informed and the issues discussed as an important aspect of the therapeutic process. Proper anticipation of adverse legal determinations can go a long way to mitigate against harm. Who better than a patient’s therapist to provide “bad news” regarding lack of support for a claim? It would appear that Greenberg and Shuman’s (1997) position is that a therapist should avoid addressing issues that negatively impact a patient’s legal position for fear of harming the therapeutic relationship; however, a good case could be made that their approach constitutes the very harm that they claim a therapist is obligated to avoid. Would it not be far more ethical for a therapist to acknowledge any adverse facts or professional opinions and process these in therapy?

An even more basic flaw with Greenberg and Shuman’s (1997) argument regarding the alleged role conflict pertains to their misapplication of the concept of the therapist’s duty of beneficence.
and nonmaleficence, by which they indicate that the potential for unfavorable testimony constitutes harm that must be ethically avoided. However, the duty to do no harm pertains to the therapist’s intentions, competence, and treatment goals, not the potential outcome of the interventions and services. The potential for a bad outcome cannot reasonably be interpreted as implying a violation of the duties of beneficence and nonmaleficence. Clinicians (e.g., surgeons) routinely—and with beneficence and nonmaleficence—provide services involving much greater known and predictable risks than those associated with expert testimony. So long as the patient has been informed of the risks and decides that the potential benefits outweigh those risks, then provision of the services is ethical, even in the event of a poor outcome.

It is also questionable whether a resulting adverse legal ruling constitutes “harm.” For instance, a denial of benefits or damage award is simply a legal determination that the individual was not entitled to those benefits or award—and therefore is not truly harmed by not receiving an award to which he or she was not entitled anyway. Furthermore, if a patient can be harmed by a legal outcome, then it would follow that successful treatment would become unethical because of the harm to the patient’s legal position—that is, reduced benefits or awards for damages. It would also follow that a consultant would be harming his or her client (the attorney for either the plaintiff or defense) by testifying contrary to the client’s legal position.

Impaired Objectivity and Bias

Reasonable expectation of impaired objectivity is identified in the EPPCC as a basis for a finding of unethical multiple relationships (3.05) or conflict of interest (3.06). Greenberg and Shuman (1997) and the Ohio Board clearly refer to impaired objectivity and bias as reasons which would render testimony by a therapist ethically hazardous. This notion is also reflected in Greenberg and Shuman’s opinion that the “evaluative attitude” of the therapist is incompatible with the attitude of the forensic expert. Whereas “[t]he therapist is a care provider and usually supportive, accepting and empathic; the forensic evaluator is an assessor usually neutral, objective, and detached as to the forensic issues” (Greenberg & Shuman, 1997, p. 53). This is a particularly poorly considered position, which could have very damaging effects to the practice of psychotherapy.

It is probably reasonable to assume and expect that a therapist will have the “supportive, accepting and empathic” attitude toward his or her patient, as described by Greenberg and Shuman (1997). What is not reasonable is to equate this attitude with impaired objectivity. A diagnostician—therapist, whether or not providing testimony, is ethically required to maintain reasonable professional objectivity, which should not be incompatible with a supportive, accepting and empathic attitude. To assert otherwise is to condemn psychotherapy as a professional activity. A therapist whose required professional objectivity is impaired by his or her “evaluative attitude,” is probably not fit to provide diagnostic services or therapy. Absolute or perfect objectivity is not possible, and less than absolute objectivity is not equivalent to impaired objectivity.

A competent diagnostician—therapist does not gullibly accept as factual all statements made by a patient. Also, the appropriate level of skepticism need not be made offensive to a patient. Most patients readily understand and appreciate the need for careful, objective evaluation when explained to them in the context of legal requirements. It is also important to emphasize to the patient that important background information presented as “fact” is subject to scrutiny by a legal adversary.

Imperfect objectivity is not unique to a therapist. A diagnostician—consultant engaged by an attorney also manifests an evaluative attitude and experiences emotional reactions to the litigant being evaluated as well as toward the attorney—client. Thus, this psychologist has one relationship as a consultant to the attorney, who pays the psychologist’s fees and whose opinions regarding the benefits of the psychologist’s services are likely to contribute to or detract from the psychologist’s reputation with the attorney and his or her colleagues. This psychologist also has another relationship to the litigant whom he or she evaluates and also has an evaluative attitude. This is not a relationship “most straightforward and free of conflict of interest,” as purported by Greenberg and Shuman (1997, p. 52).

Prior professional debate on this subject has led to a general consensus that the abstract ideal of complete objectivity for expert testimony is neither practical nor required (Diamond, 1959; Katz, 1992; Pollack, 1974; Weinstock et al., 1994). Whether serving as a therapist to the plaintiff, expert consultant to the plaintiff’s attorney or defense attorney, or as a court appointed expert, the psychologist reasonably is assumed to have a variety of biases. Greenberg and Shuman (1997) asserted that the “bias” of a therapist is incompatible with expert witness testimony. However, as Weinstock et al. (1994), stated, although the American Academy of Psychiatry and the Law have eliminated the requirement of impartiality as impossible to achieve, they have emphasized the need to strive for objectivity. Striving for objectivity includes the need to search for data that contradicts the forensic psychiatrist’s initial opinion and biases. “Honesty” has been substituted for “impartiality” (p. 8).

Weinstock et al. (1994) further asserted, “Claims of impartiality can reflect dishonesty or lack of insight” (p. 10). Ethical practice is determined not by the presence of absolute impartiality or perfect objectivity. Ethical practice is determined more by competence and integrity. Integrity requires honest effort to fairly evaluate the psycholegal issues, with appropriate consideration to alternative, competing explanations for the problems assessed.

In the Public Interest

The Greenberg and Shuman (1997) arguments appear designed to persuade state boards to enforce prohibitions against therapists offering expert testimony on psycholegal issues to protect several public interests (reliable testimony and protection of the therapy relationship). It is worth noting that the authors extended their positions in a subsequent article (Shuman, Greenberg, Heilbrun, & Foote, 1998) in which they argued that even testimony from treatment experts should be disallowed. They described their opposition to such testimony as “radical,” and “an immodest proposal.” They stated,

On what basis and by what mechanisms do we propose to bar therapists from testifying about their patients? On the basis of conflict of interest, lack of foundation, and potential for unfair prejudice, we propose that a rule of law disqualify treating therapists from offering testimony about their patients. On the basis of harm to the therapist-
A therapist’s testimony to a court is not credible, how much faith should the public have for other opinions offered by psychologists, such as diagnostic findings and treatment recommendations? If psychologists cannot be expected to have the integrity to strive for objectivity and honesty with respect to testimony, as well as treatment, what does that say about our profession?

References