Commentary: Two Sides to Every Story—the Need for Objectivity and Evidence

Joel A. Dvoskin, PhD

Dr. Thomas Gutheil, in his article, "Boundaries, Blackmail, and Double Binds: A Pattern Observed in Malpractice Consultation," provides readers with some important and useful recommendations regarding the avoidance of real or perceived boundary violations and how to avoid the pitfalls of difficult therapy. However, in doing so, he moved away from the usual even-handedness and objectivity that characterizes his work. Forensic mental health professionals rely on evidence, and always wait until they have carefully considered both (or all) relevant sides of an issue before rendering an opinion.

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Dr. Thomas Gutheil, in his article, "Boundaries, Blackmail, and Double Binds: A Pattern Observed in Malpractice Consultation,"[1] provides readers with some important and useful recommendations regarding the avoidance of real or perceived boundary violations, and I applaud his advice that the best way to prevail in ethics disputes is to avoid them altogether. However, in doing so, he has moved away from the usual even-handedness and objectivity that characterizes his work. If there is a heart and soul shared by forensic psychiatry and psychology, it is objectivity. Forensic mental health professionals always wait until they have carefully considered both (or all) relevant sides of an issue before rendering an opinion.

Early in the article, Dr. Gutheil acknowledges that his role as expert witness for the defense is a "potential source of bias," and adds the caveat that "no one truly knows what actually happened in office encounters with only two people present." I also agree with him that risk-management principles may be derived even when there is not absolute clarity about whose version of events is objectively true. Still, after offering the caveat, he loses sight of it from time to time in the paper.

Dr. Dvoskin is Assistant Clinical Professor of Psychiatry, University of Arizona College of Medicine, Tucson, AZ. Address correspondence to: Joel A. Dvoskin, PhD, 3911 East Ina Road, Tucson, AZ 85718. E-mail: joelthed@aol.com

When choosing to play the dual roles of defense expert and educator in regard to the same cases, one must be careful to delineate the source of every assertion made. However, the case examples do not provide the reader with the source of each assertion. We do not know whether Dr. Gutheil relied entirely on the version claimed by his client, but it appears that he did. It would be useful to know, for example, exactly how he knows that the patient in Case 1 was led to "(mis)interpret. . .some of the therapist's exploratory questions as sexual advances" (Ref. 1, pp 476–7). This observation came from the woman's therapist, who just happened to be Dr. Gutheil's client and the respondent to her complaint and who thus had strong reasons for denying any sexual advances.

In Case 2, Dr. Gutheil discusses what the patient "seemed to remember." Again, one can only assume, in the absence of any other source of information, that this was the stated opinion of Dr. Gutheil's client, the therapist, and respondent. Later in Case 2, Dr. Gutheil laments the fact that the patient's "highly subjective interpretation was regrettably taken as simple fact by the ethics committee" (Ref. 1, p 477). Why is the patient's interpretation labeled "highly subjective," while that of the therapist is not?

The article states, "Because the patients were in treatment, many of their dynamics were available. The therapists were only sometimes examined;

hence, their dynamics. . .are more inferred and speculative" (Ref. 1, p 476). But the patient's dynamics were not available to Dr. Gutheil. He learned of them only through the statements of the therapists whose own professional misbehavior was being alleged. It is not clear why the therapists were not examined, but even if they had been, without the examiner's being in the room at the time of the alleged misbehavior, any conclusions that derive from these accounts are inherently suspect.

The subject in Case 5 is characterized as a "highly functional but difficult, demanding, and intrusive patient." Again, what possible basis exists for such a characterization, except the protestations of the accused therapist?

Case 5 deserves special attention. Here, we are once again asked to take for granted the therapist's version of events. According to this report, "The therapist, feeling paralyzed and anxious, immediately left the office and consulted the board regulations" (Ref. 1, p 477). We are then asked to believe that he was told, by a local attorney, that he would have been deemed guilty of participating in a sexualized activity in his office, solely because he observed the behavior.

Once again, in Case 6, we are asked to dismiss as "implausible" the allegations of the patient, despite the fact that an impartial ethics board reportedly believed them. As in Case 5, Dr. Gutheil accepts without apparent skepticism the therapist's claim of "counter-transference-based paralysis." In comparing the implausibility of the respective claims, one is forced to ask which is more common—sexual misbehavior by a therapist, or "transference-based paralysis."

I want to state clearly that, like Dr. Gutheil, I have no idea which of these therapists were wrongly accused, which were inaccurately but innocently accused, and which were guilty. Nor do I dispute many of his wise admonitions, which he notes are supported by his "extensive experience in similar cases as expert for plaintiff or defense." The problem is not his suggestions about how to avoid ethics complaints; it is the fact that he bases his argument on many things in this article as if they were true.

In his prolific writings on forensic psychiatry, Dr. Gutheil has been a strong and effective advocate of thorough, objective examination. This article, in its characterization of clients, grudgingly allows that the patients' accounts may contain a "grain of truth." But he would have us believe that he is able to divine that a patient has "experience(d) being particularly well understood as seductive" (Ref. 1, p 479). The problem is that some therapists may be seductive, and then not admit it.

In the most revealing portion of the entire paper, Dr. Gutheil observes, "[Taking good notes and obtaining consultation] does not seem to prevent determined patients from acting out their projective fantasies *or credentialing bodies from believing them*" (Ref. 1, p 480; emphasis added). Given two points of view from which to choose, what logic would favor the testimony of one side's expert over the objective findings of an ethics board? It is not that such boards do not make grievous errors from time to time, but if the reader is going to be asked to believe that patients committed "blackmail" and that the boards were so badly mistaken, doesn't the reader have a right to some evidence to support such a one-sided version of the events?

Still, this article has considerable value. As is so often the case, Dr. Gutheil closes with a flourish and rewards the reader with some outstanding and sensible advice about how to avoid the pitfalls of difficult therapy. Indeed, to the extent that his clients' versions of each event were accurate, following this advice would have served them well. His six teaching points—each and every one of them—are wise and useful.

However, forensic psychiatrists and psychologists are not human lie detectors. It is for this reason that we rely so heavily on evidence before rendering our opinions and conclusions.

Reference

1. Gutheil TG: Boundaries, blackmail, and double binds: a pattern observed in malpractice consultation. J Am Acad Psychiatry Law 33:476–81, 2005