

# Approaches to Forensic Assessment of False Claims of Sexual Misconduct by Therapists

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**The author offers systematic approaches to evaluation of claims of therapist-patient sexual misconduct, together with their rationales. False accusations should be considered in all such cases in order to maintain the balanced forensic perspective and to probe for malingering, as in all evaluations. Practical techniques are offered and the underlying reasoning described.**

Change the severity of the disability of my injury in the chart to a worse condition. or else I will call the Board of Registration in Medicine and say that you molested me when we were alone together in the examining room. —Male patient to male E.R. physician in famous Massachusetts case.

Amid the dark blot on the helping professions that is sexual misconduct, there is an even darker center: a “heart of darkness,” as it were.<sup>1</sup> This is the problem of the false claim of sexual misconduct, a phenomenon that confounds and contaminates an extremely serious problem for the helping professions. A false accusation of misconduct is an entity difficult to diagnose, disprove, or

prove. In theory every clinician is potentially vulnerable to such a claim; misconduct is an allegation in relation to which it may be as destructive for the clinician to be accused (even falsely) as to be guilty.

As with child sexual abuse, some clinicians believe false claims do not exist; that all accusations are true; others admit they do exist but believe it is politically incorrect to acknowledge as much, since such acknowledgement may supposedly deter victims from coming forward.

My purpose in this article is to suggest (1) that efforts at detection of a false claim of sexual misconduct are fully as appropriate for the forensic practitioner as other detections of malingered phenomena, say, in an insanity context; (2) that the question of a false accusation should be considered for completeness

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and objectivity in *all* evaluations of misconduct; (3) that it is, indeed, politically correct to address this issue, since false accusers clearly contaminate the validity and credibility of the truly abused and should therefore be weeded out for the good of patients, not to mention for the protection of unjustly accused clinicians, as in the cynical example that serves as epigraph; and (4) that certain clinical/forensic approaches are useful in this assessment. I draw in this article upon experience with more than a dozen such cases out of a total caseload of 89 sexual misconduct suits; I welcome responses and input from my colleagues.

### Caveats

Before undertaking the more technical part of the exposition, I believe it will be important to address a few cautions. First, one can defensibly adopt the existential position that, regarding true or false accusations of sexual misconduct, one will never know exactly what happened. Therapist and patient may have so many agendas at so many levels that the ultimate certainty will probably never be achieved. Thus, humility may require us to speak of “apparently false accusations” (and, for that matter, apparently true ones). I will not develop this point here.

Second, it is essential for the forensic practitioner to keep firmly in mind that the final test of truth or falsity—that is, the ultimate issue—is for the fact finder in the case: judge, jury, licensure board, ethics committee, or whatever. However, just as in insanity cases, where the practitioner must venture an opinion

(subject, of course, to final ratification by the fact finder), so, too, the practitioner must make an independent determination and venture an opinion in these cases.

To put this another way, while ultimate “credibility” is in the hands of the fact finder, the practitioner must make his/her own threshold credibility determination to decide, at the very least, whether to take the case. Most clinicians who do many of these cases have probably found themselves on occasion disbelieving the party whose attorney is attempting to retain them, whether plaintiff or defense. The practitioner then has an ethical obligation to communicate this view to the attorney, of course.

Third, I have elsewhere noted<sup>2</sup> that the pool of false accusers is dominated by borderline patients. The expert must be careful not to slip into the fallacy, “if borderline, therefore false,” since the true accuser pool also contains its share of patients with that diagnosis.<sup>3</sup>

As a final caveat the expert should take it in stride if he/she can arrive, after due diligence, at no better answer than “I don’t know.”<sup>4</sup> Not all claims are resolvable as *either* true or false; sexual misconduct claims are notorious for being reduced to one party’s word against another’s, with no witnesses. This empirical reality is not the expert’s problem.

### Technical Considerations

In using the following listing, as with any form of criterion-based test, the forensic practitioner is more interested in

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an holistic pattern of responses, rather than in a single positive finding in one category.

**Alternative Scenario** In this author's view the question of an alternative scenario is the single most important element of the assessment. An accusation of sexual misconduct, empirically, is usually true; false accusations are in the minority.<sup>3</sup> If the accusation is false, the expert must identify the motivational basis for the claim if not truth. Without such an alternative scenario I am reluctant to diagnose a false claim, even with positive findings on some of the other criteria listed below. Some typical alternative scenarios are the following.

**Revenge or Retaliation** This is the most common alternative scenario; its most common precipitant is termination, separation or the threat thereof.

A patient whose therapist had agreed to work with her until she completed beauty school began to spend all the session time attempting to argue the psychiatrist into having a sexual relationship with her. After this subject had monopolized months of sessions without the patient being able to focus on other topics, the therapist stated that if the patient could not get off this topic, therapy would end. The patient, experiencing this as breach of the "promise" to see her through school, became enraged and stalked out of the session before it was over. She went almost directly to another therapist to whom she complained that all the sexual things she had pestered the therapist for had actually happened.

In today's climate it is worth noting that well-meaning clinicians' tendency to believe all accusers can produce bizarre and often pathogenic results. In this last case, the patient, now brandishing her identity as "victim of therapist abuse," was seeing four therapists as de-

sired, two pharmacologists (who may not have known of each other's existence), and was attending a group for abused patients (which incidentally supplied her with much raw material and lingo for her simulations). Since she was a "victim" it appeared that none of her therapist felt free to set limits with her to insist she work with one therapist only.

**Object Retention** Here the issue is captured in one patient's comment: "You want to get rid of me and to forget me; I will make sure you *never* forget me!" A lawsuit is, of course, a relationship, admittedly a hostile-dependent one, which can be used to maintain a forced object constancy with a clinician, *especially* one experienced as attempting to get rid of the patient.

**Competition with Others** This element, often conjoined with the previous one, poses an additional wrinkle. A patient may falsely claim sexual misconduct as a means of feeling closer to the therapist than other patients, real or fantasied. The situation may involve other actual claims that must be weighed. More than one claim by individuals who do not know another is a potentially mutually corroborative picture consistent with true multiple misconduct by a recidivist therapist. However, simultaneous claims by members of the same therapy group, as in one famous case, proved to be a competition as to which of four borderline patients would be most "special."

In another case a therapist who had had an ostensibly false claim brought against him, asked another one of his own patients (in the author's view, inappropriately) if the latter had

heard anything about this from the accusing patient. The present patient said no and wrote a supportive letter to the doctor. After brooding on this for a while, the second patient brought her own suit on an apparently competitive basis.

Similar mechanisms may account for some but clearly not all of the responses to publication of an accusation in the media. Such publication empowers actual other victims to come forward, to be sure. The forensic expert, however, should not mechanically assume the "out of the woodwork" model but should assess for this alternate competitive factor. For completeness note that patients may also feel competitive with therapists' spouses or significant others and lodge the claim on that dynamic basis.

*Fantasy/Wish versus Psychosis* An occasional false accusation is a wishful one, where the patient's intense longing for a sexual relationship with the therapist is made into fantasy, and the fantasy treated as reality. Diary entries unrevealed to others may be the repository for elaborate constructions that bear no connection with truth but satisfy wishful needs.

This issue must be distinguished from actual psychosis. While genuinely abusing therapists have historically cried "psychotic!" when accused, the occurrence of actual psychosis as the basis for a false claim is rare.

In a fascinating case a schizophrenic patient read "The Story of O," a famous sadomasochistic novel popular some years ago. For psychotic reasons the patient apparently concluded that the novel must be a record of what was happening with her and her psychiatrist. She brought a claim for sexual misconduct which was fairly well advanced before the at-

torneys, who had also read the book, recognized the plot line and, in embarrassment, dropped the suit.

As a general principle, therefore, the mental status exam may be helpful and even determinative in some cases.

*Money* Finally, the expert must, here as always, consider the factor of secondary gain: lawsuits are for money. Financially strapped patients and those with psychopathic traits may see such a suit (with all its witnessless difficulties of disproof and the possibility of public sympathy) as a form of income.

The expert may be misled by being consulted for a case before a licensing board, where there appears to be no monetary reward. Experts must understand the common tripartite thrust of sexual misconduct complaints: civil suit, complaint to the licensing board, and complaint to the ethics committee of the professional society. Even if the patient's only goal is the money for the civil suit, attorneys will recommend filing all three types of claim as a means of enhancing credibility; the patient is portrayed as not just interested in money but in justice as well. In addition, plaintiffs' attorneys will commonly urge that the patient file first before the licensure board, which can conduct reams of discovery on the public purse, i.e., at no cost to the plaintiffs' attorneys' "front money" investment. Once an alternative scenario is defined, additional criteria must be investigated.

*"Alibi" Evidence or External Inconsistency* Just as the expert looks to external sources for corroboration or discreditation of the subject's claims

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in many forensic contexts, so alibi evidence or evidence from witnesses that refutes the plaintiff's claims is important to the assessment. As always, alibi evidence from a spouse or partner must be considered more carefully than that from witnesses who are more neutral or disinterested.

Forensic practitioners may object that data in this category are more the province of an investigator hired by the attorney. Indeed, in some cases the practitioner will utilize just such investigator reports in the same manner that one uses police or witness reports concerning a crime. I suggest, however, that it is fully appropriate for the expert to "think investigatively" and to guide the attorney as necessary.

A patient had called her psychiatrist's office and received no answer; she concluded he was not in and chose that date and time to claim falsely that he had come over to her apartment for sex. The attorney discovered by investigation that the patient's address in the files was the wrong (expired) one, so that the doctor would have gone to the wrong house anyway, and that telephone billing records proved, as the doctor testified, that he had, in fact, been at the office at the contested time, making numerous calls but not accepting incoming messages.

In sexual misconduct litigation in general, telephone records, credit card receipts, restaurant bills, hotel or motel records, and similar "hard" financial audit trail material may prove invaluable.

**Internal Inconsistency** This somewhat self-explanatory criterion draws its strength from the old axiom, "If you tell the truth, you don't have to remember what you said." While dates and times may be slippery data for many people,

other information may be more prominently contradictory.

A patient presented several different versions of when all her clothes were allegedly first taken off by the psychiatrist. Since the patient claimed only three instances of misconduct in different locales, it was clearly not a question of being confused about a specific event occurring within a long series of similar events (where some uncertainty might be expectable).

Sometimes the internal inconsistency may lie between different sources of evidence from the patient.

A patient claimed in deposition her psychiatrist frequently grabbed her and hugged her during and at the end of sessions. Her diaries, however, unexpectedly produced in discovery, contained repeated references to her resentment at the doctor's grabbing her wrists (i.e., to prevent *her* grabbing *him*).

**Implausibility** This is clearly one of the "softer" criteria, but experience shows it is an essential one to include in the assessment. The expert draws here upon both knowledge of human nature and knowledge of how clinical entities (clinics, hospital wards, emergency rooms) function.

The expert must often familiarize himself/herself with the relevant geography or architecture, by description, drawing, or actual visit. Such observation should usually be supplemented by interviews of the clinician to determine usual policies and these, too, should be corroborated by other staff.

A patient claimed extended sexual liberties had occurred in an examining room on a ward. The expert fantasied a private room with a closed and possibly lockable door. A direct visit revealed instead that the "room" was a curtained-off bed in an open area behind the nursing station, into which nurses routinely burst without warning to obtain charts. For

the doctor to attempt anything in that site would have been ludicrous.

Sometimes the plausibility issue involves the therapist's spouse. This context must be scrutinized with some care, since there is a recognized dynamic of exploiting therapists to contrive sexual activity when the spouse is nearby or might appear suddenly; this appears to add excitement to the illicit actions. In most situations, however, the spouse's potential presence is a deterrent and may constitute an implausibility factor.

A psychiatrist's wife was working in his office under her maiden name; the relationship was not known to the patient. The psychiatrist would ask his wife or a secretary to stay until after this often-intoxicated patient had left. The office itself was separated by a thin and poorly soundproofed partition from a chart area where the doctor's wife or any of the staff might silently and unexpectedly be present. Since the patient could not be relied on not to make noises during sexual contact, the situation as a whole rendered implausible the patient's claims of extensive sexual activity in that office.

Note in this particular instance that the request that others stay until the patient leaves is utterly at odds with contrivance to have covert sexual contact. In a similar fashion some authorities (e.g., Rutter<sup>5</sup>) have noted the exploiting therapist's ability to "select" a victim for compliance and keeping secrets. The converse consideration may be a plausibility factor, as when the patient (from the above example) was known to drink to intoxication frequently and to harangue anyone who would listen with an account of her troubles—a totally self-destructive choice of victim, from the

viewpoint of the therapist concerned with concealment.

In some cases the description of the sexual activity appears to represent the patient's "ideal fantasy" but to appear to offer little exploitative gratification to the accused therapist.

A borderline patient with marked conflict over genital sexuality accused her therapist of numerous sexual contacts. According to the patient these consisted of the patient simply being held by the therapist on the couch for the whole session. Both parties had all clothes on, no sexual touching or other activity was claimed. Clearly for the patient this was an ideal sexual relationship: pregenital, holding, without any adult demands. The expert was left with the question as to what gratification supposedly accrued to the therapist from this fairly dull scenario, undertaken, moreover, at risk of his career and reputation.

The expert must factor in the question of whether the alleged abusing therapist is the "lovesick" type described by Gabbard.<sup>6</sup> Infatuated therapists may well act against their own interests and are not as circumspect as the more purely exploitative or psychopathic abusers. Such clinical data on the therapist may not be available to the expert by any channel, of course.

Plausibility factors may be very subtle (and for this reason, as with all the criteria, should never be weighed in isolation from the other factors):

A mildly demented, not very intelligent, and unattractive patient (the last, indeed, a very subjective element but one not to be dismissed out of hand) brought a claim for sexual misconduct against her internist before the Board. The internist was about 20 years younger, married to a bright, professional woman. The patient on interview repeatedly stressed how the physician was smitten with her, confided in her, consulted her, depended on her, valued

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her opinion even on technical matters, etc. In conjunction with other implausibilities, it gradually became clear that the case was a highly unusual presentation of erotomania, manifesting as a false accusation of sexual misconduct. I speculated that the complaint served the intrapsychic goal of giving validity to the delusion.

### *Ability to Describe Therapist's*

**Body** The point of this criterion is self-evident, but requires a fact situation in which the patient has seen the clinician naked, by daylight or with lights on. Can the patient correctly identify scars, tattoos, distribution of body hair, or other distinguishing marks? Is the therapist circumcised or not? Can the patient identify types of underwear (T-shirt versus tank-top style undershirt, boxers versus briefs, etc.) or jewelry (e.g., neck chains) that is not visible under clothing? Here the spouse may have to testify about the therapist's regular pattern of dress. Recall, however, that most people are poor observers under most circumstances, perhaps worse under conditions of intense affect.

**History of Deception, Lying, Fraud** Clearly this criterion is usually more easily satisfied in relation to the patient, whose often extensive medical records may reveal various forms of fraudulence. The role of pathological lying in borderline pathology has been elsewhere noted.<sup>3, 7</sup> Regardless, in the service of a balanced assessment, the forensic clinician is obligated to consider equally the accused treater's background for evidence of fraudulent conduct, deception, or perjury during various forms of discovery under oath in the instant case.

### *Empirical Comparison with Other*

**Cases** This criterion represents simply the experience factor for the expert. As one's caseload increases, repetitive patterns emerge. A given case's congruence or incongruence with these patterns may provide useful orienting information. Many of the above examples have been laced with normative comments, indicating the relevance of common patterns.

## Is There a Defense?

It should be apparent that there is no absolute defense against a false accusation: all clinicians are potentially vulnerable. Two approaches offer some grounds for cautious optimism: consultation and context defenses.

I recommend that the clinician begin presenting to an appropriate supervisor any case in which the transference appears to heat up, that is, becomes erotized.<sup>4, 8</sup> In addition to the usual supervisory and consultative benefits, this may offer some defense to a false claim. Context defenses refer to more inchoate but equally important patterns of practice: thoroughgoing professionalism in all areas of one's practice, absence of any boundary violations in one's treatment, and absence of any allegations against one of sexual harassment. While the last element, as representing most commonly a workplace issue, may seem to have no substantive connection with misconduct during therapy, plaintiffs' attorneys may attempt to emphasize such a history as an ostensible sign of a boundary problem in the clinician.

### Summary Recommendations

Just as all forensic evaluations should consider malingering in the differential for completeness, so too the expert consulting on either side in a case of sexual misconduct should entertain the possibility that the accusation is false and perform a full and balanced assessment. As always, one's data base and reasoning should be candidly described, in a report or on cross-examination. The question of truth or falsity may be ultimately unanswerable; ultimate credibility is the business of the fact finder. The approaches outlined here are intended to give the expert some orientation in this complex and challenging assessment.

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