

Subsequent Therapist Syndrome* Are We Our Worst Enemy?

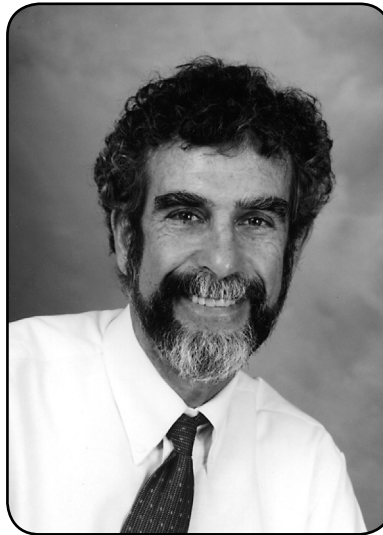
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— Ofer Zur

"Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices." (APA Code of Ethics, 2002)

The "Subsequent Therapist Syndrome" refers to those circumstances where the subsequent (current, next or new) psychotherapist, may act unethically or even illegally when providing an "expert opinion" regarding a former therapist's (supposedly) unethical or illegal conduct. These are the cases where the subsequent therapist's evaluation and judgment are solely based on their theoretical bias or rigid view of therapeutic boundaries, as well as on the client's self-report, without reviewing the psychotherapy records of the former therapist, interviewing the former therapist, or reviewing other relevant collateral evidence. I coined the term "Subsequent Therapist Syndrome" to identify situations where, regrettably, self-righteous mental health practitioners are eager to tell their current client that their former therapist acted unethically or illegally, just because the former therapist used different approaches, methodologies or interventions than the ones the subsequent-current therapist subscribes. While some subsequent therapists respond to clients' complaints about their former therapists others, in fact, put the fire under the clients, who do not have any negative evaluation of their past therapy expertise, by telling them about the wrongs of the former therapists.

Psychotherapists, as a group, have not been known to be highly tolerant or flexible (Zur, 2005). In spite of the token commitment to individual differences and cultural diversity, psychotherapists often fail to acknowledge or say, "I would have approached this situation differently;" "The theoretical orientation to which I subscribe would not endorse such interventions;" or simply saying "I disagree" but instead often say "It is inappropriate" or "It is unethical." Instead of saying "I really don't have a basis on which to form an opinion on the matter" they say "It is illegal" or "It is substandard care."



In his excellent article *Victimized by Victims*, Williams (2000) wrote:

"Psychotherapists have firm opinions regarding what constitutes appropriate and effective treatment, and they disagree with each other. Much of the time, such disagreement is carried out in a context of mutual respect—or at least with a sense that practitioners who see the field in vastly different terms from each another have every right to do so. Sometimes, though, such disagreements become more acrimonious, and they may be couched in terms of ethics. For example, a psychoanalyst may deeply believe that the cognitive-behavior therapist who previously treated a given patient both

misdiagnosed the problem and engaged in ineffective treatment that was both superficial and misleading. Similarly, a cognitive-behavior therapist might consider the previously treating psychoanalytic therapist to have been a charlatan who raked in large sums of money while keeping the patient dependent on unnecessarily long-term and unfocused treatment.

When such theoretical disagreements are communicated to the patient, they may give rise to ethics complaints or civil suits. For example, humanistic and behavioral practitioners may view therapeutic "boundaries" differently from their psychoanalytic counterparts (e.g., see Williams, 1997). The humanist who invites patients to his or her home for social events, who carries out weekend marathon group therapy, which includes use of a hot tub, and whose treatment involves a strong spiritual component, might be viewed as grossly unethical by more conservative peers. If one of these peers becomes a subsequent provider of psychotherapy to a given patient, that patient may be inculcated with the new provider's belief system. A given patient may not know that our field is often filled with controversy and that reasonable people might have very strong disagreements with neither side being "correct." Instead, the patient may come to the conclusion that the previous therapist engaged in practices that were universally held to be unethical if not criminal." (p. 80)

*While this short paper describes a serious, destructive professional phenomenon among psychotherapists and counselors, the term 'Subsequent Therapist Syndrome' that I coined, is somewhat tongue-in-cheek.

In my forensic and expert witness work, over the years, I have come across numerous times when subsequent therapists condemned a legitimate, effective and ethical intervention by a former therapist, just because they do not employ such interventions themselves. Following are a few examples where I have reviewed cases when subsequent therapists labeled as inappropriate or unethical, conduct such as when the former therapist;

- used ethical and clinically effective physical touch to soothe a distressed client;
- made a clinically appropriate home visit to an agoraphobic client;
- used clinically beneficial, extensive disclosure of personal information with a client;
- texted extensively with a young suicidal client late into the night;
- was engaged in an ethical and helpful bartering arrangement with a cash-poor but art-rich proud client;
- signed an e-mail to long-term-intermittent client of 20 years with "Love, xxx"
- went for a walk on a near by trail with a client who loves the open door environment, feel claustrophobic in the office or prefer side-by-side type communication;
- was involved in unavoidable, common, social, multiple relationships in a small town.

The Subsequent Therapist Syndrome (STS)

At least five (5) of the following ten (10) symptoms must be present in order to make an assessment of STS

1. Subsequent Therapist (ST) arrives at negative assessment of former therapy based solely on client's self-reporting, without having the data to support it.
2. ST unquestionably accepts client's self-reporting regarding the former therapy at face value, believing it to be true, complete, accurate, and valid.
3. ST's disapproval of the former therapist is based on the ST's own theoretical or other biases.
4. ST's disapproval of the former therapist's conduct is based on the ST's or on an inflexible, narrow, and misinformed view of therapeutic boundaries.
5. ST tends to be self-righteous and see him/herself as righteous and ethically superior, as well as a rescuer and savior.
6. ST tends to ignore the fact that false accusations by clients are not uncommon.
7. ST does not seem to be aware that they have a strong theoretical orientation bias and uncompromising view that their therapeutic approach is superior to all others.
8. ST fails to say, "I, respectfully, disagree" and instead claims, "This is unethical and wrong."
9. ST strongly encourages and often insists that client

files a licensing board complaint or malpractice suit against the former therapist.

10. ST goes beyond the role of therapist or clinician and enters into ill-advised and, likely, unethical forensic dual relationships when writing reports, consulting with client's attorney, giving interviews to the licensing boards' investigators, providing depositions, or testifying in courts regarding their assessment of prior therapist's clinical care and whether client suffered any harm as a result of the former therapist's substandard care.

While psychotherapists have the clear duty to protect the public from incompetent, predatory and harmful therapists, they also must be very careful in drawing premature or unsubstantiated conclusions that are solely based on a client's self-report. Rather than giving a conclusive "expert opinion" about the former therapist's conduct, a concerned and prudent therapist can tell clients something such as:

If what you told me is correct, I am very concerned about the conduct of your former therapist. However, I am aware that I only have one side, your side, of the story and I really don't have a basis on which to form a conclusive opinion on the matter. Nevertheless, if true, here are your options . . . What would you like to do about it?"

If psychotherapists hear about a potential situation of sexual misconduct, in the state of California, for example, they must also give the client the pamphlet of *Professional Therapy Never Involved Sex*, which informs the clients about their rights and their therapists' responsibilities. It should be clear that the therapist's role is neither that of investigator or facts-finder, nor of judge or jury.

In my career as an expert witness, I have seen many subsequent therapists who took on the savior-rescuer role, and based on their theoretical bias or rigid view of therapeutic boundaries and/or the client's negative self-report, passionately condemned the former therapist, told the client to file a board complaint and a malpractice suit and/or reported the therapist themselves to the licensing boards, only to be accused of similar charges by the same client at a later date. To make matters worse, some subsequent therapists enter into ill-advised forensic multiple relationships as experts, as well as treaters, when they write a report or testify in court regarding the damage done to the client by the former therapist. The psychotherapist's or counselor's role is that of patient advocate, which often presents irreconcilable conflict with the more objective-evaluative role of a forensic expert, whose job is to assess harm or damage (Eisner, 2010. Zur, 2009, 2010, 2011). As a result, serving as both a treating therapist and an expert witness may be an improper multiple relationship. Forensic and therapeutic roles are gener-

ally considered incompatible by several professional organizations' codes of ethics, because psychotherapists are generally biased in favor of their clients. Forensic experts are committed to a truthful, objective and unbiased reporting to the court.

Another potential area of unethical conduct is when therapists testify as expert witnesses regarding harm, when they neither conducted a thorough investigation regarding harm, nor are experts in harm assessment, which may mean that they unethically operated outside their scope of expertise.

The hope is that this article will help psychotherapists become more reflective and thoughtful about concerns they may have, regarding a former therapist's conduct. The intention of the article is to help psychotherapists be more aware of their biases, and use better judgment and wording when they help clients sort out their evaluation of former therapists. It is important that psychotherapists protect the public from incompetent or predatory professionals, but this must be done in an ethical, rational and conscientious way so that psychotherapists cease being their own worst enemies.

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Ofer Zur, Ph.D. is Director of the Zur Institute. His web site address is www.zurinstitute.com and correspondence regarding this article may be addressed to him at droferzur@zurinstitute.com

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