

On Wearing Two Hats: Role Conflict in Serving as Both Psychotherapist and Expert Witness

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***Objective:** This article explores the clinical, legal, and ethical problems that typically occur when a psychotherapist serves as both a treating clinician and forensic evaluator (or expert witness) in the same case. **Method:** The professional literature, ethics codes, opinion surveys, and the changing economic and institutional contexts of psychotherapy are reviewed in order to identify obstacles to widespread recognition of this straightforward ethical issue. The processes of psychotherapy and forensic evaluation are then analyzed so as to reveal fundamental incompatibilities between the psychotherapist's clinical and legal functions. **Results:** Attempting to treat and evaluate the same person typically creates an irreconcilable role conflict. This role conflict manifests itself in different conceptions of truth and causation, different forms of alliance, different types of assessment, and different ethical guidelines. **Conclusions:** Although circumstances sometimes compel a practitioner to assume the dual role of treater and evaluator, the problems that surround this practice argue for its avoidance whenever possible.*

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Should psychotherapists serve as expert witnesses for their patients? Psychotherapists of all disciplines need to confront the potential clinical, legal, and ethical problems involved in combining the roles of treating clinician and forensic evaluator. As clinicians find themselves drawn into proliferating, often ambiguously defined contacts with the legal system, clarity in role definitions becomes crucial.

DEFINITIONS

The term "therapist" refers to a clinician hired by the patient or the patient's family to provide psychotherapy; therapists treat "patients" or "clients." A "fact witness" testifies as to direct observations that he or she has made; a fact witness does not offer expert opinions or draw conclusions from the reports of others. Thus, a therapist who serves as a fact witness testifies as to

observations of the patient during therapy and the immediate conclusions (such as diagnosis and prognosis) drawn from those observations. These conclusions are offered not as an opinion but simply as a report of what the therapist thought, did, and documented during therapy.

An "expert witness" (who may also act as a forensic consultant) is a paid consultant who chooses to become involved in the case and is retained by an attorney, judge, or litigant to provide evaluation and testimony to aid the legal process. Unlike a fact witness, an expert may offer opinions about legal questions. This role typically involves participation in a trial. Forensic experts deal with "examinees" or "valuees" rather than with patients or clients. They do not attempt to form a doctor-patient relationship with their subjects.

COMMON SCENARIOS

Several common scenarios may prompt a clinician to wear the two hats of treater and expert on behalf of the same person. A patient may have suffered a traumatic incident (such as a criminal assault or an automobile accident) during or before therapy, and litigation may ensue. A patient may become involved in child custody litigation. A referral may come from an attorney osten-

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sibly seeking treatment for a client but actually seeking to document psychiatric damages or obtain favorable testimony in a custody dispute. An individual may be referred by an attorney to a single clinician for both treatment *and* forensic evaluation because the attorney is simply unaware of the incompatibility of these two procedures. Finally, there may be only one practitioner available to provide both psychotherapy and forensic services.

Role conflict may not be immediately apparent to attorneys, patients, or clinicians. Attorneys may believe that by enlisting the treating clinician as a forensic expert, they are making efficient use of the most knowledgeable source of information. After all, who is closer to the patient than his or her own therapist? Moreover, current ethical opinions of the American Medical Association state, "If a patient who has a legal claim requests a physician's assistance, the physician should furnish medical evidence" (1). The attorney may also want to save money: "Why bring in a new person, who probably charges even higher fees than the treating psychotherapist, for an evaluation the therapist can easily perform?" The patient, too, may object to a separate forensic evaluation: "Why must I repeat a painful story, and to someone I don't already know and trust?" The therapist, in the throes of countertransference (2) as well as anxious to spare the patient needless suffering, may readily endorse this reasoning. Clinicians who lack forensic training may think it natural to extend the mission of supporting the patient in therapy to advocating for the patient in court.

THE CORE CONFLICTS

It is prudent for clinicians to resist both the external pressures emanating from the attorney or patient or both and the internal pressures from the therapist's felt allegiance to the patient. The legal process is directed toward the resolution of disputes; psychotherapy pursues the medical goal of healing. Although these purposes need not always be antithetical and may even be congruent, the processes themselves typically create an irreconcilable role conflict.

In essence, treatment in psychotherapy is brought about through an empathic relationship that has no place in, and is unlikely to survive, the questioning and public reporting of a forensic evaluation. To assume either role in a particular case is to compromise one's capacity to fulfill the other. This role conflict, analyzed in detail later in this article, manifests itself in different conceptions of truth and causation, different forms of alliance, different types of assessment, and different ethical guidelines (3). Therefore, although circumstances may make the assumption of the dual role necessary and/or unavoidable, the problems that surround this practice argue for its avoidance whenever possible.

Writing in 1984, Miller (4) noted that concern about this form of dual relationship "has seldom appeared in the literature" (p. 826). Even now, it is remarkable how

little critical attention this major ethical issue has received, even in articles and texts purporting to offer comprehensive expositions of the ethics of forensic practice (5). A brief review of the professional literature shows the need for a more definitive analysis.

HISTORICAL OVERVIEW—A SLOWLY EMERGING ISSUE

Role conflict has come to preoccupy the psychotherapeutic professions as the legal, economic, and social ramifications of their work have multiplied. An early expression of this concern was Stanton and Schwartz's exploration of the therapist-versus-administrator dilemma (6). In the 1970s the term "double agent," both in psychotherapy (7) and in medicine (8), came to signify the clinician's joint responsibilities to the patient and the state.

These early critiques, however, generally neglected to ask whether the evaluatee's treating therapist is the right person to perform a forensic evaluation. Even in the early forensic psychiatric literature, clear linguistic distinctions between a forensic and a clinical examination (9) and between a forensic evaluatee and a patient (10) were not always maintained. As late as 1987, a major textbook on forensic evaluation (11) did not directly address the treater-as-expert question.

An emerging emphasis on separating the clinical and legal roles was articulated in Stone's 1983 advice to therapists who learn that a patient may have been sexually abused by another therapist (12). Stone recommended that the therapist discharge the ethical responsibilities of confidentiality and neutrality by engaging a consultant to pursue legal and administrative remedies on the patient's (and the public's) behalf. The following year, Halleck made the most explicit mention to date of the treater/expert role conflict in the literature on the double agent (13). Since then, a few clear warnings about such role conflict have appeared in the literature of forensic psychiatry (14, 15) and forensic psychology (16), but these have been oases in a desert.

Ethics Codes

The problematic treater/expert relationship differs from the dual relationships commonly proscribed in ethics codes of professional organizations (17) in that it represents a conflict between two professional roles rather than between a professional and a nonprofessional one. This particular role conflict is addressed most directly by the American Academy of Psychiatry and the Law in its *Ethical Guidelines for the Practice of Forensic Psychiatry*:

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 (18).

Sound as they are, these guidelines not only lack detailed elaboration, but are unenforceable, since the American Academy of Psychiatry and the Law refers ethics complaints to APA, which has not adopted the Academy's ethical guidelines. APA has, however, issued a comparable position statement with respect to employment-related psychiatric examinations (19).

For psychologists, the ethical boundary is less sharply drawn. The American Psychological Association's code of ethics (20) allows psychologists to serve simultaneously as consultant or expert and as fact witness in the same case, provided that they "clarify role expectations" (p. 1610). Guidelines developed specifically for forensic psychologists by the American Psychology-Law Society and Division 41 of the American Psychological Association (21) address the "potential conflicts of interest in dual relationships with parties to a legal proceeding" (p. 659). These guidelines, however, allow broader latitude than those of the American Academy of Psychiatry and the Law.

Surveys of Forensic Psychiatrists

Surveys of forensic psychiatrists' ethical concerns reveal a surprising lack of consensus on the treater/expert role conflict. In a 1986 survey of forensic psychiatrists who belonged to the American Academy of Forensic Sciences, two-thirds considered "conflicting loyalties" a significant ethical issue, yet only three of 51 respondents specifically mentioned the treater/evaluator role conflict (22). In 1989, with the ethical guidelines of the American Academy of Psychiatry and the Law recently in place, members of both the American Academy of Forensic Sciences and the American Academy of Psychiatry and the Law rated the treater/expert scenario least significant among 28 potential ethical problems listed (23). (Only 14.5% of the members of the American Academy of Forensic Sciences perceived this situation to represent an ethical problem, while 71.0% did not.)

In 1991, among 12 controversial ethical guidelines proposed for consideration, members of the American Academy of Psychiatry and the Law gave least support to extending the Academy's warning against performing forensic evaluations on current patients to include former patients as well (24). The authors of the survey attributed this opposition, as well as continuing disagreement even about the impropriety of evaluating current patients, to a "recognition of the dual treater-evaluator role sometimes being both necessary and appropriate" (p. 245). Thus, during the past decade, any increased scrutiny of this dual role has confronted the reasoning that "multiple agency and a balancing of values have become a necessary part of all current psychiatric practice, not only for forensic psychiatry" (p. 246).

CONTEXTS AND COMPLICATIONS

The resistance of highly trained specialists to such an ethical principle becomes understandable when

set against the changing landscape of psychotherapy. Limited reimbursements are making extended psychodynamic exploration a luxury. Moreover, with many patients' problems being seen as manifestations of extrapsychic (environmental, institutional, economic, legal, or political) conditions, the therapist is becoming a social worker, mobilizing resources on the patient's behalf; a gatekeeper, unlocking the doors of managed care; a detective, obtaining useful information; or an agent of social control, protecting others from the patient. The therapist, thus placed in an advocate's or case manager's role, is expected to influence external outcomes rather than simply accompany the patient on an inner exploration.

Mental health services today are commonly delivered in public institutions (such as state hospitals and prisons) where therapists are accountable to society as well as to the patient. In these settings confidentiality may be breached from the outset, and therapy often has a built-in forensic component. Even private psychotherapy takes on a forensic dimension in the case of reportable offenses or threats to third parties. To some degree, then, the treater/expert role conflict has become incorporated into the therapist's job description. "Pure," disinterested psychotherapy is compromised as legal, economic, and social responsibilities multiply and fewer clinicians really practice independently. More and more, the therapist is working for institutions, corporations, and society.

Given these conditions, rigorous separation of the treater and evaluator roles in public practice has been called unworkable and even inadvisable (25). Nonetheless, a strong reaffirmation of role clarity is still called for, especially in light of an epidemic of aggressive legal advocacy by therapists. The proliferation of cases of "recovered memory," for instance, with their dubious methodologies and controversial outcomes, shows that some therapists are losing sight of the essential distinction between subjective experience and historical reconstruction (26). These therapists, perhaps driven by unexamined countertransference (2), step out of role when they urge their patients to take to court issues that might better be resolved in therapy.

For didactic clarity, the following discussion is cast in the language of traditional psychotherapy. Nonetheless, it applies to many forms of psychiatric and psychological treatment, including psychopharmacological, behavioral, and cognitive therapies. Since questions of trust, rapport, and confidentiality enter into all clinical treatment, the evaluator's role of gathering and reporting information from multiple sources external to the dyad is always in conflict with the treater's role.

TRUTH AND CAUSATION

Clinical and forensic undertakings are dissimilar in that they are directed at different (although overlapping) realities, which they seek to understand in correspondingly different ways.

Psychic Reality Versus Objective Reality

The process of psychotherapy is a search for meaning more than for facts. In other words, it may be conceived of more as a search for narrative truth (a term now in common use) than for historical truth (27). Whereas the forensic examiner is skeptical, questioning even plausible assertions for purposes of evaluation (28), the therapist may be deliberately credulous, provisionally "believing" even implausible assertions for therapeutic purposes. The therapist accepts the patient's narrative as representing an inner, personal reality, albeit colored by biases and misperceptions. This narrative is not expected to be a veridical history; rather, the therapist strives to see the world "through the patient's eyes." Personal mythologies are reviewed, constructed, and remodeled as an individual reflects on himself or herself and his or her functioning.

Although the therapist withholds judgment and does not rush to reach (let alone impose) a conclusion, the ultimate goal is to guide the patient to a more objective understanding. Nonetheless, the achievement of insight, one of the principal goals of psychotherapy, is not a fact-finding mission and cannot be reliably audited by an external source. What emerges with insight often cannot be objectively corroborated, confirmed, or validated so as to meet legal standards of proof.

One possible consequence of the clinician's tactical suspension of disbelief in the patient's subjective reality is that a plaintiff's psychotherapist may fail to diagnose malingering (29). If the patient's agenda, conscious or unconscious or both, includes building a record for future court testimony, a psychotherapeutic goal will not be achieved, whether or not the therapist eventually testifies. Distortions of emphasis and a withholding of information, affect, and associations will likely compromise both the therapy and the testimony. Therefore, in cases that may have legal ramifications, the limits of the therapist's role with respect to forensic evaluations and court testimony should be made clear as part of the treatment contract. Of course, the therapist cannot always anticipate the litigable issues that may emerge in therapy or assume that an initial disclaimer will dispose of the patient's unconscious agendas.

Descriptive Versus Dynamic Approach

Whereas the treating clinician looks out from within, the forensic expert, who must adhere to an ethical standard of objectivity (18), looks in from outside. Thus, whereas the treater might appropriately take a psychodynamic perspective, with its emphasis on conflict and the role of the unconscious, the forensic evaluator's view is more likely to be a descriptive one. The objective/descriptive approach to psychiatry, with its emphasis on classification and reliable diagnosis, tends to be favored by forensic practitioners because the law is interested in categorization. Diagnosis A may be compensable or potentially exculpatory, while diagnosis B may not be.

This is not to say that the stereotypical forensic psy-

chiatrist, who reconstructs an individual's inner world (if at all) only from tangible (e.g., crime scene) evidence, is truly representative of this specialty. It may well be that forensic psychiatry is best practiced by those who can immerse themselves in the evaluatee's inner world and then exit that world with useful observations and testable hypotheses in a search for corroboration or lack of corroboration. For the most part, however, the law sees human beings as operating consciously, rationally, and deliberately (30). Although it allows for mental state defenses and gives selective attention to particular dynamic mechanisms, such as transference in sexual misconduct litigation (31), the law has little interest in the unconscious.

On the other side of the coin, although a therapist may have a high degree of confidence in a patient's clinical diagnosis, this determination is not to be confused with the forensic evaluator's effort to document an accurate historical reconstruction. A therapist must tolerate ambiguity to such a degree as to be often unable to answer a legal question with the "reasonable degree of medical certainty" (32) required of an expert opinion. To say, "I am reasonably certain that this person is presenting with posttraumatic stress disorder," is not to say, "It is my opinion, to a reasonable degree of medical certainty, that the trauma was caused by the sexual abuse she says she suffered at her father's hands." Equating these two statements is a damaging mistake that clinicians unfamiliar with the courts often make when they move into the legal arena.

THE NATURE OF THE ALLIANCE

The clinical and forensic situations differ with respect to the nature and purpose of the relationships formed within them. Involvement in litigation inevitably affects the empathy, neutrality, and anonymity of the clinician.

Psychological Versus Social Purpose

Like the psychotherapist and patient, the forensic evaluator and evaluatee jointly undertake a task. But the two tasks are not the same. In treatment, the purpose of the alliance is the psychological one of benefiting the patient by promoting healing and enlarging the sphere of personal awareness, responsibility, choice, and self-care. In the forensic context the purpose is the social one of benefiting society by promoting fair dispute resolution through the adversarial legal system. At its best, the forensic psychiatric evaluation has been characterized as sharing some qualities of a working alliance but only for the limited purpose of conducting the evaluation (28).

Because amelioration through civil law usually takes the form of financial compensation, the contrast between the two alliances is, in one sense, that of making whole psychologically versus making whole economically. These separate restitutions only sometimes overlap. The respective outcomes may also be thought of as insight versus justice, as changing primarily the internal

world rather than the external world. In the course of a therapeutic alliance the patient must often accept personal responsibility as a condition of change. This contrasts strongly with the plaintiff's quest to assign responsibility to others in order to achieve recompense, cost sharing, or equity—as well as vindication. In therapy, the patient frequently must learn to understand and forgive; these considerations are largely irrelevant to the forensic evaluatee and antithetical to the retributive thrust of litigation.

In building a treatment alliance the psychotherapist attempts to ally with that part of the patient that seeks to change, to give up psychopathological symptoms, and to resume or develop healthy adaptations (33). The perspective is future oriented; troubles should be ameliorated for a better, happier life. Entitlements may have to be discarded so that one can cope with everyday existence. One must accept that life is hard and often unjust and assume responsibility for one's role.

The forensic evaluator, on the other hand, may be allied with (or else opposed to) that part of the evaluatee which seeks concrete redress for injury, exculpation from responsibility, or avoidance of responsibility through a finding of incompetence. The evaluator's approach may emphasize psychopathology, in contrast to the normalizing approach of the psychotherapist. The attention paid to a psychopathological slice of past life, without any hope-giving search for renewal and remediation, may foster a depressive rather than an encouraging outlook.

People often bring legal action in the belief that it will be therapeutic and empowering. Sometimes it is, but it can also be traumatic. Moreover, the sense of entitlement fostered by an unremitting quest for justice tends to harden characterological defenses, thereby making constructive change more elusive. In such cases, litigation may be said to bring about a developmental arrest or regression antithetical to therapeutic growth. Given such risks, the proper role of a treating therapist is not to encourage a lawsuit or to be the patient's legal advocate. Rather, it is to assist the patient in deciding whether or not to bring suit and to provide support in going through the legal process, if that be the decision. The therapist ought to stand at the same distance from the lawsuit as from any other significant event in the patient's life.

Empathy

Empathy, when used as a therapeutic technique, enables the patient to feel understood and facilitates the achievement of insight. Contrary to stereotype, empathy is not necessarily absent from the forensic evaluation, since a skilled evaluator creates an atmosphere in which the evaluatee feels free to speak within the limits set by the absence of confidentiality (28). However, even the legitimate use of empathy can lead to a quasi-therapeutic interaction that ultimately leaves the evaluatee feeling betrayed by the evaluator's report (34).

The clinician's habit of empathic identification, if not balanced by objectivity, can bias a forensic evaluation

even in the absence of a treating relationship. Stone (35) argues, therefore, that forensic evaluators must be prepared to withdraw from the forensic role when a forensic evaluation turns into a therapeutic encounter. How much greater, then, the likelihood of bias in the case of a treating therapist, whose mission of promoting patient welfare calls for deliberate identification (at the risk of overidentification) with the patient.

Neutrality

Therapeutic neutrality (36)—that posture of helping the patient listen to himself or herself without critical judgment, and fostering self-knowledge through the emergence of hidden feelings and attitudes—is undermined when the clinician acts as a forensic consultant to the patient or attorney; judgmental assessments are inevitable in that role, and serious real-world consequences may turn on every utterance of the patient. The crucial therapeutic posture of expectant listener, to whom anything may be said without consequence or penalty, is compromised. Free access to the patient's inner world is impeded as each disclosure is weighed, not just against "What will she [or he] think of me?" but also "How will what I say affect the outcome of my case?" Neutrality vanishes as the therapist assumes the consultant's role of advocacy for an opinion supporting the patient's cause (37), a role assumed in the U.S. Supreme Court's *Ake* decision (38). Both patient's and therapist's rescue fantasies are activated, with their potential for idealization of the therapist and regression and infantilization of the patient. Patient autonomy and responsibility correspondingly diminish.

Anonymity

The anonymity of the psychotherapist, which aids in the development and interpretation of transference (39) and the mobilization of clinically useful projections onto the therapist, is clearly compromised by the legal process. Such anonymity, which may be a key to the residual attitudes of the patient's relationships with important figures in his or her past, is contaminated when the therapist steps out of the transference relationship and into the patient's present, external world. The patient who sees his or her therapist on the witness stand may have strong reactions, not only to the testimony itself, but to whatever is exposed about the clinician's professional background, character, or personal history. Problems also arise if the patient sees the therapist embarrassed by a vigorous and effective cross-examination. Will confidence and trust not be diminished by fears of the therapist's vulnerability?

ASSESSMENTS

Further incompatibilities between the roles of treater and expert become apparent when we consider how each obtains, evaluates, and interprets information. A clinical assessment is not the same as a forensic assessment.

Evidence Gathering and the Use of Collateral Sources

Therapeutic assessments tend to rely much less on collateral sources of information than do forensic evaluations. While spouses and other family members may be interviewed (with the patient's permission) as part of a clinical assessment—particularly for hospitalized or substance-abusing patients—a forensic evaluation routinely requires meticulous examination of multiple sources of information, such as medical, insurance, school, and occupational records, as well as interviews with family members, co-workers, employers, friends, police officers, and eyewitnesses. Such far-ranging scrutiny by a psychotherapist, especially in outpatient treatment, would be highly unusual. Indeed, were a therapist to seek external “truth” so diligently, the patient might well exclaim, “Doctor, don’t you believe me?”

In practice, forensic assessments may also include observing the evaluatee in the home, the workplace, the courtroom, and other nonclinical settings. Except in some types of couple or family therapy, comparable behavior by a psychotherapist would likely be perceived by the patient as highly intrusive (and hence destructive of confidence and trust) or as a therapeutic boundary violation (40).

Interview Strategies

Psychotherapists and forensic psychiatrists approach their patients/evaluatees with divergent interviewing strategies. The forensic psychiatrist begins with an explicit legal question to be answered by marshalling relevant psychiatric data (41). For the psychotherapist this external question would be a distraction from the patient's inner world and therapeutic goals. Moreover, the direct probing necessary for forensic evaluation is inconsistent with the “evenly hovering attention” (42, pp. 111–112) of the dynamic psychiatrist. Using an open-ended approach, the psychotherapist starts with the problem as perceived by the patient and proceeds to collect an associative anamnesis (43) intended to yield a dynamic understanding of the issues. The language of the therapist deliberately emulates that of the patient, who is encouraged to tell his or her own story in his or her own way.

In contrast, the forensic evaluator's gaining informed consent to the interview opens with a defining statement of purpose. While the forensic examiner's initial inquiries may be phrased open-endedly to encourage the interviewee's participation, the questioning becomes increasingly structured in keeping with implicit legal standards, if not the actual statutory issue and vocabulary. (In some jurisdictions, such as New York, the evaluatee is permitted to have a lawyer present, giving the interview the cast of a legal deposition rather than a clinical interview.) If such an examination is undertaken by the treating psychotherapist, it may well be experienced by the patient as a failure of empathy.

Psychological Defenses

Psychotherapy, the “talking cure,” requires that thoughts and feelings be put into words in order to effect change. While enactments of various past and present conflicts inevitably occur and, indeed, are often instructive when they can be explored, verbal communication is the mode of choice. In any psychotherapy, resistances and defenses may impede the work. Litigation tends to enhance these defensive maneuvers: it may provide a defense against experiencing affect or a distraction from considering meaningful aspects of the past. Thus, a therapist who is drawn into a patient's litigation is participating in an enactment or acting out.

Time

Time limitations also differentiate forensic from treatment evaluations, except for certain deliberately short-term therapeutic techniques. A sense of urgency and a need to move toward closure, while characteristic of managed care settings, are not inherent to traditional psychotherapy. Except in an emergency, the treating psychiatrist usually has some leeway to wait for material to emerge in its own time or to wait to intervene until the moment is right. The intrinsic schedule is that of the patient, not that of the court. The forensic specialist usually does not have this luxury. “Having one's day in court” requires respect for deadlines and inevitably leads to temporal closure, whether or not clinical end points have been reached.

ETHICAL GUIDELINES

Problems occur when the ethic of healing (doing “individual good”) collides with the ethic of objectively serving the legal system (doing “social good”). The following are some of the ethical dilemmas that arise when one attempts to serve one client in two arenas.

“First, Do No Harm”

The ethical dictum of *primum non nocere*, by which treating physicians are bound, does not apply directly in the courtroom (44). An evaluatee may suffer substantial harm from a forensic expert's testimony, not only through lost self-esteem, financial loss, or deprivation of liberty, but even through loss of life in capital sentencing. Moreover, the damage done by inadequate or ineffective testimony resulting from a therapist's incomplete understanding of the legal system may be financially as well as emotionally costly (45). Even when the testifying expert is a qualified forensic specialist, the experience of hearing one's intimate life revealed and analyzed in court may be exceedingly traumatic (46).

Mossman (47) opines that honest forensic evaluations and testimony, even when they do immediate harm to individuals, confer long-range benefits on all concerned (including those adversely affected) by up-

holding the fairness of the justice system. Nonetheless, that way of doing good is not part of the *treating* physician's role. A person who suffers harm from adverse or painful testimony should not suffer the additional pain of having that testimony emerge from a doctor-patient relationship.

Reimbursement

Another ethical issue arises when the psychotherapist goes to court. If a prognosis is offered that a patient will require long-term treatment, the therapist, as treater, stands to benefit directly from this statement (29). This financial stake in the outcome may destroy the credibility of the therapist's testimony. It places the therapist in the position of testifying for a built-in contingency fee, which is unethical for forensic psychiatrists (18) and forensic psychologists (21)—and, by extension, for treaters who testify.

Agency

Clear disclosure of whose "agent" one serves as—i.e., whom one is working for—is required in both the clinical and forensic arenas. Barring an emergency, including danger to others or "public peril," a therapist works only for the patient. Such an "agency statement" is usually implicit in a contract between psychiatrist and patient for individual psychotherapy (33). In the forensic context, however, the combined therapist/expert witness must serve two masters, the patient/examinee and the law. When the therapist thus blurs his or her role, the patient's claim to sole allegiance is compromised.

The biasing effect of agency on forensic evaluations, a matter of concern to forensic specialists (48), is called forensic identification—a process by which evaluators unintentionally adopt the viewpoint of the attorneys who have retained them (49). If agency biases forensic opinion, agency conflict, or double agency, must influence both the evaluator (therapist) and evaluatee (patient).

Confidentiality

The question of confidentiality goes hand in hand with that of agency. Who is listening? What will be revealed and where? The privacy of the consulting room, protected by law, is essential to frank communication during which a patient suspends self-judgment. In its *Jaffee v. Redmond* decision in 1996 (50), the U.S. Supreme Court gave unequivocal protection to the confidentiality of the psychotherapeutic relationship. Given the Court's reaffirmation of the primacy of therapeutic confidentiality, over and above other vital interests of society, clinicians would be unwise to compromise this right by carelessly crossing the boundary into the forensic arena.

A patient who puts his or her mental condition at legal issue and thereby waives privilege loses that privacy. Although the patient may consent to breaching

privacy for the purpose of litigation, the prior confidential relationship may be incapable of being restored after the litigation is over. Moreover, the patient's consent to reveal treatment records may not constitute informed consent to full disclosure in court to family members, the press, or curious bystanders (46). A warning that the adversarial discovery process may reveal closely held personal details may not address the full extent of the exposure that occurs and its emotional consequences.

These hazards of litigation are present whether or not the therapist actually testifies. If the therapist agrees to act as a forensic evaluator, the hazards intensify. While a treating therapist may sometimes successfully appeal to exclude intimate material because of its irrelevance, the forensic evaluator is less likely to be able to withhold anything learned in the course of an evaluation.

RISKS FOR THE CLINICIAN WHO ACTS IN A DUAL ROLE

At a time when forensic experts have been held liable for negligence in evaluation (51), the therapist who attempts to combine the roles of treating clinician and forensic evaluator embarks on especially treacherous waters. Even a clinician who testifies as a fact witness may find this seemingly unambiguous role compromised (50). In court, the fact witness may face pressure to give an expert opinion without receiving an expert witness's fee (52). Worse, a therapist whose factual testimony displeases the patient may later be charged with negligence for having failed to carry out the investigatory tasks of a forensic expert (53).

These problems are best avoided by offering the patient's treatment records in lieu of testimony. The clinician who does testify as a fact witness should rigorously maintain role boundaries by declining to perform the functions of an expert witness, such as reviewing the reports or depositions of other witnesses. A therapist who is asked to give expert testimony about a patient can respond to an attorney's request, a subpoena, or (at last resort) courtroom questioning with a disclaimer such as this: "Having observed the patient only from the vantage point of a treating clinician, I have no objective basis for rendering an expert opinion, with a reasonable degree of medical certainty, on a legal as opposed to a clinical question."

CAVEATS

1. *Ruling out this form of dual relationship is not meant to limit the expert role to a small group of specialists.* Any professional can serve as an expert witness within the limits of his or her expertise. A psychiatrist without specialized credentials in forensic psychiatry can still perform evaluations and testify as an expert in psychiatry.

2. *Separating the roles of treater and expert implies no denigration of clinical expertise.* "Expert witness" is a legal term that describes the particular role a person plays in the legal process. To insist that the role of an expert witness is incompatible with that of a treating clinician is not to imply that clinicians are any less expert in their own realm.

3. *Treating clinicians do have legitimate roles in legal proceedings.* Treating clinicians properly participate in certain legal determinations as part of their clinical responsibilities. For example, the assessment of competence to give informed consent to treatment is inherently part of the clinical interchange. Similarly, the clinician who petitions a court for involuntary commitment of a patient usually testifies as a fact witness—an involved party, a partisan for safety and patient health—about his or her observations of the patient during therapy. There is, however, an inherent ambiguity in this role in that legal conclusions are being reached on the basis of the testimony. Although the clinician's temporary assumption of an oppositional role in court for the patient's benefit may strain the therapeutic alliance, inpatient treatment can restore the patient's insight, so that the patient comes to understand why hospitalization was necessary and the treatment alliance can resume.

4. *Sometimes the dual role is unavoidable.* Institutional policies increasingly force clinicians to wear two hats with the same patient. Similarly, in commitment hearings and disability determinations the clinician may be drawn into a quasi-expert role. Geography can also be a limiting factor; in a small town or rural area there may be only one practitioner available with the requisite credentials to perform a forensic evaluation (54). Even in less than ideal circumstances, however, one should be vigilant to avoid compromising one's role, especially through unnecessary breaches of confidentiality (50).

CONCLUSIONS

The psychotherapist's wish to help the patient too often carries over into more direct, active forms of "helping" that (however well-motivated) are contrary to the therapeutic mission. In particular, a therapist's venturing into forensic terrain may be understood as a boundary violation that can compromise therapy as surely and as fatally as other, more patently unethical transgressions. For the numerous reasons detailed previously, such dual agency is unsound and potentially damaging both to the evaluatee/patient and to the evaluator/clinician. As the psychotherapist's role boundaries widen, there is a proportional increase in the intensity of ethical conflict and legal liability. Notwithstanding the growing pressures from the complex clinical/legal marketplace to perform simultaneously in multiple roles, two heads are better than one only if they really are two distinct heads, each wearing its own hat.

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