Ethics Packet

Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations

Introduction

There is increasing motivation among psychologists to understand culture and ethnicity factors in order to provide appropriate psychological services. This increased motivation for improving quality of psychological services to ethnic and culturally diverse populations is attributable, in part, to the growing political and social presence of diverse cultural groups, both within APA and in the larger society. New sets of values, beliefs, and cultural expectations have been introduced into educational, political, business, and health care systems by the physical presence of these groups. The issues of language and culture do impact on the provision of appropriate psychological services.

Psychological service providers need a sociocultural framework to consider diversity of values, interactional styles, and cultural expectations in a systematic fashion. They need knowledge and skills for multicultural assessment and intervention, including abilities to

- recognize cultural diversity;
- understand the role that culture and ethnicity/race play in the sociopsychological and economic development of ethnic and culturally diverse populations;
- understand that socioeconomic and political factors significantly impact the psychosocial, political, and economic development of ethnic and culturally diverse groups;
- help clients to understand/maintain/resolve their own sociocultural identification; and
- understand the interaction of culture, gender, and sexual orientation on behavior and needs.

Likewise, there is a need to develop a conceptual framework that would enable psychologists to organize, access, and accurately assess the value and utility of existing and future research involving ethnic and culturally diverse populations.

Research has addressed issues regarding responsiveness of psychological services to the needs of ethnic minority populations. The focus of mental health research issues has included

- the impact of ethnic/racial similarity in the counseling process (Acosta & Sheehan, 1976; Atkinson, 1983; Parham & Helms, 1981);
- minority utilization of mental health services (Cheung & Snowden, 1990; Everett, Proctor, & Cartmell, 1983; Rosado, 1986; Snowden & Cheung, 1990);
- relative effectiveness of directed versus nondirected styles of therapy (Acosta, Yamamoto, & Evans, 1982; Dauphinais, Dauphinais, & Rowe, 1981; Lorion, 1974);
- the role of cultural values in treatment (Juarez, 1985; Padilla & Ruiz, 1973; Padilla, Ruiz, & Alvarez, 1975; Sue & Sue, 1987);
- appropriate counseling and therapy models (Comas-Diaz & Griffith, 1988; McGoldrick, Pearce, & Giordano, 1982; Nishio & Bilmes, 1987);
- competency in skills for working with specific ethnic populations (Malgady, Rogler, & Costantino, 1987; Root, 1985; Zuniga, 1988).

The APA's Board of Ethnic Minority Affairs (BEMA) established a Task Force on the Delivery of Services to Ethnic Minority Populations in 1988 in response to the increased awareness about psychological service needs associated with ethnic and cultural diversity. The populations of concern include, but are not limited to, the following groups: American Indians/Alaska Natives, Asian Americans/Pacific Islanders, Blacks/African Americans, and Hispanics/Latinos. For example, the populations also include recently arrived refugee and immigrant groups and established U.S. subcultures such as Amish, Hasidic Jewish, and rural Appalachian people.

The Task Force established as its first priority development of the Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations. The guidelines that follow are intended to enlighten all areas of service delivery, not simply clinical

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or counseling endeavors. The clients referred to may be clients, organizations, government and/or community agencies.

Guidelines

Preamble: The Guidelines represent general principles that are intended to be aspirational in nature and are designed to provide suggestions to psychologists in working with ethnic, linguistic, and culturally diverse populations.

1. Psychologists educate their clients to the processes of psychological intervention, such as goals and expectations; the scope and, where appropriate, legal limits of confidentiality; and the psychologists' orientations.

a. Whenever possible, psychologists provide information in writing along with oral explanations.

b. Whenever possible, the written information is provided in the language understandable to the client.

2. Psychologists are cognizant of relevant research and practice issues as related to the population being served.

a. Psychologists acknowledge that ethnicity and culture impact on behavior and take those factors into account when working with various ethnic/racial groups.

b. Psychologists seek out educational and training experiences to enhance their understanding and thereby address the needs of these populations more appropriately and effectively. These experiences include cultural, social, psychological, political, economic, and historical material specific to the particular ethnic group being served.

c. Psychologists recognize the limits of their competencies and expertise. Psychologists who do not possess knowledge and training about an ethnic group seek consultation with, and/or make referrals to, appropriate experts as necessary.

d. Psychologists consider the validity of a given instrument or procedure and interpret resulting data, keeping in mind the cultural and linguistic characteristics of the person being assessed. Psychologists are aware of the test's reference population and possible limitations of such instruments with other populations.

3. Psychologists recognize ethnicity and culture as significant parameters in understanding psychological processes.

a. Psychologists, regardless of ethnic/racial background, are aware of how their own cultural background/experiences, attitudes, values, and biases influence psychological processes. They make efforts to correct any prejudices and biases.

Illustrative Statement: Psychologists might routinely ask themselves, "Is it appropriate for me to view this client or organization any differently than I would if they were from my own ethnic or cultural group?"

b. Psychologists' practice incorporates an understanding of the client's ethnic and cultural background. This includes the client's familiarity and comfort with the majority culture as well as ways in which the client's culture may add to or improve various aspects of the majority culture and/or of society at large.

Illustrative Statement: The kinds of mainstream social activities in which families participate may offer information about the level and quality of acculturation to American society. It is important to distinguish acculturation from length of stay in the United States and not to assume that these issues are relevant only for new immigrants and refugees.

c. Psychologists help clients increase their awareness of their own cultural values and norms, and they facilitate discovery of ways clients can apply this awareness to their own lives and to society at large.

Illustrative Statement: Psychologists may be able to help parents distinguish between generational conflict and culture gaps when problems arise between them and their children. In the process, psychologists could help both parents and children to appreciate their own distinguishing cultural values.

d. Psychologists seek to help a client determine whether a "problem" stems from racism or bias in others so that the client does not inappropriately personalize problems.

Illustrative Statement: The concept of "healthy paranoia," whereby ethnic minorities may develop defensive behaviors in response to discrimination, illustrates this principle.

e. Psychologists consider not only differential diagnostic issues but also the cultural beliefs and values of the client and his/her community in providing intervention.

Illustrative Statement: There is a disorder among the traditional Navajo called "Moth Madness." Symptoms include seizure-like behaviors. This disorder is believed by the Navajo to be the supernatural result of incestuous thoughts or behaviors. Both differential diagnosis and intervention should take into consideration the traditional values of Moth Madness.

4. Psychologists respect the roles of family members and community structures, hierarchies, values, and beliefs within the client's culture.

a. Psychologists identify resources in the family and the larger community.

b. Clarification of the role of the psychologist and the expectations of the client precede intervention. Psychologists seek to ensure that both the psychologist and client have a clear understanding of what services and roles are reasonable.

Illustrative Statement: It is not uncommon for an entire American Indian family to come into the clinic to provide support to the person in distress. Many of the healing practices found in American Indian communities are centered in the family and the whole community.

5. Psychologists respect clients' religious and/or spiritual beliefs and values, including attributions and taboos since they affect world view, psychosocial functioning and expressions of distress.

a. Part of working in minority communities is to become familiar with indigenous beliefs and practices and to respect them.

Illustrative Statement: Traditional healers (e.g., shamans, curanderos, espiritistas) have an important place in minority communities.

b. Effective psychological intervention may be aided by consultation with and/or inclusion of religious/spiritual leaders/practitioners relevant to the client's cultural and belief systems.

6. Psychologists interact in the language requested by the client and, if this is not feasible, make an appropriate referral.

a. Problems may arise when the linguistic skills of the psychologist do not match the language of the client. In such a case, psychologists refer the client to a mental health professional who is competent to interact in the language of the client. If this is not possible, psychologists offer the client a translator with cultural knowledge and an appropriate professional background. When no translator is available, then a trained paraprofessional from the client's culture is used as a translator/culture broker.

b. If translation is necessary, psychologists do not retain the services of translators/paraprofessionals who may have a dual role with the client, to avoid jeopardizing the validity of evaluation or the effectiveness of intervention.

c. Psychologists interpret and relate test data in terms understandable and relevant to the needs of those assessed.

7. Psychologists consider the impact of adverse social, environmental, and political factors in assessing problems and designing interventions.

a. Types of intervention strategies to be used match the client's level of need (e.g., Maslow's hierarchy of needs).

Illustrative Statement: Low income may be associated with such stressors as malnutrition, substandard housing, and poor medical care; and rural residency may mean inaccessibility of services. Clients may resist treatment at government agencies because of previous experience (e.g., refugees' status may be associated with violent treatments by government officials and agencies).

b. Psychologists work within the cultural setting to improve the welfare of all persons concerned, if there is a conflict between cultural values and human rights.

8. Psychologists attend to, as well as work to eliminate, biases, prejudices, and discriminatory practices.

a. Psychologists acknowledge relevant discriminatory practices at the social and community level that may be affecting the psychological welfare of the population being served.

Illustrative Statement: Depression may be associated with frustrated attempts to climb the corporate ladder in an organization that is dominated by a top echelon of White men.

b. Psychologists are cognizant of sociopolitical contexts in conducting evaluations and providing interventions; they develop sensitivity to issues of oppression, sexism, elitism, and racism.

Illustrative Statement: An upsurge in the public expression of rancor or even violence between two ethnic or cultural groups may increase anxiety baselines in any member of those groups. This baseline of anxiety would interact with prevailing symptomatology. At the organizational level, the community conflict may interfere with open communication among staff.

9. Psychologists working with culturally diverse populations should document culturally and sociopolitically relevant factors in the records. These may include, but are not limited to

a. number of generations in the country
b. number of years in the country
c. fluency in English
d. extent of family support (or disintegration of family)
e. community resources
f. level of education
g. change in social status as a result of coming to this country (for immigrant or refugee)
h. intimate relationship with people of different backgrounds
i. level of stress related to acculturation.

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LMFTs DO NOT REPORT DOMESTIC VIOLENCE

By Zachary Pelchat
Legislative Counsel

Licensed Marriage and Family Therapists are not mandated reporters of domestic violence. If an LMFT reports domestic violence, it is a breach of confidentiality, regardless of the work setting or employer. As reported in the November/December 1994 issue of *The California Therapist,* LMFTs are not to report domestic violence, even though there still seems to be confusion about this subject in practice.

California Penal Code §11160(a) states that a health practitioner who is providing medical services for a **physical condition** is a mandated reporter. LMFTs do not provide services for physical conditions. Therefore, LMFTs do not report domestic violence. There is no exception for LMFTs in settings where physical health treatment is provided. There is no exception for LMFTs even if your employer has a different policy. No local policy of any agency or county takes precedence over state law.

California Penal Code §11160 reads as follows:

11160. (a) Any health practitioner employed in a health facility, clinic, physician's office, local or state public health department, or a clinic or other type of facility operated by a local or state public health department who, in his or her professional capacity or within the scope of his or her employment, provides medical services for a physical condition to a patient whom he or she knows or reasonably suspects is a person described as follows, shall immediately make a report in accordance with subdivision (b):

(1) Any person suffering from any wound or other physical injury inflicted by his or her own act or inflicted by another where the injury is by means of a firearm.

(2) Any person suffering from any wound or other physical injury inflicted upon the person where the injury is the result of assaultive or abusive conduct.

(b) Any health practitioner employed in a health facility, clinic, physician's office, local or state public health department, or a clinic or other type of facility operated by a local or state public health department shall make a report regarding persons described in subdivision (a) to a local law enforcement agency as follows:

(1) A report by telephone shall be made immediately or as soon as practically possible.

(2) A written report shall be prepared and sent to a local law enforcement agency within two working days of receiving the information regarding the person.

(3) A local law enforcement agency shall be notified and a written report shall be prepared and sent pursuant to paragraphs (1) and (2) even if the person who suffered the wound, other injury, or assaultive or abusive conduct has expired, regardless of whether or not the wound, other injury, or assaultive or abusive conduct was a factor contributing to the death, and even if the evidence of the conduct of the perpetrator of the wound, other injury, or assaultive or abusive conduct was discovered during an autopsy.

(4) The report shall include, but shall not be limited to, the following:

(A) The name of the injured person, if known.

(B) The injured person's whereabouts.

(C) The character and extent of the person's injuries.

(D) The identity of any person the injured person alleges inflicted the wound, other injury, or assaultive or abusive conduct upon the injured person.

(c) through (h): omitted

It is important to distinguish, however, between reporting domestic violence and the duty to make other mandated reports. Obviously, if the victim of the domestic violence is a minor, elder, or dependent adult, you must make a mandated report. In such a case, the report would be required due to the abuse of a protected class, not due to the domestic violence.

Another confusing, yet common, circumstance is a child who is not the direct victim of abuse, but is a witness to domestic violence between adults. In this case, you are not necessarily a mandated reporter because domestic violence has occurred, or even because the minor witnessed the domestic violence. You may, however, be mandated to report depending upon the effect on the minor. If the actions of the abuser cause the minor "unjustifiable mental suffering," you must report. If the abuser willfully permits the person or health of the child to be placed "in a situation such that his or her person or health is endangered," you must report. (California Penal Code §11165.3).

Thus, you may be mandated to report because of the effect the observation of domestic violence has on the child, even though you are not a mandated reporter of domestic violence. However, you are a mandated reporter for child abuse. If domestic violence rises to the level of child abuse, then it must be reported.

IMPORTANT REMINDER

Regardless of what your employer directs you to do, do not report domestic violence. It is a breach of confidentiality.

Informed Consent/Therapist Disclosure

By Bonnie R. Benitez
General Counsel

Even though not required by law or regulation, therapists have a duty to obtain the informed consent of patients prior to treatment. The following are answers to the most commonly asked questions with regard to informed consent.

Patients have the right to make their own decisions with regard to mental health treatment (as well as medical treatment). The overarching principle of informed consent is that patients should be provided with sufficient information so that their decisions for or against treatment are meaningful. The information provided should include the potential benefits and risks of the treatment, the therapist's policies and procedures, his or her theoretical orientation, as well as any other information that the therapist knows of should know would be needed to make an informed decision regarding the proposed treatment.

"Informed" Consent

Providing informed consent is important for three main reasons. First, because patients have the right to consent to or refuse to consent to treatment, it is critical that they have sufficient information about the potential therapist and that therapist's policies, procedures and theoretical orientation so as to make that consent meaningful. Second, informed consent, preferably in writing, assists patients and therapists in avoiding misunderstandings. Third, it helps therapists in organizing their practices, and causes them to develop sound policies and procedures, as well as a rational approach to their businesses.

If a therapist obtains a patient's consent to treatment that lacks adequate information to make the consent meaningful, the patient may attempt to bring an action against the therapist for negligence based on lack of informed consent. This kind of suit is typically brought against physicians, but is also applicable to therapists. In such a case, the patient need not show that the treatment was negligently provided. However, the patient would have to show that a reasonable person in the patient's position would not have consented to the treatment (or specific technique) if he or she has been properly informed, and that the treatment was the legal cause of the patient's harm. On the other hand, in a malpractice action based on negligent treatment, a patient must show that the therapist did not conform to the applicable standard of care, and that the nonconforming care was the legal cause of the patient's harm.

Viewing Informed Consent as a Process

Just as the treatment itself is a process, so is informed consent. Informed consent cannot be achieved in one shot. It must be revisited periodically, at different intervals depending upon the patient and the nature of the therapist. Therapists should view informed consent as a continuing obligation. It should be revisited whenever there is a major change in the treatment approach, when the patient comes back to therapy after a reasonable or extended absence, when a new technique is introduced, etc. Therapists should create a calendaring system that reminds them to revisit issues of informed consent at regular intervals as well, perhaps every ninety days or so, depending upon the patient. Therapists should consider how the therapeutic process has changed over time, what the current goals are, whether the patient's presenting problem remains within the scope of practice and scope of competence, etc.

Information to be Disclosed

LMFTs are required to make two disclosures to patients prior to the commencement of treatment. These disclosures can be made orally or in writing.

Section 49823(n) "Unprofessional Conduct"

Prior to the commencement of treatment, failing to disclose to the client or prospective client the fee to be charged for the professional services, or the basis upon which that fee will be computed.

and

Section 4980.46 "Fictitious Business Names"

Any licensed marriage, family, and child counselor who conducts a private practice under a fictitious business name shall not use any name which is false, misleading, or deceptive, and shall inform the patient, prior to the commencement of treatment, of the name and license designation of the owner or owners of the practice.

Section 4987.7 "Name"

The name of a marriage, family, and child counseling corporation shall contain one or more of the words "marriage," "family," and "child" together with one or more of the words "counseling," "counselor," or "therapist," and wording or abbreviations denoting corporate existence. A marriage, family, and child counseling corporation that conducts business under a fictitious business name shall not use any name which is false, misleading or deceptive, and shall inform the patient, prior to the commencement of treatment, that the business is conducted by a marriage, family, and child counseling corporation.

Clearly there is other pertinent informatio that may be disclosed to patients, and eac patient presents a unique situation wi regard to consent. The patient's mental a emotional condition must be taken int consideration when deciding how to prope achieve informed consent. Therefore, it difficult to have a blanket information/d closure statement for all patients. General speaking, a therapist should disclose information that is material to the patie decision of whether to proceed. This standa does not require the disclosure of all exceptio to confidentiality or every possible risk ass

ated with the therapy, however; it also does not require a mini-course in psychotherapy.

The patient should be provided enough information, in lay terms, to make an informed decision, given his/her mental or emotional state and overall ability to understand what is being provided. There are four main areas that should be discussed: (1) the nature of the treatment; (2) the risks and expected benefits associated with the treatment, including the likelihood of success; (3) any alternatives to treatment, including the alternative of no treatment, and their risks and benefits; and (4) any other information that may be required by the standard of practice in a specific case.

Informed Consent Forms

Because what constitutes "informed" consent varies from patient to patient, as illustrated above, it is difficult to create a "one size fits all" consent form. However, there are some content areas that should be included in any form. If such a form is used, patients should read, sign and date it. In addition to providing information in a form, it is critical that therapists also discuss each area of information with each patient to be certain that there are no misunderstandings. Additionally, records should document these discussions.

Therapists should create a checklist that can be used to remind the therapist of all of the areas that should be discussed. That checklist should then become a part of the patient record. In addition, periodic informed consent discussions should be well-documented in the patient record. The notes should include the nature and date of the discussion, the reasons why the therapist chose to have the discussion and a general description of the patient's reactions.

Therapist Background and Information – General

Therapists should provide patients with a general introduction to the therapist him/herself. This may include information like how long the therapist has been practicing, his/her qualifications, specific areas of professional interest and experience, theoretical orientation, etc. Personal information need not be disclosed in this area.

Description of the Therapeutic Process

In addition to disclosing his/her theoretical orientation, the therapist should describe to the patient how therapy works, and also explain some of the problems that may occur during the process. Therapists should explain not only the potential risks and benefits of a given treatment approach, but also the expected outcome. For example, it is a good idea to let patients know that therapy is not always successful. Some patient's may experience periods of depression or increased difficulty along the way. Sometimes one needs to get worse in order to get better. Most importantly, patients need to understand that therapy is indeed a process. No quick fix is available. Goals should be set and revisited periodically. Some patients may not like what they learn about themselves as the treatment moves along. Expectations should not be too high. Sometimes patients may find that the therapeutic relationship is not what they anticipated and that is okay. With regard to termination, patients should be informed that they are free to terminate treatment at any time. The therapist may also choose to terminate treatment for reasons the patient may not always agree with or understand.

Ethical Standards

Therapists may want to include in their consent forms excerpts from the CAMFT Ethical Standards or attach the entire document. This lets patients know that you take the ethical standards of your profession seriously. Sections one, two and three of the standards deal specifically with the therapist-patient relationship. Section one addresses responsibility to patients, section two deals with confidentiality and section three tackles professional competence and integrity. It may be helpful for therapists to incorporate some of the language of the ethical standards into their consent forms.

Fees and Cancellations

Therapists should clearly articulate their fees and payment policies. If a reduced fee is available, it should be agreed upon in writing, while allowing for discretion on the part of the therapist with regard to changes in the fee arrangement. Therapists should agree to provide patients reasonable notice prior to raising fees.

Therapists should also ask patients to agree to a specific payment schedule and develop a policy for late or missed payments. If interest on balances is to be charged, the patient should be informed and agree to the terms. Therapists should also explain to patients that it may be disruptive to the therapeutic relationship if large balances accumulate. The therapist does not want to become the patient's creditor. Patients should also be informed that the therapist may need to terminate due to an unpaid balance. If this occurs, the patient would be referred to another therapist or agency that is more affordable. Collection of outstanding balances may also be pursued through small claims court or other endeavors.

Patients should also be informed of the therapist's cancellation policy. Therapists may choose to have a 24 or 48-hour cancellation notice requirement. Because the patient may be responsible for paying for a session he/she did not attend, the terms of the policy should be clear and agreed upon by the patient.

Insurance and other Third Party Payors

Therapists who accept insurance should explain their policies regarding the use of insurance to patients. It is important that patients not be led to believe that their health insurance will cover all forms of treatment. Typically, health insurance does not cover marital therapy, and most policies require that any covered mental health treatment be "medically necessary." Some insurance companies or other third party payors will require that the insured seek treatment from specified providers. Many third party payors will reimburse for service only after the patient has been referred by a primary care physician. Patients should understand that they are responsible for verifying that the treatment is covered by their policy. Therapists can avoid that lag time in waiting for insurance reimbursement by having patients pay for the therapy at the time the service is provided and providing the patients with super bills that they can submit to their payors for reimbursement.

Confidentiality

Although many therapists choose to inform patients of the limits of confidentiality and the specifics of the reporting requirements, this is not mandatory. It may be sufficient to simply say something like "information disclosed by you during the course of your therapy is generally confidential. However, there are exceptions to confidentiality including, but not limited to, reporting child, elder and dependent adult abuse, expressed threats of violence towards an ascertainable victim, and where you tender your mental or emotional state in a legal proceeding." There are several other exceptions to confidentiality, but trying to explain the various circumstances in which you are permitted or mandated to disclose information can be confusing to both the patient and the therapist. Keep it simple, yet clear.

Availability and After-hours Contact Information

Each therapist has his or her own policies with regard to the extent he or she is accessible to patients. It is important that each patient be aware of your policy. It may be

it you carry a pager, check your answering achine/service regularly each day, or are t available after hours or on weekends. hatever you decide, be clear about the limits your availability for all of your patients.

A therapist's general policy of not carrying a ger may need to be changed in some es. For example, if you are treating someone crisis, or actively suicidal, you may need make yourself more readily available to a tient in order to meet the standard of re. Keep flexibility in mind when creating d carrying out your policies.

Therapists who are planning a leave-of-sence or vacation will want to notify their tients in advance. It is helpful to have a lleague who would be willing to serve as emergency contact during your absence. tients should also be informed of the lleague's availability and contact information.

elegation of Informed Consent uties

The duty to properly inform patients ior to obtaining consent resides with the ating therapist. As a general rule, therapists ould not delegate this duty to another aff person, either clinical or non-clinical.

nformation for Specific ituations

Therapists who choose to develop nformed consent forms may want to have ifferent forms for different therapeutic situations. For example, a separate form may be reated for conjoint therapy. Such a form ould include information about the therapist's o secrets" policy. Having a "no secrets" olicy means that any information shared ith the therapist by one member of the ouple outside of the presence of the other ember of the couple may be disclosed to e other member of the couple at the therapist's iscretion. In other words, the therapist will ot allow him/herself to be put in the position f holding the secrets of a patient participating n conjoint therapy. Each of the conjoint atients should be informed of and agree to his policy. Too many therapists find themselves eceiving information from one member of couple that he or she does not want disclosed o the other member of the couple without aving informed the patients of a "no ecrets" policy.

Therapists who conduct groups should lso have a specific form for each member f the group. Such a form should include ot only the rules of confidentiality for the herapist, but also the rules of confidentiality, s established by the therapist for the group articipants. For example, the therapist may want to have each group participant agree o keep all information disclosed in session confidential as a condition of group therapy. The therapist may also want to develop a policy regarding outside relationships among group participants.

Contractual Requirements

Some government contracts for the provision of mental health services may require either the use of specific forms or the use of an interpreter when forms are written in English only. Therapists should take care to read and understand the terms of any contracts they may have for the provision of mental health services on behalf of third parties.

Exceptions to Informed Consent Requirements

There are three general exceptions to the informed consent doctrine: (1) emergency situations, (2) patient requests not to be informed, and (3) simple procedure with remote danger. Therapists who choose to utilize any of these exceptions are best protected by carefully documenting the reasons why the exception was appropriately invoked. Therapists should note that these exceptions are typically invoked by physicians and should not regularly be utilized.

Emergency Situations

Circumstances may arise in which a patient's immediate need for treatment outweighs the need for the informed consent. A distraught patient may not be able to appreciate the information being provided, thus it may be prudent at times for a therapist to defer the informed consent process to a time when the patient will be more receptive and understanding of the information provided.

Patient Requests not to be Informed

The court in Cobbs, also held "a medical doctor need not make disclosure of risks when the patient requests that he not be so informed." This case did not address issues therapist are faced with, however, this exception may be applicable in some limited circumstances. A therapist faced with a patient who requests treatment absent informed consent should consider whether he or she wants to treat the patient at all, revisit the informed consent issue in a subsequent session, and document his or her records as to the patient's request, as well as any further actions taken.

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Simple Procedure with Remote Danger

A disclosure need not be made if the procedure is simple and the danger remote and commonly appreciated to be remote. While this may appear to be a good exception to be utilized by therapists who see the patient's treatment as short-term, it should not be seen as providing immunity from liability should the patient later initiate a legal action.

Forms for third party non-patients

Many patients will at some time during the course of their therapy bring a third party into a session or sessions. For example, an adult man who is focusing, at one point during individual therapy, on his relationship with his girlfriend/sister/mother, will have her attend a session or two. And while it may be obvious to the therapist that the third party "visitor" is only attending the session(s) for the purpose of the treatment of the actual patient, the "visitor" may see things differently. This issue may not even arise until some time later when the actual patient is requesting that the therapist send a copy of his or her records to his or her attorney. It is at this point that the therapist may realize that there is information contained in the record about that visitor. Is the visitor entitled to confidentiality? Maybe. Would the visitor have an expectation of confidentiality? Perhaps. The therapist can address these and other issues when the visitor first attends the therapy session with the patient. The therapist should inform the visitor that he/she is not a patient and therefore is not entitled to confidentiality or psychotherapist-patient privilege under the law. Obviously the therapist will respect the confidential nature of the session, but the visitor should have no expectation of the legal protections afforded patients. This kind of disclosure falls under informed consent in that the third party is being informed of what role he or she is playing in the process and consenting to participation under the conditions outlined by the therapist.

Another common example of third parties being involved in therapy is the participation of parents in the therapy of their minor children. Sometimes therapists conduct family therapy, in which all or some member of a family are identified as patients. However, there are times in which the identified patient is the minor child and not adult members of the family. In this case, the therapist should make it clear to the parents that the patient is the child, and while the parents may play a part in the child's therapy, they are not identified by the therapist as patients, and should have no expectation of the legal protections afforded the patient. Therapists should both explain this concept to the parents and also have them read and sign a form addressing the issue.

Conclusion

Any treatment that takes place absent informed consent falls below the standard of care and can subject the therapist to civil-liability. It is imperative that therapists understand the doctrine of informed consent and incorporate these guidelines into their practice.

This information is intended to provide guidelines for addressing difficult legal dilemmas. It is not intended to address every situation that could potentially arise, nor is it intended to be a substitute for independent legal advice or consultation. When using such information as a guide, be aware that laws, regulations and technical standards change over time, and thus one should verify and update any references or information contained herein.

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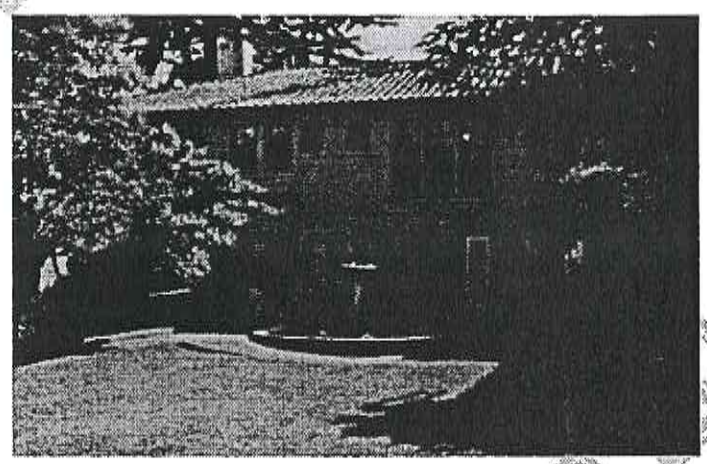

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child abuse reporting & investigation

The following information has been supplied to the viewing public from the Child Abuse Prevention Handbook and Intervention Guide, Crime and Violence Prevention Center, California Attorney General's Office, Bill Lockyer, Attorney General. January 1982, revised August 1992 and January 2000.

Please note that legislation in the field is constantly being revised and as it changes, The Department of Family and Childrens Services within the Social Services Agency will revise the website with major changes. The following information was compiled for this website April, 2001.

What is Child Abuse?

To many, child abuse is narrowly defined as having only physical implications. In reality, child abuse includes:

- Physical abuse
- Neglect
- Sexual Abuse
- Emotional maltreatment

The act of inflicting injury or the failure to act so that injury results, rather than the degree of injury, is the basis for making the decision to intervene. A parent or caretaker may begin by inflicting minor injuries, then may increasingly cause more serious harm over a period of time. Therefore, detecting the initial small injuries and intervening with preventive action may save a child from future permanent injury or death.

Physical injuries and severe neglect and malnutrition are more readily detectable than the subtle and less visible injuries which result from emotional maltreatment or sexual abuse. However, all categories of abuse endanger or impair a child's physical or emotional health and development and demand attention.

Certain persons, commonly referred to as mandated reporters, are required by law to report any known or suspected instance of child abuse. Indicators for suspected child abuse are presented in this publication to assist mandated reporters in meeting their responsibilities under the Child Abuse and Neglect Reporting Act.

One of the most important indicators for suspecting child abuse is when a child tells someone that he or she has been abused. When a child tells a particular person who is an individual required to report child abuse, the communication is not privileged. That individual, by law, must report what the child has related to him or her. This requirement applies to physical abuse, willful cruelty or unjustifiable punishment of a child, severe neglect or sexual abuse. Mandated reporters who report such suspected child abuse cases have absolute immunity, both civilly and criminally, for making such reports.

CHILD ABUSE COUNCIL
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What is Child Abuse?
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Making a Report

This page contains information and resources about reporting suspected child abuse and what happens after reporting.

To report suspected child abuse, call:

In cases of an immediate emergency always call 911 for Law Enforcement intervention. Where the situation is not an emergency needing the police, reports should be made to the Child Abuse and Neglect Hotline in the following areas:

San Jose Area	(408) 299-2071
Gilroy/Morgan Hill Area	(408) 683-0601
Palo Alto Area	(650) 493-1186

The Department of Family and Children Services operates a Child Abuse and Neglect Screening Center 24 hours a day, seven days a week, 365 days a year.

The Hotline social workers answer the telephone, in the office, from 7 AM until 10 PM. After 10 PM the telephone is switched to a Social Work Supervisor on duty for the evening at another location.

At non-critical times (after 6 PM) there may only be one person on duty and your call may go to voice mail to be returned as soon as possible in the order received into the Agency.

- Reporting Child Abuse
- Guidelines for Mandated Reports
  - Reporting Child Abuse and Neglect
  - Who are mandated reporters
- Child Abuse Reporting: Commonly Asked Questions
- Child Abuse Reporting Guidelines for Sexual Activity Between and with Minors
- Duty to Assess Maternal Substance Abuse
- Confidentiality Manual - Sharing Information between Professionals Dealing with Children
- Santa Clara County Department of Family and Children's Services
- Children's Interview Center
- Juvenile Dependency Process
- Santa Clara County Abuse & Neglect Complaints for FY 1997 - 98

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Child Abuse Reporting: Commonly Asked Questions

1. Who am I to say what is abusive?

Professionals often feel reticent to label behavior as abusive. They may feel they have no right to pass judgment on other people. However, if reasonable suspicion exists, the protection of the child and compliance with the law must take precedence over these concerns. This protective action could be beneficial to parents, who might not recognize their behavior as abusive, or are reluctant to seek help.

2. What is the fine line between abuse and discipline?

If the discipline is excessive or forceful enough to leave injuries, physical abuse has occurred. The use of instruments increases the likelihood of injuries as does the excessive punishment of young children. The intent of the reporting law is not to interfere with appropriate parental discipline, but to respond to extreme or inappropriate discipline which is abusive. Some parents hit their children in places where injuries are not visible (the buttocks, the thighs, the back) using belts, whips or other potentially dangerous instruments. If one has reasonable suspicion of abuse, even with no visible signs, a report is required. Under California Welfare and Institutions Code Section 300(a), reasonable and age appropriate spanking to the buttocks where there is no evidence of serious physical injury does not constitute abuse.

3. What if abuse occurred in the past?

There is no time limitation regarding the reporting of child abuse. If a victim is under age 18, the abuse must be reported.

4. What if an adult states he or she was abused as a child?

The child abuse reporting law mandates a report when there is a reasonable suspicion or knowledge that minors may be in need of protection. Therefore, childhood abuse of adults should be reported if there is a reasonable suspicion that there may be another potential child victim.

5. At what age is a child most at risk of abuse?

All children are at risk of abuse, but infants and toddlers are most likely to sustain serious injuries due to their fragility. The mortality rate is highest for children ages 0-2.

It is possible to respond inappropriately to suspected abuse due to the age of a child. For example, sexual abuse of infants is more difficult to fathom than sexual abuse of adolescents, yet it does occur. Adolescents are also at risk of abuse but may not receive needed help because some adults may believe that adolescents sometimes provoke abuse or are better able to protect themselves or run away from abusive situations. Despite their age and size, adolescents are often just as vulnerable as younger children to physical, sexual and emotional abuse and neglect.

6. **At what age can children legally be left alone?**
There is no specific law which gives an age at which children can be left alone, nor is there any law which specifies a minimum age for a caretaker. Good judgment on the part of the parents is expected. The ages, number of children, the children's maturity, the length of time in care, and other characteristics should be considered.

7. **Do I have to report consensual sexual intercourse involving children?**

Reporting sexual intercourse between minors is governed by law and by court decisions. It is most important that the reporter is sure that the sexual intercourse is truly consensual; all non-consensual sexual intercourse must be reported. All incest, that is, sexual intercourse between closely related people, is reportable whether it is consensual or not. In all other situations the following apply:

a. If both children are under the age of 14, and are close together in age, consensual sexual intercourse is not reportable. The courts have held that to report this is a breach of the right to privacy clause in the California Constitution. This is also true of minors ages 14 to 18.

b. If one minor is over 14 years and one is under 14 years, the activity must be reported.

c. Sexual intercourse between any minor and any adult should be reported. This is illegal sexual intercourse (formerly called statutory rape). Emergency Response will not investigate, but the incident will be reported to the appropriate police jurisdiction.

d. Pregnancy of a minor is not reportable.

8. **What is the difference between children's "normal" sex play and sexual abuse?**

The lack of contemporary normative data regarding sexual activity among young children makes differentiating between normal sex play and sexual abuse difficult. It is clear, however, that very young children without exposure or experience do not usually have substantial or detailed knowledge about sexual activity, and that the child who exhibits developmentally inappropriate behaviors has probably either been exposed to that behavior or has experienced it. Exposure may have occurred directly, (by observing people engaged in those activities), by having personally been involved or indirectly through TV or pictures in a magazine.

Factors to be considered in addition to developmental appropriateness include the dynamics of the situation. Was coercion, threat, intimidation or force involved? Were age and size of the children involved similar? Even in cases involving children of similar age and size it is possible that the activity is abusive if threat, force or coercion is present.

Differences in emotional maturity and status must be evaluated. For example, a child who has been delegated the authority of "baby-sitter" by parents has a distinct status or power advantage over other children, even if the age differential is not large.

Many assessment questions must be considered when professionals are presented with situations in which children are engaging in sexual activity. It is important to understand not only the child's knowledge base but also the source of this knowledge.

9. **Are clergy mandated to report?**

Any clergy member who has knowledge of or observes a child, in his or her professional capacity whom he or she knows or reasonable suspects has been a victim of child abuse is required to report that abuse to a child protective agency. The only exception is for knowledge which a clergy member may acquire during a penitential communication which is defined as a communication intended to be in confidence, including, but not limited to a sacramental confession made to a clergy member who, in

the practice of his or her church is authorized or accustomed to hear those communications and under has a duty to keep those communications secret.

10. **Are alcohol programs exempt from reporting child abuse?**

No. The exemption in effect until 1987 for federally-funded alcohol/drug programs has been withdrawn. Today all alcohol or drug programs are required to make appropriate child abuse reports.

11. **Is a mandated reporter "on duty" twenty-four hours a day and required to make reports on family, neighbors or friends?**

In California the mandated reporting law specifically states that reporting is required when the reporter has knowledge of or observes a child, in his or her professional capacity or within the scope of his or her employment. Therefore a report is not required when information is obtained in a personal relationship. However, persons with knowledge of child abuse or neglect should examine their moral and ethical responsibilities to children when making such a decision.

12. **May reports be made anonymously?**

Mandated reporters are required to identify themselves when making child abuse reports; persons not legally required to report may make anonymous reports.

13. **Have I met my responsibility as a mandated reporter by putting the victim on the phone to make the report?**

No. The law is requires that the mandated reporter make both the telephone report and complete the Suspected Child Abuse Report form. Some mandated reporters believe that there is some therapeutic benefit to having the victim report. The volume of calls coming into the Child Abuse is often very high and the social workers assigned are not prepared to meet the therapeutic needs of clients on the telephone.

14. **Should I inform the family that I have made a report to Emergency Response?**

As there is no law or regulation regarding this, good professional judgment should be used. If a child is in imminent danger and the perpetrator has access to the child it is better not to advise anyone in the family so that the child is not coerced into changing any disclosure. In other instances letting the family know can be helpful and therapeutic and may assist the professional who wishes to preserve a relationship with a client. Most psychotherapists or counselors do advise their patients. Parents should be advised of a report whenever possible since it is important that standards for acceptable child care be promulgated by all professions.

15. **What happens after a report is made?**

Child Protective Agencies (Social Services or the appropriate police jurisdiction) are responsible for investigating the referral once it is made. Emergency Response social workers and law enforcement will work together and share information, although their investigations are separate. When abuse has occurred within a family, the social worker's emphasis is to ensure the safety of a child and provide services to keep the family together.

Removing a child from the home is an action taken only when a child cannot remain there safely. If removal becomes necessary, the Juvenile Court has several options for placement including the non-custodial parent, relatives, foster homes, and group homes, in that order. Parents should be reassured that the Court's removal standards are stringent. The Court will order the Social Services Agency which provides child welfare services and the parents to work together for reunification as quickly as possible.

When abuse has occurred where the alleged perpetrator is not a member of the household (for example, a stranger molesting a child), law enforcement is responsible for investigating the referral. The Child Protective Agency will investigate to determine if the child is being protected at home. Once the agency has determined that the child is safe at home, then it may refer the family for counseling or medical care and to appropriate local community resources. A case of out-of-home abuse is generally closed by the Department of Family and Children's Services with the law enforcement agency continuing its investigation.

16. **What about testifying in court?**
The majority of cases do not go to trial. When they do, and the reporter is required to testify, it is important to remember that the testimony may be essential for the protection of the child.

Developed by the Emergency Response Bureau of the Santa Clara County Department of Family and Children's Services and adopted in part from "The California Child Abuse & Neglect Reporting Law," State Department of Social Services, Office of Child Abuse Prevention. March, 1998.

CHILD ABUSE AND NEGLECT REPORTING ACT FOR 2001

Ronnie Benitez, General Counsel and
Zachary Pelchat, Legislative Counsel

The Child Abuse and Neglect Reporting Act (CANRA) has had much attention lavished upon it during this year's and this past year's legislative session. To see where the State is going, we will take a look at where CANRA has come from and the changes that impact mandated reporters, as well as immunity for making reports. We are also going to step into the shoes of a plaintiff's attorney and see what mandated reports look like from the "other side."

History

In the beginning, there was confidentiality. Information shared in session was to remain confidential no matter what was revealed. Confidentiality began to be eroded in 1963 with the introduction of the first child abuse reporting law (Penal Code §11161.5). These laws were largely ineffective because the reporters were subject to liability for making reports. At a November 1978 hearing on child abuse reporting before the Assembly Committee on Criminal Justice, an official of the State Department of Justice testified that, despite the enactment of a mandatory child abuse reporting law, as few as ten percent of all cases of child abuse were being reported to responsible government agencies.[1] In a report on proposed child abuse reporting legislation, the State Bar of California wrote: "The seriousness of the problem of child abuse cannot be over estimated. Repeated instances of abuse of the same child tend to lead to progressively more severe results, including death, brain damage, and disabling emotional handicaps. It's not a tiny fraction of the child population we're talking about, either. Approximately ten percent of all trauma seen in emergency rooms affecting children under three years of age is inflicted."[2]

In an effort to correct this problem, the California Legislature brought forth the Child Abuse and Neglect Reporting Act (CANRA) in 1980. It was designed to encourage reporting with two very powerful tools. First, failure to report child abuse was criminalized. Second, mandated reporters were given immunity for making reports. After 20 years of use, amendment, and interpretation in the courts, CANRA is again "in the news" thanks to AB1241. The legislature has made many procedural changes and some substantive changes designed to improve the protection of minors and make reporting easier for mandated reporters.

Specific Changes

There are four major changes to CANRA about which therapists should be aware: the removal of the permissive reporting of "emotional abuse;" the deletion of the term "child protective agency" from the definitional and functional provisions of the Act and the enumeration of designated agencies authorized to receive reports of child abuse and neglect; the requirement that the named agencies accept a report even if the agency lacks jurisdiction to investigate the case; and the provision for additional information that is to be included in reports of child abuse and neglect. Each of these changes will be explained in detail below.

Permissive Reporting of Emotional Abuse

The change that has received the most attention, and caused much confusion involves both the permissive and mandatory reporting of "mental suffering," which therapists often refer to as "emotional abuse." In order to address the reportability of "mental suffering," let's first take a look at the mandated reporting requirements as they exist previously and after January 1, 2001.

- Therapists are required to report "child abuse or neglect," the definition of which includes:
- a physical injury that is inflicted by other than accidental means on a child by another person;
- sexual abuse (as defined in Section 11165.1);
- neglect (as defined in Section 11165.2);
- **willful cruelty or unjustifiable punishment** (as defined in Section 11165.3);
- unlawful corporal punishment or injury (as defined in Section 11165.4); and
- abuse or neglect in out-of-home care (as defined in Section 11165.5).

The definition of "willful cruelty and unjustifiable punishment of a child" includes the reporting of **"mental suffering"** as follows:

"As used in this article, 'willful cruelty or unjustifiable punishment of a child' means a situation where any person willfully causes or permits any child to suffer, or inflicts thereon, unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully causes or permits the person or health of the child to be placed in a situation such that his or her person or health is endangered."

This section clearly mandates the reporting of unjustifiable mental suffering of a child. However, many therapists relied upon a different section of the Act to report the "emotional abuse" of children. The section authorized the "permissive" reporting of "mental suffering" as well as the reporting of situations in which a child's "emotional well-being" is endangered. This permissive section was removed effective January 1, 2001. The subsection that was removed is:

*"Any...[mandated reporter]...who has knowledge of or who reasonably suspects that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way, **may** report the*

known or suspected instance of child abuse to a child protective agency."

The critical point here is CANRA, in its prior form, and on and after January 1, 2001 **mandates** the reporting of "unjustifiable mental suffering." Because willful cruelty or unjustifiable punishment of a child falls under the definition of child abuse, therapists who have a reasonable suspicion of "unjustifiable mental suffering" must report the known or suspected abuse. When therapists make such reports, by law, they are immune from liability.

Why was this change made? There are some who believe that prior law was both confusing and duplicative in that it both mandated the reporting of "unjustifiable mental suffering" and permitted the reporting of "mental suffering." Arguably, in an effort to clear up this confusion, the permissive reporting was eliminated, making it clear that such a report is mandatory. In fact, this issue was discussed in the legislative analysis as this bill was progressing through the legislature. It is stated in the analysis that if a provision was added to the bill to authorize, but not require, mandated reporters to report mental suffering, the law would be "vague and inconsistent with respect to the reporting requirements for mental suffering." Thus it seems to be clear that the intent was to mandate the reporting of "unjustifiable mental suffering," and not to leave open the fact that mental suffering that is not "unjustifiable" may be reported.

Whatever the reason for the change, and whatever may happen in the future with regard to the possible re-emergence of permissive reporting language, mandated reporters should simply be aware of their reporting requirements and comply with them. We understand that legislation may be pursued in 2001 to amend the law to include permissive reporting of mental suffering or emotional abuse. We will be involved in this process, as will others, should the law be further amended.

Child Protective Agencies Enumerated

The term "child protective agency" is being deleted from the definitional and functional provisions of the Act and instead, the Act now specifies the designated agencies authorized to receive reports of child abuse and neglect as follows:

"Reports of suspected child abuse or neglect shall be made by mandated reporters to any police department, sheriff's department county probation department if designated by the county to receive mandated reports, or the county welfare department. It does not include a school district police or security department."

Requirements for Agencies Receiving Reports

The enumerated agencies must accept a report of suspected child abuse or neglect whether offered by a mandated reporter or another person, or referral by another agency, even if the agency to whom the report is being made lacks subject matter or geographical jurisdiction to investigate the reported case, unless the agency can immediately electronically transfer the call to an agency with proper jurisdiction. When an agency takes a report about a case of suspected child abuse or neglect in which that agency lacks jurisdiction, the agency shall immediately refer the case by telephone, fax, or electronic transmission to an agency with proper jurisdiction.

This change is most helpful to mandated reporters who may have in the past, been bounced between child protective agencies, with each one telling the reporter that it is not the proper agency to receive the report. Effective January 1, 2001, each of the agencies enumerated above will be required to accept a child abuse report even if the information contained in the report falls outside the jurisdiction of that agency.

Additional Information to be Included in Reports

Reports of suspected child abuse or neglect are to include, if known, the following information:

- the name, business address, and telephone number of the mandated reporter, and the capacity that makes the person a mandated reporter;
- the child's name and address, present location, and where applicable, school, grade, and class;
- the names, addresses, and telephone numbers of the child's parents or guardians;
- the information that gave rise to the reasonable suspicion of child abuse or neglect and the source or sources of that information; and
- the name, address, telephone number, and other relevant personal information about the person or persons who might have abused or neglected the child.

The mandated reporter shall make a report even if some of this information is not known or is uncertain to him or her.

Immunity

Mandated reporters have absolute immunity for the reports that they make. The law states: "No child care custodian, health practitioner, (list of others omitted) who reports a known or suspected instance of child abuse shall be civilly or criminally liable for any report required or authorized by this article."[3] CANRA shields reporters from liability by providing immunity. The California courts have interpreted this immunity as absolute immunity. Even if you make a mistake in suspecting child abuse and make a report, you are still not liable for any damages that may result.[4] Thus, if a mandated reporter made a report of "unjustifiable mental suffering" and it could somehow be proven to be "justifiable suffering," that reporter would face no liability for his or her mistake.

Immunity is necessary because it protects reporters from retaliation. If reporters had to fear a lawsuit for every call to Child Protective Services, fewer of those calls would be made. Hence, immunity protects reporters as well as children by immunizing reports. Even so, immunity does not stop every litigious individual. Effective January 1, 2001, if you incur attorney's fees or costs defending a suit based on a mandated report, you may be reimbursed by the State Board of Control up to $50,000.[5]

Chris Hulbert
San Diego
Trial Attorney of the Year

A Plaintiff's Attorney's View

CAMFT also interviewed outside counsel in regards to the changes made in CANRA. If you really want to see if any of the changes are going to be "bad" for providers, find out what a medical malpractice attorney thinks. We interviewed Attorney Chris Hulburt –Trial Attorney of the Year for 2000 in San Diego – fresh after a 4.3 million-dollar judgment against a local doctor. Mr. Hulburt said he was "quite disappointed" by the immunity laws

When asked about the immunity provisions of CANRA, Mr. Hulburt immediately remembered a case where he thought immunity allowed a tragedy. A young child was outside in the yard with the family dog. The dog was large and on a leash. The boy lost control and the dog ran around and wrapped the leash around the boy and dragged him. By the time the parents stopped the dog, the child was injured.

At the emergency room, the ER Doctor saw that the boy had a twisting fracture on the leg. He suspected child abuse because twisted fractures are common in child abuse. An orthopedic surgeon was consulted. The specialist concluded that the injury was not caused by abuse, but was accidental. Even though the Doctor with more training, education, and experience in orthopedics concluded it was not abuse, the ER doctor made a child abuse report pursuant to CANRA. A CPS agent arrived and was hostile and aggressive with the parents. The injured child was taken away from his family and not returned for a matter of days.

The parents were furious. They had brought their son in for emergency medical care and ended up under CPS investigation and torn away from their injured boy. It was a nightmare for the parents and the young boy. When the dust settled, the parents negligence on the part of the ER doctor, he refused to even take the case. Why? Immunity for mandated reporters includes mistakes. If a reporter believes the report to be true, as the ER doctor did, he is immune from liability.

Mr. Hulburt believes that the bias of a plaintiff's attorney is in protecting an innocent victim. Clearly, in the above case, the parents and child were all wrongly harmed. Immunity for reporting can protect innocent children by encouraging reports, but it can also protect negligent providers. Mr. Hulburt said "as a father of four and a protector of innocent people, I have no philosophical problem with mandated reporting." He accepted the necessity of mandated reporting to protect children, but fears that immunity can be abused. In his words, "liability increases awareness."

After gathering his thoughts about CANRA, we asked him about the specific change of removing the permissive reporting of mental suffering and sole reliance on the mandated report of "unjustifiable mental suffering." His response was that "if it is a subjective test, the absolute immunity is invoked simply by the statement of the provider that he or she thought there was something 'unjustifiable' there. Obviously, that is the best situation for the therapist. The subjective test would absolutely immunize the therapist. By its own language, the statute is [illegible] mandatory obligation to report."

What it all means

There will always be competing interests in society. Society has an interest in encouraging people to seek out mental health treatment by ensuring the confidentiality of that treatment. Society also has an interest in protecting children by mandating the reporting of child abuse. CANRA tries to balance those two opposing interests. As an LMFT you are in the middle of that conflict. Therapists who are members of CAMFT may consult with CAMFT legal or executive staff when unclear about one's responsibility to report child abuse.

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1 Hearing before the Assembly Committee on Criminal Justice on Child Abuse Reporting (1977-1978 Reg.Sess.) Nov. 21, 1978, p. 7

2 Krikorian v Barry (1987) 196 Cal.App.3d 1211, 1216-1217

3 California Penal Code §11172(a)

4 See, generally: Storch v Silverman (1986) 186 Cal.App.3d 671; Krikorian v Barry (1987) 196 Cal.App.3d 1211; Ferraro v Chadwick (1990) 221 Cal.App.3d 86; and Thomas v Chadwick (1990) 224 Cal.App.3d 813.

5 California Penal Code §11172(c)

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30th Anniversary Gestalt Therapy Training Program ◆ July 22 - August 3, 2001
- Five levels of training
- Individual & group work
- Theory lectures
- Practicum
- Trios
- Supervision
- Optional Evening Programs
- Special Organizational Seminar
- Fee: $2500 - $2800 inclusive

This course meets the qualifications for 63 hours of CE credit for MFCCs and/or LCSWs as required by the CA. Bd. of Behavioral Sciences BBSE approval no. PCE 841.

Gestalt Associates Training Los Angeles Tel: 310.395.6844 Fax: 310.319.1663 E-mail: SweetRita@aol.com Website: www.gatla.org

SUSPECTED CHILD ABUSE REPORT

To Be Completed by Reporting Party
Pursuant to Penal Code Section 11166

A. CASE IDENTIFICATION — *TO BE COMPLETED BY INVESTIGATING CPA*
VICTIM NAME: _____
REPORT NO./CASE NAME: _____
DATE OF REPORT: _____

B. REPORTING PARTY
NAME/TITLE
ADDRESS
PHONE ( ) | DATE OF REPORT | SIGNATURE

C. REPORT SENT TO
☐ POLICE DEPARTMENT ☐ SHERIFF'S OFFICE ☐ COUNTY WELFARE ☐ COUNTY PROBATION
AGENCY | ADDRESS
OFFICIAL CONTACTED | PHONE ( ) | DATE/TIME

D. INVOLVED PARTIES

VICTIM
NAME (LAST, FIRST, MIDDLE) | ADDRESS | BIRTHDATE | SEX | RACE
PRESENT LOCATION OF CHILD | PHONE ( )

SIBLINGS

NAME	BIRTHDATE	SEX	RACE	NAME	BIRTHDATE	SEX	RACE
1.				4.			
2.				5.			
3.				6.			

PARENTS

NAME (LAST, FIRST, MIDDLE)	BIRTHDATE	SEX	RACE	NAME (LAST, FIRST, MIDDLE)	BIRTHDATE	SEX	RACE

ADDRESS	ADDRESS

HOME PHONE ( )	BUSINESS PHONE ( )	HOME PHONE ( )	BUSINESS PHONE ( )

E. INCIDENT INFORMATION
IF NECESSARY, ATTACH EXTRA SHEET OR OTHER FORM AND CHECK THIS BOX. ☐
1. DATE/TIME OF INCIDENT | PLACE OF INCIDENT | *(CHECK ONE)* ☐ OCCURRED ☐ OBSERVED
IF CHILD WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE:
☐ FAMILY DAY CARE ☐ CHILD CARE CENTER ☐ FOSTER FAMILY HOME ☐ SMALL FAMILY HOME ☐ GROUP HOME OR INSTITUTION
2. TYPE OF ABUSE: *(CHECK ONE OR MORE)* ☐ PHYSICAL ☐ MENTAL ☐ SEXUAL ASSAULT ☐ NEGLECT ☐ OTHER
3. NARRATIVE DESCRIPTION:
4. SUMMARIZE WHAT THE ABUSED CHILD OR PERSON ACCOMPANYING THE CHILD SAID HAPPENED:
5. EXPLAIN KNOWN HISTORY OF SIMILAR INCIDENT(S) FOR THIS CHILD:

SAMPLE

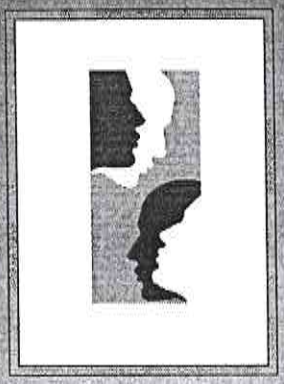
SS 8572 (Rev. 1/93)

INSTRUCTIONS AND DISTRIBUTION ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). A CPA is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS-8583 if (1) an active investigation has been conducted and (2) the incident is **not** unfounded.

Police or Sheriff-WHITE Copy; County Welfare or Probation-BLUE Copy; District Attorney-GREEN Copy; Reporting Party-YELLOW Copy

Professional Therapy Never Includes Sex



State of California

DEPARTMENT OF CONSUMER AFFAIRS

www.dca.ca.gov

Publishing Information

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Acknowledgments

The Department of Consumer Affairs, the Boards of Psychology and Behavioral Sciences, and the Medical Board of California wish to thank Senator Diane Watson, whose Senate Task Force on Psychotherapist and Patient Sexual Relations brought about the mandate for development of the first edition of *Professional Therapy Never Includes Sex* in 1990, as well as Janet Sonne, Ph.D. and Joseph George, Ph.D., for reviewing the earlier document and suggesting revisions for this update.

Table of Contents

Patient Bill of Rights

You have the right to:

- Request and receive full information about the therapist's professional capabilities, including licensure, education, training, experience, professional association membership, specialization, and limitations.
- Have written information about fees, method of payment, insurance reimbursement, number of sessions, substitutions (in cases of vacation and emergencies), and cancellation policies *before* beginning therapy.
- Receive respectful treatment that will be helpful to you.
- A safe environment, free from sexual, physical, and emotional abuse.
- Ask questions about your therapy.
- Refuse to answer any question or disclose any information you choose not to reveal.
- Request and receive information from the therapist about your progress.
- Know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others.
- Know if there are supervisors, consultants, students, or others with whom your therapist will discuss your case.
- Refuse a particular type of treatment, or end treatment without obligation or harassment.
- Refuse electronic recording (but you may request it if you wish).
- Request and (in most cases) receive a summary of your file, including the diagnosis, your progress, and the type of treatment.
- Report unethical and illegal behavior by a therapist (see Reporting Options, page 10).
- Receive a second opinion at any time about your therapy or therapist's methods.
- Have a copy of your file transferred to any therapist or agency you choose.

Introduction

Professional therapy never includes sex. It also never includes verbal sexual advances or any other kind of sexual contact or behavior. Sexual contact of any kind between a therapist and a patient is illegal and unethical. It can also be harmful to the patient. Harm may arise from the therapist's exploitation of the patient to fulfill his or her own needs or desires, as well as from the therapist's loss of the objectivity necessary for effective therapy. All therapists are trained and educated to know that this kind of behavior is inappropriate and can result in license revocation.

By the nature of their profession, therapists are trusted and respected, and it is common for patients to admire them and feel attracted to them. However, a therapist who accepts or encourages these normal feelings in a sexual way—or tells a patient that sexual involvement is part of therapy—is using the trusted therapy relationship to take advantage of the patient. And once sexual involvement begins, therapy for the patient ends. The original issues that brought the patient to therapy are postponed, neglected, and sometimes lost.

Many people who endure this kind of abusive behavior from therapists suffer harmful, long-lasting emotional and psychological effects. Family life and friendships are often disrupted, sometimes ruined.

> *I foolishly put my trust in him. I assumed he was the professional. He told me that a body massage, touching me in intimate areas, was a legitimate part of therapy. When I felt uneasy about it, I told myself that it was my hangup getting in the way of therapy.*

California's lawmakers, licensing boards, professional associations, and ethical therapists want this kind of behavior stopped. This booklet was developed to help persons who have been sexually exploited by their therapists. It outlines their rights and options for reporting what happened. It also defines therapist sexual exploitation, gives some warning signs of unprofessional behavior, presents a Patient Bill of Rights, and answers some frequently asked questions.

Definitions

According to California laws:

- Any kind of sexual contact, asking for sexual contact, or sexual misconduct by a therapist with a patient is illegal, as well as unethical, as set forth in Business and Professions Code Sections 726, 729, 2960(o), 4982(k), 4986.71, and 4992.3(k).
- "Sexual contact" means the touching of an intimate part (sexual organ, anus, buttocks, groin, or breast) of another person, including sexual intercourse.
- "Touching" means physical contact with another person, either through the person's clothes or directly with the person's skin (Business and Professions Code Section 728).

Sexual contact can include sexual intercourse, sodomy, oral copulation, fondling, and any other kind of sexual touching. Sexual misconduct covers an even broader range, such as nudity, kissing, spanking, and verbal suggestions, innuendos, or advances. This kind of sexual behavior by a therapist with a patient is sexual exploitation. It is unethical, unprofessional, and illegal.

Throughout this booklet, the general terms "therapist," "therapy," and "patient" will be used. "Therapist" refers to anyone who is licensed to practice psychotherapy, or is training to become licensed, and includes:

- Psychiatrists (physicians practicing psychotherapy)
- Psychologists
- Registered psychologists
- Educational psychologists
- Psychological interns
- Psychological assistants
- Licensed clinical social workers
- Registered associate clinical social workers
- Licensed marriage, family, and child counselors
- Marriage, family, and child counselor registered interns and trainees

"Therapy" includes any type of mental health counseling from any of the licensed or registered therapists listed above. "Patient" refers to anyone receiving therapy or counseling.

Warning Signs

In most sexual abuse or exploitation cases, other inappropriate behavior comes first. While it may be subtle or confusing, it usually feels uncomfortable to the patient. Some clues or warning signs are:

- Telling sexual jokes or stories.
- "Making eyes at" or giving seductive looks to the patient.
- Discussing the therapist's sex life or relationships excessively.
- Sitting too close, initiating hugging or holding of the patient, or lying next to the patient.

Another warning sign is "special" treatment by a therapist, such as:

- Inviting a patient to lunch, dinner, or other social activities.
- Dating.
- Changing any of the office's normal business practices (for example, scheduling late appointments so no one is around, having sessions away from the office, etc.).
- Confiding in a patient (for example, about the therapist's love life, work problems, etc.).
- Telling a patient that he or she is special, that the therapist loves him or her.
- Relying on a patient for personal and emotional support.
- Giving or receiving significant gifts.
- Providing or using alcohol (or drugs) during sessions.

Signs of inappropriate behavior and misuse of power include:

- Hiring a patient to do work for the therapist, or bartering goods or services to pay for therapy.
- Suggesting or supporting the patient's increased isolation from social support systems, increasing dependency on the therapist.
- Any violation of the patient's rights as a consumer (see Patient Bill of Rights, page 4).

He started to tell me his troubles, and the burden was heavy. Then he made me feel like I had to comfort him, to have sex with him. I was the one who needed help. I have more problems now than when I started.

Therapy is meant to be a guided learning experience, during which therapists help patients to find their own answers and feel better about themselves and their lives. A patient should **never** feel intimidated or threatened by a therapist's behavior.

If you are experiencing any of these warning signs, trust your own feelings. Check on the therapist's behavior with a different therapist, or with any of the agencies in *Where To Start* (see page 9). Depending on what you find out, you may want to find another therapist.

She told me I didn't have to make payments, that I would just do work on her house. Then it turned into sex. I feel powerless because she still helps me.

What If It's Me?

If you have been sexually abused or exploited by your therapist, you may be feeling very confused. You may feel:

- Guilty and responsible—even though it's the **therapist's** responsibility to keep sexual behavior out of therapy.
- Mixed feelings about the therapist—protectiveness, anger, love, betrayal.
- Isolated and empty.
- Distrustful of others or your own feelings.
- Fearful that no one will believe you or understand what happened, or that someone will find out.
- Confused about dependency, control, and power.
- Numb.

You may even have nightmares, obsessive thoughts, depression, or suicidal or homicidal thoughts. You may feel overwhelmed as you try to decide what to do or whom to tell.

It's essential that you face what happened. This may be painful, but it is the first major step in healing and recovering from the experience. You may have both positive and negative feelings at the same time, such as starting to feel personal control, being afraid of what may happen in the future, remembering the experience, and feeling relieved that the sexual relations are over.

The second step in the healing process is to decide what YOU want to do next. Try to be open-minded about your options.

Please remember: **It doesn't matter** if you, the patient, started or wanted the sexual involvement with the therapist. Therapists are responsible for keeping sexual intimacy out of the therapy relationship and are trained to know how to handle a patient's sexual attractions and desires.

I trusted and believed in him. I had always felt safe with him, which was something I've rarely ever felt. He told me we had to keep our relationship secret because of the harm it could cause to his career. I've lied to everyone about us. I'm barely talking to my family, and I have no friends. I hate living like this.

Where To Start

You may need to (1) talk to someone who will understand what you're going through, (2) get information on whether the therapist's behavior was illegal and/or unethical, and (3) find out what you can do about it. Three places to get help are:

- Licensing Boards—In the Department of Consumer Affairs, three different boards license therapists. They can give general information on appropriate behavior for therapists and your rights for reporting what happened, as well as how to file a complaint with them. See page 11 for addresses and phone numbers.
- Sexual Assault/Crisis Centers—These centers have staff trained in all types of sexual abuse and exploitation. They can provide general information on appropriate behavior for therapists, crisis services, your rights for reporting what happened, and names of therapists and support groups that may be helpful. Numerous centers are located throughout California. Look in your telephone book under "sexual assault center" or "crisis intervention service."
- Professional Associations—Each licensed therapy profession has at least one professional association. Associations can give general information on appropriate behavior for therapists, your rights for reporting what happened, and how to file a complaint with them. They can also provide names of therapists who may be helpful. See page 13 for association addresses and telephone numbers.

What You Can Do

You can deal with your situation in several different ways. Take time to carefully explore all of your rights and options. It may help to decide what your goals are.

- *Reporting the Therapist*

  Perhaps you want to prevent the therapist from hurting other patients. You may want to receive monetary compensation for the damage you have suffered and to help pay for future therapy sessions. You may want to make it known that sexual exploitation is always wrong. You may want to do all of these. If this is your decision, there are several reporting options. It is important to note that some reporting options have limits on the time that may pass before the report is made (called a statute of limitations). As you consider your options, be aware of those limits.

- *Your Recovery*

  You may also want to explore and process what happened between you and the therapist. If you decide to do this, you can look into therapy or support groups (see pages 16–17).

- *Moving On*

  You may wish simply to move on past this experience as quickly as possible and get on with your life. Remember—you have the right to decide what is best for you.

REPORTING OPTIONS

If you decide to report a therapist's unethical and illegal behavior, there are four different ways to do so. Each option has both strong and weak points. You may choose any one or all of these options:

- *Administrative Action*—file a complaint with the therapist's licensing board.
- *Professional Association Action*—file a complaint with the professional association's ethics committee.
- *Civil Action*—file a civil lawsuit.
- *Criminal Action*—file a complaint with local law enforcement.

Administrative Action

Three licensing boards license and regulate therapists:

Medical Board of California
1430 Howe Avenue
Sacramento, CA 95825
(916) 263-2388 or (800) 633-2322
www.medbd.ca.gov
This board licenses and regulates physicians, including psychiatrists.

Board of Psychology
1422 Howe Avenue, Suite 22
Sacramento, CA 95825
(916) 263-2699 or (800) 633-2322
www.dca.ca.gov/psych
This board licenses and regulates psychologists, psychological assistants, and registered psychologists.

Board of Behavioral Sciences
400 R Street, Suite 3150
Sacramento, CA 95814
(916) 445-4933
www.bbs.ca.gov
This board licenses and regulates educational psychologists; licensed clinical social workers; registered associate clinical social workers; licensed marriage, family, and child counselors; and registered marriage, family, and child counselor interns and trainees.

The purpose of these licensing boards is solely to protect the health, safety, and welfare of consumers. Licensing boards have the power to discipline therapists by using the administrative law process. Depending on the violation, the board may revoke, suspend, and/or place a license on probation with terms and conditions. When a license is revoked, the therapist cannot legally practice. (Note that Business & Professions Code Section 2960.1 requires revocation of the license or registration whenever sexual misconduct is admitted or proven against a psychologist, psychological assistant, or registered psychologist. Section 4982.26 requires revocation of a marriage, family, and child counselor license under the same circumstances.)

There is **no time limit** for reporting a sexual exploitation case to a licensing board. However, it is best to report such conduct as soon as possible, since delays may restrict the disciplinary options available to the board. (For example, current law prevents the Medical Board from filing an accusation against a psychiatrist more than seven years after the violation occurs, except in cases of procuring a license by fraud or misrepresentation.)

How the Complaint Process Works

The licensing boards can give you detailed information about the complaint filing process and discuss your situation with you. To file a complaint, you can either request a complaint form or write a letter. Be sure to include your name, address, and telephone number; the therapist's name, address, and telephone number; a description of your complaint; copies of any documentation available (for example, letters, bill receipts, canceled checks, or pictures); and names, addresses, and telephone numbers of any witnesses.

Each complaint is evaluated and investigated, and you and the therapist will be notified if the board has sufficient evidence to initiate disciplinary action. You and the therapist will be interviewed separately.

Most cases are settled by a *stipulated agreement*—the therapist typically admits to the violation(s) and accepts the disciplinary action, no hearing is held, and the patient does not have to testify. In the unlikely event that your case is **not** settled by a stipulated agreement, a hearing will be held by an administrative law judge, and you will be required to testify. When the judge makes a decision about the case, the board will then decide whether to accept this decision or to issue its own.

It is policy to use only initials, rather than full names, to identify patients in public documents. However, hearings are open to the public, and there is a possibility that confidentiality may be jeopardized during the investigation process or at the hearing itself. If you are concerned about this, discuss it with the licensing board investigator.

The disciplinary process may take about two years from the time a complaint is received to the time a final decision is made. Sometimes the process takes even longer. Please keep in mind that you cannot receive monetary compensation from the therapist by using this option, but you may affect the therapist's ability to practice and thereby protect other potential patients from similar misconduct.

Professional Association Action

Many therapists join professional associations—organizations that provide education and guidance to people in a certain profession. Each association has its own ethics guidelines, and all clearly state that sexual involvement with patients is unacceptable and unethical.

If your therapist is a member of a professional association, you may file a formal complaint with the association. After investigating the complaint, the association may recommend certain disciplinary actions or may remove the therapist from its membership. Removing a therapist from the association will let other members know about the person's unethical behavior, **but it will not keep the therapist from practicing.** Only a licensing board or court action can do that. In addition, it will not result in monetary recovery for you (only a civil action can do that), and it will not result in criminal action against the therapist.

Each association has different ways of filing complaints. Call or write the appropriate association for this information. To find out which association, if any, the therapist belongs to, call the therapist's office and request this information; have a friend call the office or therapist for you; or check with the different associations.

Below are associations listed by profession:

PSYCHIATRIST, PHYSICIAN

American Psychiatric Association
1400 K Street, NW
Washington, DC 20005
(202) 682-6000

California Medical Association
221 Main Street
San Francisco, CA 94105
(415) 541-0900

California Psychiatric Association
1400 K Street, Suite 302
Sacramento, CA 95814
(916) 442-5196

LICENSED PSYCHOLOGIST

American Psychological Association
750 First Street, NE
Washington, DC 20002
(800) 374-2721

California Psychological Association
1022 G Street
Sacramento, CA 95814
(916) 325-9786

LICENSED CLINICAL SOCIAL WORKER

National Association of Social Workers
1016 23rd Street
Sacramento CA 95816
(916) 442-4565

California Society for Clinical Social Work
720 Howe Avenue
Suite 112
Sacramento, CA 95825
(916) 923-0255

LICENSED MARRIAGE, FAMILY, AND CHILD COUNSELOR

American Association for Marriage and Family Therapy
1133 15th Street, NW, Suite 300
Washington, DC 20005
(202) 452-0109

California Association of Marriage and Family Therapists
7901 Raytheon Road
San Diego, CA 92111
(619) 292-2638

Civil Action

Suing the therapist or his/her employer

Generally, civil lawsuits are filed to seek money for damages or injuries to a patient. For a sexual exploitation case, a patient may want to sue the therapist for injuries suffered and for the cost of future therapy sessions. Under California law, you may file a lawsuit against either the therapist or the therapist's employer if you believe the employer knew or should have known about the therapist's behavior. You may also sue the local or state public mental health agency for which the therapist works, but you must first file a complaint with the agency within six months of the sexual exploitation. (In some cases, this six-month period may be extended to one year.)

Time limits

If you think you want to file a lawsuit, it is important to consult an attorney as soon as possible, since there are different time limits for filing civil lawsuits. Most civil lawsuits must be filed within one year after the sexual exploitation.

Media attention

Once a legal suit is filed, there is the possibility of media coverage, especially if the patient or therapist is well-known. While many cases are settled out of court, some do go to trial, and it can take years before your case is actually tried.

Patients don't always win

You should also be aware that some cases end up being decided in favor of the therapist, rather than the patient.

Finding An Attorney

Take some time to choose an attorney to represent you. You may need to interview several. Here are some points to consider:

- Get a list of attorneys from the State Bar Association or your County Bar Association's referral service. Also, check with your local legal aid society for legal assistance. Look in the telephone book yellow pages under "attorney."
- While some attorneys are willing to wait to be paid based on the outcome of the suit (contingency basis), some will not.
- Be sure that the attorney has civil litigation experience in the area of medical and/or psychological malpractice.
- Check with the State Bar Association to make sure that the attorney has a clear license.
- Make sure that you feel comfortable with your attorney and can trust and confide in him or her.

Criminal Action

California lawmakers want everyone to know that sexual exploitation of patients by therapists is wrong. The law makes it a crime for a therapist to have sexual contact with a patient (SB 1004, Chapter 795, Statutes of 1989, Business and Professions Code Section 729). For a first offense, an offender would be charged with a misdemeanor. Second and following offenses may be misdemeanors or felonies, and the offender may be (1) fined up to $1,000 and/or sentenced to county jail for up to one year or (2) fined up to $5,000 and/or sentenced to state prison for up to one year, respectively.

This law applies to two kinds of situations:

- The therapist has sexual contact with a patient during therapy, or
- The therapist ends therapy to start having sexual contact with the patient.

To file a criminal complaint against a therapist:

- Contact your local police. Police agencies in most larger cities have sexual assault units that handle these kinds of complaints.
- Contact your local Victim/Witness Assistance Program for help through the legal process. Look in your local telephone book under "District Attorney," or call 1-800-VICTIMS (842-8467) for your local program.

Once a complaint is filed, the police will investigate it and give the results to the district attorney's office. The district attorney's office will decide whether there is enough evidence to file criminal charges. Criminal prosecution must be initiated within two years of the offense.

Where To Get Help

For many patients who have been sexually exploited by therapists, it's difficult to see another therapist for help and support. However, for most people, the issues that brought them to therapy were never worked on or resolved, and the sexual exploitation created even more issues to handle. If this is your situation, therapy may be an important tool in your healing process.

Before selecting a therapist, interview several until you find one you are comfortable with. Use the Patient Bill of Rights as a guide. If you are unsure after one session, either consider a different therapist or set up a follow-up session to clarify your concerns. Do not feel pressured to stay with one therapist.

Finding a Therapist

Some ways of finding a therapist are:

- Ask someone you know who has been in therapy, feels good about the experience, and has changed in ways you consider positive.
- Call your local sexual assault center or crisis intervention service (in the telephone book yellow pages). These centers can refer you to therapists experienced in dealing with persons who have suffered sexual exploitation or abuse.
- Call the professional associations (see page 13) and ask for some referrals to therapists who specialize in helping persons who have been sexually abused or exploited by therapists.

After getting several names, call the appropriate licensing board (see page 11) and professional association and ask if the therapists are licensed and if any disciplinary actions have been filed against them. Also check your county Superior Court to see if there is a record of any malpractice lawsuits filed against them.

Self-Help Support Groups

There is an informal network of self-help support groups throughout California. While there might not be a group specifically about sexual exploitation by therapists in your area, there may be more general ones on other kinds of sexual abuse. To find out if there are any in your area, call your local sexual assault center or crisis intervention service (in the telephone book yellow pages).

Frequently Asked Questions

Is it normal to feel attracted to my therapist?

Yes. It is normal to feel attracted to someone who is attentive, kind, and caring. This is a common reaction toward someone who is helping you. However, all therapists are trained to be aware of this and to maintain a therapy relationship that is beneficial to the patient.

What if I was the one who brought up having sex?

That doesn't matter. The therapist is the one who is responsible for keeping sexual intimacy out of therapy.

Does this happen a lot?

A national study revealed that probably fewer than 10% of all therapists have had sexual contact with their patients and that 80% of the sexually exploiting therapists have exploited more than one patient. In other words, if a therapist is now sexually exploiting a patient, he or she probably has done so before and is likely to do so again.

Why do some therapists sexually exploit their patients?

There are probably as many excuses as there are therapists. But no excuse is acceptable for using the trusted, therapeutic relationship for the therapist's own sexual gain. All therapists know that this conduct is unethical and illegal.

Why do I feel scared or confused about reporting my therapist?

Feelings of confusion, protectiveness, shame, or guilt are especially common in this type of situation. After all, in most cases, the therapist is an extremely important person in the patient's life. However, it is important for you to get as much information as possible about your options. Keep in mind that you are in control and can choose what to do.

What if the therapist retaliates against me, harasses me, or files a lawsuit against me for reporting him or her?

Retaliation and harassment of complainants are illegal and can be prosecuted. Contact your local district attorney. If the therapist files a lawsuit against you, you will be required to defend yourself in the lawsuit. However, the law does provide immunity from monetary liability for reporting misconduct to a licensing board.

How can I prevent this from happening again?

1. Acknowledge your right to be free from sexual exploitation.
2. When choosing a therapist, check with the licensing board (see page 11) to see if the therapist is licensed and if the license is under suspension or probation. Also check on any complaints filed with a professional association and with your county Superior Court to see if any malpractice lawsuit judgments are on file against the therapist.
3. Question any action that may seem sexual in nature.
4. Remember that while feelings of attraction are natural, therapy is supposed to be a means to explore and resolve feelings, without having to act them out.
5. Feel free to end a relationship that no longer seems safe.

Can I file an anonymous complaint with a licensing board?

Anonymous complaints are accepted, but they are almost impossible to investigate without the cooperation of the accuser.

Once I told my therapist I didn't want to see him anymore, I felt free. I'm beginning to feel better, stronger.

Reader Survey

The Department of Consumer Affairs would appreciate your comments on this publication. Please take a moment to circle your responses and add comments below.

1. Do you generally find the information presented in *Professional Therapy Never Includes Sex* useful?

5	4	3	2	1
Very Useful	Useful	Neutral	Somewhat Useful	Not Useful

2. Do you find the information easy to understand?

5	4	3	2	1
Very Easy	Easy	Neutral	Somewhat Easy	Difficult

3. Your Comments

_____

_____

Please cut out, fold, tape at edge, and mail to the address below.

_____

Nancy Hardaker
DCA Communications and Education Division
400 R Street, Suite 3060
Sacramento, CA 95814