WHEN THE BOUNDARY IS CROSSED: A PROTOCOL FOR ATTORNEYS AND MENTAL HEALTH PROFESSIONALS

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A protocol is offered to facilitate an understanding of the complicated psycholegal issues inherent in the situation where an individual indicates that he or she has been harmed as a result of sexual boundary violations by a prior therapist. The benefits of developing a collaborative clinician-attorney relationship are addressed. The rights of the client/patient and the responsibilities of the respective professionals are explored. The central theme of this protocol is the issue regarding the potential for the subsequent therapy, as well as the legal, administrative and criminal systems of redress, to be damaging in similar ways as was the original sexual boundary violation. The mental health practitioner faced with the prospect of treating such an individual needs to be aware of the unique needs of these individuals and the potential conflicts and pitfalls likely to be encountered in the process of addressing the emotional and legal issues.

The issue of boundary violations, in general, and sexual boundary violations, in particular, has recently received increased attention by mental health professionals (1-11). In most professions, boundaries are established between a professional and client for the purpose of providing a service and, presumably, a benefit to the client while ensuring protection from harm. Given the extremely personal nature of relationships which develop in psychotherapy, boundaries are particularly important. In contrast to most other professional relationships, the connection between a therapist and patient can become highly intimate. Such relationships often involve regular contact over long periods of time and may involve the expression of the client's deepest, most profound feelings. Given such a highly charged, emotionally significant context, the potential for boundary violations is increased. The feelings induced in both the therapist and the patient carry the potential for evoking actions which go beyond what is clinically healthy or appropriate, ethical or even legal.

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In defining boundary violations, recent authors (7) distinguish between boundary crossings, which may or may not be unethical, and boundary violations, which generally have a greater impact upon the patient and are often unethical and sometimes illegal. There are a number of contexts in which boundary crossings could occur. These include role (for example, certain forms of touching), time (ending sessions early or late), place (meeting a patient for lunch), money (for example, seeing a patient for free without discussing it), gifts, services, language and self-disclosure. With the exception of sexual boundary violations, which are always unethical, determination of the wrongfulness of a boundary crossing will depend upon the type of therapy (for example, traveling in a car with an agoraphobic patient would be appropriate for a behavior therapist), the dynamics and level of functioning of the patient, the intentions of the therapist and how the crossing is perceived by the patient.

Regarding the correlation between boundary crossings and sexual misconduct, Gutheil and Gabbard (7) cogently point out:

> First, sexual misconduct usually begins with relatively minor boundary violations...Second not all boundary crossings or even boundary violations lead to or represent evidence of sexual misconduct...(and) Third, fact finders often believe that the presence of boundary violations (or even crossings) is presumptive evidence of, or corroborates allegations of, sexual misconduct (pp. 188-189).

This article will address the specific issue of sexual boundary violations which occur between a mental health practitioner and a patient(s). Following a brief overview of the extent and nature of this problem, the focus will be on providing a protocol for mental health professionals and attorneys to meet the needs of clients who may have been sexually involved with their therapists.

INCIDENCE AND DYNAMICS OF THERAPIST SEXUAL MISCONDUCT

The exact prevalence of sexual boundary violations between mental health practitioners and patients is unknown. However, the results of several recent, national questionnaire surveys (12) estimates the incidence to be between 9 and 12 percent among male therapists and between 2 and 3 percent among female therapists. These figures are likely underestimates

of actual occurrence, given both the high non-response rates of these surveys and the reluctance of therapists to admit such behavior. Interestingly, there appears to be no difference in the reported incidence of sexual misconduct among psychiatrists,.psychologists and social workers (12).

Sexual boundary violations may occur for a variety of reasons and may be more likely to occur when certain personality dynamics are present in patients and therapists. Several common dynamics of sexual boundary violations have been identified (2). These include:

1) psychopathic exploitation by severely narcissistic therapists (this is believed to occur fairly rarely),
2) confusion of the therapist's needs to be loved with those of the patient, particularly when the therapist is vulnerable due to personal problems,
3) the potential for the therapist and patient to reenact past incestuous relationships,
4) the therapist's belief that love, in itself, will cure the patient, and
5) the acting out of hostility against patients (often borderline patients with histories of severe abuse and neglect) who repeatedly thwart the therapist's appropriate attempts to be helpful, thereby threatening the therapist's sense of omnipotence, and who demand physical contact for cure.

Several levels of functioning of therapists who may be prone to become involved in sexual boundary violations have also been elaborated (14). These include (in order of decreasing potential for treatment and rehabilitation): uninformed/naive, mildly neurotic, severely neurotic and socially isolated, impulsive character disorder, sociopathic or narcissistic character disorder, and psychotic or borderline personality.

Finally, a number of characteristics commonly evident in patients involved in sexual boundary violations with their therapists have been delineated (3, 13-15). These include dynamics of vulnerability, aspects of borderline personality disorder, previous sexual abuse, and various bonding mechanisms, such as idealization of the therapist, dependency, and the "presence of shallow and usually fragile feelings of specialness, increased

self-esteem, and an exaggerated sense of gratification of preoedipal wishes disguised as genitality" (13).

As professional and public awareness of the nature and extent of this problem increases, mental health professionals and attorneys alike can anticipate seeing an increase in the number of patients and clients who have been involved in such relationships with their therapists (5, 16-21). (For the remainder of this article, "client" will be used to refer to an individual served by both health care and legal professionals). It is also very likely that there will be an increased number of administrative, civil, and criminal proceedings arising from these reported violations. Consequently, each profession could benefit from a readily available protocol which would guide them in responding to both the short and long-term emotional and legal needs of the affected clients.

PRELIMINARY CONSIDERATIONS AND CAUTIONS

Ideally, both attorneys and mental health professionals should have received formal training in and possess a working knowledge of the appropriate interventions and therapeutic options, the legal and administrative procedures, and the various reporting requirements of both the legal and mental health fields, relative to complaints of boundary violations made by psychotherapy clients. Armed with this knowledge, either professional would be prepared to appropriately assist the client by assessing his or her needs and administering the necessary interventions, including referral to other professionals.

However, in reality, when a client reports or alludes to boundary violations which have occurred in the context of a relationship with another mental health professional, many practitioners may be aware of only those issues germane to their own profession, and possess a limited knowledge of the ethical and procedural standards of other disciplines. The purpose of this article is to provide attorneys and mental health professionals with a protocol, which incorporates the perspectives of both disciplines, in order to educate them about the salient issues in dealing with victims of boundary violations and to assist them in responding to these individuals in a knowledgeable and competent manner. To do this, both professions must be aware of the unique problems of these clients as well as the potential

difficulties they will likely encounter in attempting to address their emotional and legal needs. It is with this goal of serving the dual needs of the client on the road to wellness and/or redress that this protocol is presented.

It is critically important at the outset to note that both the attorney and mental health practitioner be cognizant of their feelings about the "offending" clinician. The "victim's" story is likely to induce a variety of feelings, ranging from anger to compassion and concern to disbelief and suspicion or, perhaps, identification with the other professional. The practitioner must be vigilant to these reactions so as not to act on them by jumping to conclusions or seeking to rescue, blame, accuse or take any other form of precipitous action, but simply, initially, to listen, without prejudice. Yet, this may be very difficult as the nature of sexual boundary violations between a therapist and client can evoke powerful emotional reactions. One professional may be quick to judge another in order to re-affirm his own virtue regarding such matters ("I'm not like that guy. I would never do such a thing"). Or, the practitioner may feel protective of another professional; similar accusations, which may be unwarranted, though no less distressing, may have been or could be made against him by prior clients.

The practitioner also needs to be aware of the potentially powerful countertransferential feelings toward the client that are likely to be induced in the professional. Countertransference refers to the attitudes and feelings, both conscious and unconscious, that the therapist has towards the client. These can come from the therapist's own unresolved issues stemming from past life experience (subjective countertransference) and/or reactions to the actual personality and behavior of the client (objective countertransference). The recognition and understanding of one's own countertransference often provides a means for understanding the dynamics of the client. However, in order to be able to use countertransference constructively in this way, the therapist must, first, be aware of and admit to the feelings being aroused by the client, and, second, be able to accurately analyze the source of these feelings. To the extent possible, the therapist should first begin to sort out these issues privately or, if necessary, with the support of a colleague, before taking action by introducing them into the therapeutic relationship.

Similarly, attorneys will develop attitudes and feelings about these clients and may be unaware of the potentially powerful and seductive transference and countertransference reactions induced by a client who is claiming to have experienced a boundary violation. The situation is further complicated because the lawyer qua champion-advocate is trained to recognize wrongs and, through action, seek redress, that is, to "fix" it. However, this may directly conflict with the emotional needs of the client. Consequently, in order to fully benefit the client, the attorney must recognize these attitudes, be sensitive to how they might affect the client, and be willing to modify his or her own professional behavior to accommodate the best interests of the client.

It would also behoove both therapists and attorneys to look into their own personal histories to examine any particular propensities for correcting injustices or punishing wrongdoers. How the therapist or attorney acts or intervenes with the client should not be based so much on such personally driven motivations, but rather on an objective, professional assessment of the client's individual needs and how these might best be served.

A MULTIDISCIPLINARY PROTOCOL

Having briefly outlined the nature of the problem of therapist sexual misconduct, the remainder of this article will be devoted to the provision of a protocol to assist attorneys and mental health professionals to work collaboratively in responding to the special needs of these clients. The protocol is quite specific in its delineation of the steps typically necessary. Obviously, each case will be unique. The order and substance of the steps outlined here is meant merely to guide the professional and to sensitize him to the perhaps unforeseen issues that will likely arise from the synthesis of legal and mental health concerns.

Initial Contact and Preliminary Meetings

The "victim" of a boundary violation will either present directly to an attorney or to a therapist, or may initially have consulted with a friend, clergyman, or physician who makes the referral. The client may still be involved with the original therapist sexually, emotionally, and/or therapeutically and may not perceive that there is a problem, or feel the need to deal with it. Indeed, the client may be very protective of the prior thera-

pist, the relationship, and/or may not want to reveal the name of the actor or the full range of involvement.

At this first meeting, attention must be paid to the issue of termination or closure of the original therapeutic relationship. If the initial therapy is still in the process at the time of this consultation, the decision to continue or terminate must be explored. If the treatment has been terminated prior to this consultation, the issue of closure must still be addressed, as the client may still have unresolved feelings about the therapist and the relationship. At this juncture, it is the client's treatment needs that must take precedence over any possible legal or other agenda. Often, the initial therapy involved an intense and close personal relationship of several years duration. The therapist might have become an important, beneficial force in the client's life, both practically and symbolically. The session(s) addressing this issue will likely include guidance, suggestions and strategies; primarily, the process is one of exploration. Indeed, it is not uncommon for the client to describe factual events which give rise to the therapist's belief that a boundary violation has occurred or is occurring, but the client does not see it that way and/or does not reveal the full range of the violation. Because of the characteristic dynamics of the client population generally "violated," the therapist must be even more careful to elicit information neutrally and not to suggest violations to the client: Does the client see the relationship as a problem? What does the client want to do about it, if anything? The mental health professional will need to work with the client on exploring these issues and helping the client to understand them before progressing into the legal and administrative arenas, if at all. Ultimately, it must be the client's decision as to whether and when to terminate the prior therapeutic relationship. Whatever the decision, the achievement of some form of closure between the client and the original therapist must remain an important objective.

Practitioners need to be cognizant of any state mandatory requirements as well as the directives of their professional codes of ethics which may encourage or mandate reporting of such violations to ethics committees and/or licensing boards. For instance, recent state law in New Hampshire mandates that a psychologist who becomes aware of sexual activity between another psychologist and a client has an affirmative duty to inform

the client that such behavior is unethical and to further advise the client that such conduct is cause for discipline by the state psychology licensing board (22). Other states vary in what action, if any, a mental health professional must or may take when made aware that a sexual boundary violation has occurred. In California, for example, a psychotherapist who becomes aware of prior sexual contact in prior treatment must give the client a copy of the state procedure delineating the client's rights and discuss it with the client (23). Minnesota is the only state to have mandated reporting of the prior psychotherapist's name, even over the objections of the victim (24). Since each jurisdiction's reporting requirements are specific and different, it is beyond the scope of this paper to give a definitive response to each situation, except to say that the therapist should know in advance what the obligations are so as to properly advise the client.

The issue as to whether, when and how a multidisciplinary approach is to be taken might arise during the first session, but if not, then shortly thereafter, before important rights are jeopardized. The client must be asked what, if anything, he or she wants to do about the prior therapist. It must be made clear early and often that it is the client who has the option to proceed or not to proceed and in what forum to proceed.

However, the therapist must also understand that while the client might remain protective of the offending therapist and might be resistant to legal interventions, he or she should be made aware that important time deadlines might pass or have already passed. Once the needs of the client have been identified and agreed upon (for example, referral to a therapist for treatment or referral to an attorney), the professional selection process can commence. It will require a careful and deliberate consideration of the personal and professional qualities and experience of this therapist and attorney. Gender issues are also appropriate considerations. Again, the prerequisites for the selection require the practitioner to be knowledgeable about the issues, empathic but not judgmental, and capable of intervention without the imposition of his or her will upon the client. In addition, the selected practitioner must be someone who has no potential conflict of interest with the offending therapist or the client.

Once a referral has been agreed upon, all parties must acknowledge the waiver of the attorney/client privilege, and/or the therapist/patient privi-

lege. More specifically, the client must understand that the therapist will reveal to the attorney therapy notes, therapy session results, and what has been said thus far to the therapist.

It is critical to inform the client at this early juncture and throughout the process that he is not tied to either this particular attorney or this particular mental health professional. The dynamics of what the client has just been through make it even more important to understand that the hiring and firing decision will always belong to the client, who must be so apprised early on and reminded as the stages of the therapeutic and legal process evolve. Since clients may have low self esteem and the patterns of control by the abusing therapist may have been very subtle, the client may be submissive, used to following orders, and have difficulty disagreeing. All parties need to reinforce that the client's decisions are controlling, except as dictated by ethical considerations of both professions. Also, the attorney needs to define clearly the tactical considerations which are uniquely and solely within his province.

The Meeting of Professionals

Once the client has expressed satisfaction with the multidisciplinary team, the collaborative process can begin. Upon authorization of the client, a joint meeting is held between the respective professionals and without the client. Because some or all of the therapist's notes, impressions and work may ultimately be discoverable, and because the attorney/client privilege attaches only to communications between the attorney and client and is waived by the presence of a third party, if this meeting included the client it would probably not be a privileged meeting. If the meeting is solely between professionals with the therapist using the attorney for reference and as an adjunct to therapy, and the attorney being hired in that role, the chances of discoverability are diminished. (See later discussion.)

At this time, there should be a frank exchange of initial impressions regarding a tentative diagnosis, treatment strategy, legal consequences, legal plan and caveats in dealing with this particular client. Therefore, both the clinician and the attorney must apprise themselves and each other of the unique needs of this individual.

Whether the psychotherapist will be involved in treatment or litigation must be considered. There is a clear conflict in roles between the two. If the therapist is to be used for treatment only, then the majority of the work is arguably not discoverable and, therefore, serves as a safe harbor for the client. On the other hand, if the treating therapist is also to serve as an expert witness, then clearly all of the work between the treating therapist and the client is discoverable, should litigation be pursued. Conversely, if the mental health practitioner is to be used solely for forensic purposes, then a referral to a treating clinician should be considered. The treating clinician's objective is to facilitate the client's return to a state of wellness. The forensic expert's objective is to evaluate the client as he or she first presents, to give a diagnostic summary, to give a prognosis, and to document the damages incurred as a result of the boundary violations. These roles are dramatically different. The forensic expert serves a solely evaluative role.

The issue of discoverability of the treating clinician's versus the forensic clinician's work is unclear. It is clear, however, that if the clinician serves both functions, the client's privacy rights will be waived once litigation commences. If a dichotomy in roles is maintained, the therapist can arguably maintain privacy with the client as long as the strictures on the relationship are clearly explained to the client and the attorney, and the role is defined as a non-witness. However, the only thing that can be said with certainty, relative to the ultimate discoverability of the therapist's work, is that potentially all of his or her writings and mental impressions may be scrutinized. Consequently, the clinician should conduct himself with an eye to peer/legal review and an expectation that, should administrative or legal recourse be sought, he may be drawn into the fray. All concerned need to realize that client records may be ordered by the court against the client's will or with the client's consent, and that each jurisdiction will differ in this respect. Indeed, even the meeting of the trial teams could be discoverable. This issue of non-confidentiality must be made explicitly clear to the client in order to prevent additional breaches of trust and emotional damage.

The Meeting of the Client and Professionals

The meeting of the professionals themselves is followed by a meeting involving the client and the two collaborating professionals. By necessity, ample time must be provided for this joint session as there will be many issues to discuss. It is important for all parties to collaboratively explore the legal and psychological issues raised by the client's reported boundary violation. The issues to be included in this discussion might include the following:

1) After acknowledging the attorney/client and therapist/client waivers of confidentiality as between themselves, and the potential discoverability later, a clearly-documented history of the original problem that brought the client to the original therapist must be outlined.
2) A clearly-documented presentation of the client's perception of current problems should also be outlined.
3) A follow-up discussion regarding closure and/or termination of the relationship with the prior therapist should occur.
4) A discussion should occur as to the statutes of limitation so that all parties are cognizant of the time frame within which any possible actions can be brought. The statute of limitations precluding suit begins when the ordinary reasonable person who has been subject to the experience could have discovered that injury was caused by the experience (25).
5) An exploration of the available range of options including criminal, civil, or regulatory means of redress is conducted. The pros and cons of each, and the option of the client to pursue none of these options, is also to be explored. A reaffirmation of the client's right to discontinue working with the clinician and/or attorney, to get a second opinion, or to desist from any further action should be made.
6) The issue of whether the therapist is to be used for treatment or litigation purposes and the inconsistent roles of each, discussed above by the professionals themselves, must now be raised with the client, and the referral to a forensic expert should be considered.
7) At this joint session, the client should be advised to postpone making a final decision regarding any action until there is a full understanding of

what is involved in the pursuit of a particular option. If considering filing a civil lawsuit for monetary damages, the client must be made aware of the following:

- By filing a civil lawsuit for money damages, all rights to privacy are given up; all medical and mental health histories become discoverable.
- The client's life may be investigated, which may include surveillance. Spouses, significant others, neighbors, friends and family may be questioned. Co-workers, former friends, lovers, and teachers may be contacted.
- If claims are to be made for lost wages, lost earning capacity or loss of income, past tax records, employment history and employment records will become discoverable.
- If loss of consortium is claimed, the spouse and spousal relationship will come under close scrutiny.
- All prior suits, claims, and their grounds, will become discoverable.
- Records of prior treatment with other clinicians, as well as physical treatment and/or hospitalization, will become discoverable.
- The client's deposition will be taken, as will the depositions of the treating and forensic mental health practitioners.
- Interviews may be conducted with individuals who knew the client from a prior or current group therapy program.
- In general, a "psychological, forensic autopsy" of the client will be conducted. The client's general reputation in the community for truthfulness and veracity will be at issue. In addition, the suit will be a matter of public record, and there may be public comment or even media attention.

8) On the legal side, the attorney needs to make all parties aware of the difference between discoverability and admissibility. What is admissible in court is that which the trial judge deems relevant and probative on the issues raised by a lawsuit. That is far more narrow than what is discoverable. The rule of discovery is generally that any information sought is discoverable if it is relevant, or if it may lead to relevant in-

formation. Discoverability is quite broad and is often used in cases of harassment in order to deter frivolous litigation.

9) On the psychological side, the client must be made aware of the potentially destructive effects of whatever path of redress might be sought. The alleged events will be repeated in interviews (depositions) and at trial (or administrative hearing). The proceedings will force the client to relive these events and will necessitate repeated and/or extended contact with the offending therapist. There may be publicity attendant to the trial or hearing. The process will likely be long in duration; and the client may be disbelieved, the damages minimized, and his or her own conduct scrutinized. Consequently, a frank discussion of what the client thinks is best for himself is suggested. Last, the client needs to understand that the evolution of the legal process can be both frustrating and stressful. The trial calendar, continuances, and the ebb and flow of the process has its own life, and will probably create anxiety, stress and possibly decompensation in the client as each date nears, is possibly postponed, and passes.

10) The client also needs to be made aware of the extent to which improvement might be construed as a limitation of damages. The more improvement, the less the case might be worth. Conversely, a lack of such improvement might be interpreted as "secondary gain" or malingering. These issues should be explored before the client enters into a process that is likely to be fraught with many "damned if you do, damned if you don't" conflicts.

11) The client also needs to be informed about the potential costs of litigation. Usually this cost must be borne by the client. Indeed, a frank discussion of a contingency fee arrangement, if that is what the client seeks with the lawyer, should be aired. The client must be aware that, in spite of his not paying the attorney, except for a percentage of any recovery, the ultimate decision of whether to proceed with the case is the client's. The attorney will draw no judgments from the client's decision to try or to compromise the claim. The client must also be made aware of the fact that the decision to accept or reject a settlement offer, if made, is his alone, after consultation with the attorney and/or the therapist. The client should be informed that this is a complicated deci-

sion, both legally and psychologically, and that he will actively participate in the decision-making process. The attorney must be certain to have no hidden agenda and to not use the client for some personal, political or social crusade. Similarly, the treating therapist must be certain that the focus of his efforts is for the client's redress and wellness, and no other reason.

12) Again, as the process evolves, it must be reaffirmed that the client is bound to neither the therapist nor the attorney and that the hiring and retention decisions always remain the client's.

13) As there are always at least two sides to every case, the professionals should present to the client the other side of the case, and the points the other side will likely expose/argue. The offending therapist may argue that the prior relationship was not all bad. Indeed, the other side may portray the offending therapist as the victim of a seductive patient. The role of devil's advocate is important in this context as it promotes a fuller understanding to all involved. It is probably important to distinguish for the client that the therapeutic process assumes the truth (or irrelevance) of what the client says happened, while the litigation process concerns itself with the search for the truth and its corroboration.

14) A critically important component of this protocol is that all three participants join in an extended group session(s) as detailed above. This will help to reduce the potential for misunderstanding and additional disappointment and emotional damage. Presumably, if all participants have heard and understood what each has to say, the process will do much to facilitate a positive outcome for the client.

THE PROCESS CONTINUES ON PARALLEL TRACKS WITH INTERSECTING CONTACT

Once these initial considerations have been examined and a direction has been decided, the mental health practitioner and attorney commence their work with the client along their respective professional tracks. As they do so, they keep each other and the client informed as to how the process is unfolding. Both the mental health practitioner and the attorney must consult, regularly, to assess the client's ability to withstand the risks and stresses of the process. They must assist each other in continually clarifying the client's goals, while being mindful that the client is ulti-

mately the authority regarding the decision to continue treatment and/or seek legal redress.

Attorney/Client Meeting

A written fee agreement must be signed, memorializing the parties' understanding of the contingent fee, the hourly rate if that is to be used, and the responsibility for expenses that are generated.

Similarly, the client must be made aware of the fact that the decision to accept or reject a settlement offer, if made, is his or hers alone.

At this juncture, the attorney begins the traditional legal process, keeping the client apprised of what is going on by way of copying correspondence to the client on relevant pleadings.

The attorney must be appropriately available to the client for consultation, and the attorney's staff must be aware of the client's unique needs and be instructed on and prepared to handle this unique and often demanding kind of client.

Mental Health Practitioner/Client Meeting

Similarly, the mental health practitioner commences with the process of psychotherapy. In addition to attending to the psychological needs of the client, the treating clinician must be conscious of the impact of the vicissitudes of the legal process, in and of itself, which can be invasive, intrusive, and often overwhelming.

The therapist should advise the attorney as to the client's current condition and perception of the client's ability to endure each stage of the legal process.

The psychotherapist and the attorney should facilitate each other's exploration of any potential hidden agendas and biases that might be affecting their work with the client. Through the process of personal introspection and through a dialogue among the practitioners, any countertransferential issues will, hopefully, be identified and appropriately resolved.

Time

Obviously, one cannot predict the time in which the client will return to wellness, and this is dependent on a variety of factors often beyond the

clinician's and client's control. Similarly, depending upon which avenues of redress are sought legally, the time frame for resolution of litigation is difficult to predict. The exigencies of court dockets and administrative hearing dates being what they are make time projections difficult if not impossible. Despite this, though, the steps in the process can be delineated. What can be communicated to the client is that there will be a considerable amount of time on the legal side, and that a long, slow and laborious process should be anticipated. Speedy and swift justice went out with the days of the pharaohs and the guillotine.

Resolution

The client continues to be made aware of the psychological ramifications and consequences of each step in the legal process. Goals must continue to be articulated and reexamined. The degree to which wellness versus redress might be at variance needs to be continually explored so that the client can make an independent decision as to whether or not to continue to pursue any legal action. The client needs to understand that he or she still has the right to sue, drop the case, settle the case, or take the case as far as the law allows. The clinician, attorney, and forensic expert, following appropriate exploration, must support any such decision. This continuous evaluation and reevaluation process can become tedious and can result in elevated levels of tension and anxiety for all parties concerned. The parties should bear in mind that the goal of any legal process may not be so much a "search for truth" as it is a quest for a resolution. Sometimes it is a glorious end, and sometimes it is a hollow, pyrrhic victory. The client needs to be made aware of, and psychologically prepared for, the possibility that the ultimate decision might go against him. Even in the event of a favorable decision, the award given might be woefully inadequate. The psychological ramifications of these various outcomes need to be addressed in treatment.

This process, when followed to the end, will eventually lead to a critical decision point, and after the case has been resolved, there needs to be closure for all parties.

If the clinician is still treating, then a determination of whether to continue therapy should be made jointly between the client and therapist.

Consideration should be given as to whether the original problem which brought the client to the original therapist has been adequately addressed or has been masked or mired by the process of the boundary violation.

On the legal side, appropriate releases need to be signed if the matter is settled, privacy agreements are also often mandated and need to be completed, an the winding down of the legal process needs to be completed.

Clearly in both legal and therapeutic arenas, the client needs to be disengaged from the attorney and from the therapist. Frank and candid discussions need to be had among the parties jointly relative to the client's future, (for example, the onus of receiving a large sum of money). The client needs to be given certain tools in order to know when more therapy may be required.

It is suggested that the client critique the attorney and therapist regarding how and in what way their actions minimized conflict and anxiety and maximized efficiency and wellness or recovery (or, vice-versa), so that subsequent clients might benefit from the lessons learned in the process of addressing these complex legal and treatment issues.

Ultimately, the most important consideration is the client's well-being. Awareness of the degree to which the concern for the client's best interests might be inconsistent with the attorney's and/or the clinician's best interests is most critical in preventing additional damage to the client. What makes someone healthier or less healthy is very subjective. The professional involved in this process must continue to make the client aware of the degree to which the legal, administrative and/or criminal processes may be damaging in the same or similar ways as was the boundary violation itself. The principal purpose of this protocol is to provide the attorney and the subsequent clinician with a system that minimizes the potential to replicate or exacerbate any harm done by a previous therapist.

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