IN THE SUPREME COURT OF PENNSYLVANIA

No. 70 W.D. Appeal Docket
No. 71 W.D. Appeal Docket

NICOLE L. ALTHAUS, a minor, by RICHARD T. ALTHAUS and CHERYL RENEE ALTHAUS, her parents and natural guardians, and RICHARD T. ALTHAUS and CHERYL RENEE ALTHAUS, in their own right,

Appellees

v.

JUDITH A. COHEN, M.D. and UNIVERSITY OF PITTSBURGH WESTERN PSYCHIATRIC INSTITUTE AND CLINIC,

Appellants

BRIEF OF AMICUS CURIAE, PROGRAM IN PSYCHIATRY AND THE LAW AND THE AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN, IN SUPPORT OF APPELLANTS

Appeal from the Order of the Superior Court of Pennsylvania at Nos. 1138 PGH 96 and 1217 PGH 96 on April 13, 1998, affirming the Order of the Court of Common Pleas of Allegheny County, Civil Division, Pennsylvania, docketed on May 23, 1996 at No. G.D. 92-20893

Dennis A. Watson, Esquire
Pa. I.D. No. 25500
Grogan, Graffam, McGinley & Lucchino, P.C.
Firm I.D. No. 072
Three Gateway Center
22nd Floor
Pittsburgh, PA 15222

Counsel for Amicus Curiae, Program in Psychiatry and the Law and The American Professional Society on the Abuse of Children

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INTEREST OF AMICUS CURIAE - THE PROGRAM IN PSYCHIATRY AND THE LAW

As part of its consultative role, the Program in Psychiatry and the Law at the Harvard Medical School (see Appendix "A") has for many years reviewed and critiqued clinical practice guidelines and legal decisions which have consequences for patient care and public safety; and interpreted their significance for both local and national professional audiences.[1] Because the case of *Althaus v. Cohen, et al.*, has significant implications for society and mental health practice, especially as it relates to treatment of allegedly traumatized and sexually abused children, the Program is offering this brief for the consideration of the court.

Since childhood sexual abuse is a recognized, serious, valid and under-reported national problem—and since patients who accurately or falsely believe they have been abused are at greater risk for self harm and are in need of treatment—a legal case which negates the principles of sound clinical assessment and treatment for this problem has chilling implications for the welfare of large numbers of helpless children. To aid in preventing these potentially serious implications from having their destructive effects, Program members, as seasoned mental health and medical forensic professionals, respectfully request to offer to the court in this brief some information and principles of analysis for the court's consideration in its deliberations.

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[1]For a list of the members of the Program in Psychiatry and the Law, see Appendix "B".

INTEREST OF AMICUS CURIAE - THE AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

The American Professional Society on the Abuse of Children is a multidisciplinary society of professionals working in the fields of child abuse research, prevention, treatment, investigation, litigation, and policy. The purposes of the APSAC are to promote effective identification, intervention and treatment of abused children, their families and offending individuals, to increase knowledge about abuse, and to improve the competence of professionals working with abused children and their families. APSAC was founded in 1987, and now has more than 5,000 members.

APSAC's interest in this case is to ensure that victims of child abuse have access to treatment, and that professionals engaged in such treatment can provide the best possible care for their clients.

ORDER IN QUESTION

Amici adopt the Order in Question set forth in the brief of Appellants.

STATEMENT OF JURISDICTION

Amici adopt the Statement of Jurisdiction set forth in the brief of Appellants.

STATEMENT OF QUESTION INVOLVED

Amici adopt the statement of the question set forth in the brief of Appellants.

STATEMENT OF THE CASE

Amici adopt the statement of the case set forth in the brief of Appellants.

SUMMARY OF ARGUMENT

A treating professional such as Dr. Cohen owes a fiduciary duty to her patients. That ethical duty would be compromised here by the imposition of a duty of care in favor of the person charged with child abuse. Imposition of a duty of care would also cause damage to the patient-therapist relationship and would decrease the likelihood that child sexual abuse victims would receive effective treatment. For these policy reasons, the Program in Psychiatry and the Law and the American Professional Society on the Abuse of Children urge the Court to reverse the decision of the Superior Court en banc and hold that a mental health professional, who is treating a child who had previously charged her parents with child sexual abuse, does not owe a duty of care to the alleged abusers, the non-patient parents.

ARGUMENT

A. A TREATING PROFESSIONAL SUCH AS DR. COHEN OWES A FIDUCIARY DUTY TO HER PATIENT.

1 The Treating Professional Has a Duty, Termed Therapeutic Privilege, to Refrain from Confronting her Patient with Information That May Be Directly Harmful to Her Patient or May Lead to Flight from Treatment.

The treater has a well-established duty to always act in the patient's best interests and to avoid harmful actions. This ethical principle is enshrined in the Latin phrase for clinicians: "primum non nocere", which may be translated, "As a first priority, do no harm." The treater should be free to give his full, undivided and undiluted attention to the treatment needs of the child.

Any patient has the right to expect a fiduciary duty from her treater, and to assume that her welfare will be the treater's primary concern. In the instant case, larger social issues of the safety of abused children were appropriately delegated to social services and police, who were charged with the investigation of Nicole Althaus's claims and allegations. Dr. Cohen was thus free to perform the vital therapeutic task of seeing the world through her patient's eyes; that is, to understand how Nicole herself saw and interpreted the behavior of her parents, family members, friends, school, etc. It would have violated Dr. Cohen's primary duty to her patient's welfare for Dr. Cohen to discount and question the patient's view of things. Alleged trauma victims whose claims are challenged, even for good reasons, come to feel that their trusted therapist does not believe them, and, as the literature makes clear, their condition deteriorates. See

J.Am.Acad.Adolesc.Psychiatry, Vol. 36, No. 3 (March 1997) at 433-434. (Appendix "C-1".) The Code of Ethics of the American Medical Association specifically exempts clinicians from informing patients about their condition when there is a reasonable risk that doing so would cause the patient's condition to deteriorate. *See* American Medical Association Principles of Ethics, § 8.08 (March 1981) (Appendix "C-2"). This exemption is called therapeutic privilege, an exception to the duty of informed consent. See Appelbaum & Gutheil, Clinical Handbook of Psychiatry and Law at 161 (Balt. 1991).

Abused children often come to therapy after their initial claims have been disbelieved by parents, school authorities and others; this fact places greater onus on treaters to begin by accepting the patients' claims and working from that premise. Note further that some patients may come to psychiatrists with palpably unlikely (e.g., psychotic) claims; these, too must be listened to and patiently explored without peremptory contradiction by the therapist, in order to determine the underlying feelings and pathology so as to treat the patient.

To draw an illustration from the present case, Dr. Cohen needed to work only with Nicole's perception that her father was making inappropriate comments about her body, breaching her bathroom privacy, etc. It was the duty of the authorities, and not Dr. Cohen, to determine whether this or other behavior actually occurred and whether it constituted child sexual abuse—i.e., whether Nicole's internal perceptions matched an external reality.

Dr. Cohen had an additional duty to maintain a therapeutic relationship ("alliance") with Nicole and to encourage her staying in treatment. For Dr. Cohen to

challenge Nicole's perceptions would be to violate her duty not to alienate a suffering and self-described traumatized and endangered child.

Finally, Dr. Cohen has a duty to remain credulous about Nicole's claims at first, even the dubious ones, to permit Nicole to explore fully her feelings about them and, perhaps later to come to a more accurate and mature understanding of them.

If Dr. Cohen had taken a position disbelieving Nicole's claims, her expressed public skepticism would make it impossible for Nicole to trust her. Most trauma victims are well known to fear disbelief by parents or others if they report even legitimate trauma. Thus it was essential for Nicole's treatment that Dr. Cohen not challenge her views but to wait patiently until Nicole had sorted out the issues with her doctor's help.[2]

2. The Duties of Treater and Investigator/Evaluator Should be Separated from the Outset.

The clinic at Western Psychiatric Institute and Clinic at which Nicole Althaus was treated by Judith Cohen, M.D. had in force at that time a firm policy that no child would be treated there for alleged abuse unless and until the suspected abuse had been reported to, and was already being investigated by, the appropriate social and juvenile

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[2]As the literature and studies reflects, even where a child's accounts of abuse contain fantastic and improbable elements, such elements should not necessarily lead the treating professionals to the conclusion that the child's abuse claims have no merit. See M. Everson, Understanding Bizarre, Improbable and Fantastic Elements in Children's Accounts of Abuse, CHILD MALTREATMENT, Vol. 2, No. 2 (May, 1997). (Appendix "C-3".)

authorities. (R. 461a - 463a.) The purpose of this correct division of roles was to leave the treater free to concentrate on the child's welfare, treatment and recovery without a divided loyalty to others than her patient and without being distracted by the various investigative considerations that properly belong to civil and criminal authorities. See Strasburger, Gutheil & Brodsky, On Wearing Two Hats: Role Conflict in Serving as Both Psychotherapist and Expert Witness, Am.J. Psychiatry 154:4, April, 1997 (Appendix "C-4"). To those latter authorities would be delegated those functions that went far beyond the therapy, such as evaluations of the parents, determination of the reliability of various sources of information, assessment of the validity of legal evidence and so on.

3. Accompanying Trauma Patients to Stressful Situations (Such as Court) Is an Appropriate Duty for the Treating Physician.

Dr. Cohen accompanied her patient, Nicole, to court on more than one occasion as an emotional support to her traumatized patient who was going to give public testimony about her alleged abuse in the presence of the alleged abusers. Treaters of trauma victims routinely accompany their patients to stressful encounters of this sort, whether those encounters are family meetings, depositions or trials, meetings with social service authorities and the like. Their role is simply to provide the reassuring presence of a helping person when a child faces the terrors and stresses of the adult legal world, a realm that—though ultimately aimed at child protection—is thoroughly strange and usually frightening to the victimized child.

B. IMPOSITION OF A DUTY OF CARE ON MENTAL HEALTH PROFESSIONALS TOWARDS THE NON-PATIENT ALLEGED ABUSER RAISES A NUMBER OF SIGNIFICANT POLICY ISSUES THAT ARE RELEVANT TO THE PRACTICE OF MENTAL HEALTH PROFESSIONALS AND TO THE TREATMENT OF ABUSED CHILDREN.

1. Physicians Treating Alleged Trauma Victims Should Not Have Duties to Non-Patient Parents, Especially If the Latter Are Alleged Abusers.

A mental health professional is, among other roles, a fiduciary who has a duty to place foremost the interests and welfare of the patient or client. For successful treatment, therefore, the fewer other potentially competing duties on the treater, the better for the patient and, by extension, the mental health of the citizenry

Certain tensions will always exist between therapists' duties to the patient and to so-called "third parties" or to society at large: conditions triggering mandated reporting; danger to others, communicable diseases and the like. But these latter conditions can be distinguished sharply from cases of child sexual abuse where, as here, family members challenge and attempt to refute what the patient tells the treater. It is the treater's duty to pay attention only to what the patient is saying is worth protecting. If the treating clinician must look over her shoulder, lest the family of a patient who believes herself abused can being suit against the clinician, then good treatment is undermined; and the patient's interests alone are no longer decisive and determinative of the aims of treatment.

Note how this issue is in danger of proliferation. If the treater of a child or adolescent must fear that family members can "object" to what emerges in treatment,

then severe constraints are placed on the openness and trust that are essential to all therapies. Patients could not freely report, say, teen-age drug use or homosexual feelings or otherwise forbidden impulses to therapists, for fear that parents would object and litigate in response. Thus, parents or family members could coercively control by intimidation the treatment that patients could obtain.

2. Establishing a Duty to Non-Patient Parents Places Child Victims of Sexual Abuse at Greater Risk.

It is a sad but established fact that much child sexual abuse occurs within the family matrix and that it is markedly under reported. Among the barriers to disclosure by the child him/herself, and objective investigation by forensic mental health professionals, are issues directly relevant to this case.

When a child is being treated for the serious and damaging effects of child sexual abuse, the treater cannot be in fear of the parents for any of the results of frank disclosure and comprehensive exploration of the matter. If society wants to prevent child sexual abuse and support the treatment of abused children, giving to accused parents the power to block, interfere, or—as here—blame and retaliate against the treater, would thwart those laudable social goals. The separation of treatment of a suffering child from independent forensic evaluation of the case, as occurred in this case, is recognized as essential for the validity of both processes.

In a similar vein, an allegedly abused child must feel safe in the treatment setting for any intervention to be successful. If the treater was required to owe a duty to the alleged abusers, the child's protection from being intimidated into silence could not be maintained.

If competent professionals who treat abused children risk being successfully sued for their efforts, their only logical response would be to withdraw from such practice as too risky, a result allowing abused children to go untreated or to be treated by less able practitioners. Socially preferable and more useful alternatives would be to increase instruction of police and social agencies in how to examine and interview children and adolescents correctly. Those efforts would decrease the likelihood of false claims and false arrests for the protection of the larger community, while meeting the goals of protecting children from both abuse and such suffering as is likely when treatment is denied.

CONCLUSION

For the above ethical, clinical and public policy reasons, the Amicus Curiae, the Program in Psychiatry and the Law, and the American Professional Society on the Abuse of Children, respectfully request that the decision of the Superior Court en banc be reversed.

Respectfully submitted,

GROGAN, GRAFFAM, McGINLEY & LUCCHINO, P.C.

By: _____

Dennis A. Watson, Esquire
Three Gateway Center
22nd Floor
Pittsburgh, PA 15222
(412) 553-6300

Counsel for Amicus Curiae, Program in Psychiatry and the Law and the American Professional Society on the Abuse of Children

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