

When the Shrinks Ignore Science, Sue Them

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In 1793, there was an outbreak of yellow fever in Philadelphia. Benjamin Rush, a leading colonial physician and signer of the Declaration of Independence, accepted the conventional wisdom that the condition should be treated with bloodletting. This treatment contributed to the demise of many of his patients. Nevertheless, as the epidemic waned, Rush was more convinced than ever of the efficacy of his methods. When Rush's patients recovered, he attributed their recovery to his intervention. When they died, he chalked it up to the inevitable course of the disease.



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Medical practice has come a long way since Rush. Antibiotics and vaccines, to name two obvious examples, have been transformative. Without exception, these advances have been driven by the application of science to health care. Science substitutes controlled scientific data and statistical predictions for the practitioner's intuition and clinical lore, which are prone to biases in decision making, as Rush illustrated.

By promulgating practice guidelines, institutions like the United Kingdom's National Institute for Clinical Effectiveness and the United States' Comparative Effective Institute work to codify medical practice based on the best

available scientific evidence. But not everyone is sanguine about dethroning practitioners' judgment in favor of science, and spirited defenses of clinician autonomy have emerged in both the professional literature (Hagemoser 2009) and the popular press (Greenfield 2010).

But consider recent cases involving mental health care. A father lost custody of his child because the mental health evaluation of the parent relied upon the scientifically unfounded Rorschach "ink-blot" test. A depressed patient experienced severe side effects from antidepressant medications but was never informed about the option of equally effective treatments like cognitive-behavior therapy. And a number of therapists promise that repeatedly tapping (yes, tapping!) on their patients will cure serious disorders and addictions by adjusting the body's invisible "energy field" (Gaudiano and Herbert 2000).

One of our own patients suffered from severe obsessive compulsive disorder. He would spend hours each day showering and washing his hands until they bled. He sought treatment from a psychoanalyst, who insisted that his symptoms reflected unconscious drives that he must "work through." After his symptoms gradually worsened over

several years of this analysis, he eventually sought behavior therapy and within weeks was completely cured of his condition.

Although many psychological interventions may be ineffective but otherwise benign, research has demonstrated that others can be quite harmful (Lilienfeld 2007). Crisis debriefing is promoted to decrease post-traumatic stress reactions following a trauma, but in fact it actually increases the risk of such problems (McNally et al. 2003). So-called “attachment therapies” have led to the death of several children (Mercer et al. 2003). Facilitated communication, a technique promoted as allowing otherwise severely impaired individuals with autism to communicate fluently via typing on a keyboard while a facilitator supports his or her hand or arm, has led to parents being falsely accused of sexual abuse (Herbert et al. 2002; Romanczyk et al. 2003). These are only a few potentially harmful interventions. Despite data illustrating their potentially harmful effects, they remain surprisingly popular and continue to be used.

Such practices represent the tip of the iceberg of a persistent problem in mental health care: the chasm between science

and practice. To close that gap, several steps must be taken. Of course we need malpractice reform, but not as it is usually conceived. The pernicious effects of frivolous malpractice suits in encouraging unnecessary diagnostic and intervention procedures are widely discussed. But when mental health practitioners use methods that are totally lacking in scientific support, particularly when the treatment has been demonstrated to be harmful and evidence-based alternatives are available, they should be liable for malpractice.

Yet unlike lawsuits against other medical professionals, lawsuits against psychiatrists and psychologists have been exceptionally rare—and successful suits even rarer. Mental health practitioners have been able to escape liability by relying on prevailing community practices—no matter how misguided—to define the permissible standard(s) of care. A defendant can always round up some likeminded community practitioners who will testify that the procedure in question is widely practiced, even if it is scientifically unfounded.

Although suits against mental health professionals remain uncommon, litigants can and should make use of a Supreme Court case to make their

claims viable. In *Daubert v. Merrell Dow Pharmaceuticals* (1993), the Court ruled that expert testimony must be based upon reliable “scientific knowledge” rather than common practice. Thus, when a mental health professional is sued for treating a patient with harmful or unscientific techniques, expert witnesses called upon to describe the prevailing standard of care must base their testimony on science. No longer can defendants argue that they met the standard of care merely because they employed techniques often used by others in the profession.

We acknowledge that clinical practice is complex and often does not lend itself to a simple application of scientifically established treatment protocols. For example, patients do not always fit neatly into diagnostic categories; this requires clinicians to use interventions established for closely related conditions. Patients do not always respond to first-line evidence-based interventions, therefore modifications of an established treatment or even a different approach may be necessary. Evidence-based treatments may not yet be established for some disorders or symptoms, so modifications of established treatment strategies or even a novel or experimental approach may be required. Moreover, in the case of psychotherapy, even relatively straightforward cases necessarily involve some degree of tailoring of the treatment to each individual’s unique circumstances. Each of these scenarios requires judicious clinical judgment. But such judgment should always be informed by the best available scientific evidence. Clinical judgment does not represent a *carte blanche* to escape scrutiny or legal liability.

A related issue is informed consent. Despite being ethically mandated, mental health practitioners rarely obtain fully informed consent from their patients for their interventions. An interesting issue centers on the question of whether clinicians should be permitted to offer services that are completely devoid of scientific support as long as the

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patient is fully informed of this fact, is informed of any known risks associated with the treatment, is informed of alternative options, and is paying out-of-pocket rather than through a private or governmental insurer. Without resolving this particular issue, it is clear that clinicians should always obtain fully informed consent, and such consent becomes even more important the further one deviates from scientifically established practices.

It will take time for case law to sort through the nuances of these real-world complexities. In the meantime, clinicians can minimize their risk of malpractice liability by using scientifically supported procedures whenever possible, ensuring that modifications to established treatments are scientifically informed, avoiding interventions that have been shown to be harmful while providing little or no benefit, and obtaining fully informed consent, especially for experimental procedures. In contrast, by seeking relief through the courts, not only can consumers who have been harmed by unscientific mental health practices seek appropriate damages, but they can also exert a positive influence on the field as a whole by encouraging scientifically based practice.

In addition to malpractice suits, other changes are needed to place routine clinical practice on stronger scientific footing. We need an unequivocal commitment to scientific practice by professional organizations, third-party payers, and state licensure boards. Organizations such as the American Psychological Association pay lip service to scientific standards, but they leave gaping loopholes that allow psychologists to practice all kinds of pseudoscientific nonsense. All too often psychiatrists, psychologists, and other mental health clinicians use unproven and even demonstrably harmful assessment and treatment procedures, even when alternative scientifically supported methods are available. A key principle inherent in health-care reform is that in order to

save costs and improve outcomes, medical practice should be driven by the best scientific evidence (The Hastings Center 2009). That principle should also be applied to mental health professionals, particularly because research has found a number of psychological and psychiatric interventions to be effective (sometimes more so than treatments for physical disorders).

Next, we need user-friendly practice guidelines that are based on the best available scientific evidence and are free of undue influence from interest groups. Reflecting the influence of the pharmaceutical industry, the American Psychiatric Association's guidelines for the treatment of depression are heavily skewed toward drug therapies despite many scientific studies showing that certain forms of "talk therapy," such as cognitive behavior therapy, yield longer-lasting effects with fewer complications. (Of course, the best guidelines are not overly rigid but allow the practitioner to tailor them to an individual patient's unique clinical picture.)

Finally, we must improve consumer education. Paradoxically, the growth of the Internet and advertising of pharmaceuticals makes information more available to consumers but also makes it more difficult to filter good science from potentially harmful pseudoscience.

Each of these strategies has an important role to play, but malpractice suits against mental health professionals may

become *the* critical motivating force behind change, so that the shrinks, too, are guided by science rather than their modern-day versions of bloodletting. ■

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