False Accusations:

Genesis and Prevention*

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Professionals engaged in trust relationships can become the target of false allegations in courts and ethics committees. An allegation is considered false when it is not possible to establish a direct and clear causal link between actions (or inactions) of the accused and damage sustained by the accuser. Long-term psychotherapy allows a unique setting to observe and document the formation of false allegations in slow motion over time. Expert witness work can be likened to a detailed analysis of a battery of psychological tests in which a profile of abusive experiences spanning a lifetime can be constructed to demonstrate the likelihood that the current allegation is false. In such instances the accuser confuses in transference the perpetrator of past abuse with the person in the present trust relationship. Guidelines for prevention of false accusations in professional practice are suggested.

THE PHENOMENA OF FALSE ACCUSATIONS

It is possible for all professionals working in trust relationships to be falsely accused by people with whom they work or have worked. But psychotherapists engaging in long-term depth work are especially vulnerable to being falsely accused since the nature and purpose of this kind of psychotherapy is often to reactivate, for examination in the present therapeutic relationship, the deep and damaging scars left over from past emotional relationships. A close examination of false accusations as they arise in the psychotherapeutic relationship can provide a revealing "slow motion" view of the accusatory process in general as it affects all helping professionals.

A false accusation can be functionally defined as an allegation in which it is not possible to establish a direct and clear causal link between actions (or inactions) of the therapist and damage claimed or sustained by the client. It is often not possible to establish, beyond a reasonable doubt, that

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the activities of the therapist were exploitative. Since allegations of professional misconduct are so serious and so potentially devastating to the professional, a rigorous burden of proof is essential.

FALSE ACCUSATIONS AND ADMINISTRATIVE LAW

The most puzzling aspect of the false accusation cases I have reviewed as a consultant and expert witness is that the clients seem *actually to believe* what they are saying against the therapist is true. There is apparent good faith in their efforts to prosecute the therapist as perpetrator of their damage. There is also a seemingly genuine belief that the therapist actually did exploit a client when there is no clear evidence of either damage or exploitation by the therapist. Attorneys are well trained in identifying lies as well as malicious and pecuniary motivations. They know how to gather evidence to expose such devious motivations. In these cases where the client is vociferously certain of the nature of the damage and of the exploitative motives of the therapist and where the client has worked out a set of vividly portrayed scenarios in an effort to prove the alleged abuse or misconduct, attorneys on both sides of the case, as well as the judges all *know* that something is wrong, but they can't quite get hold of what it is.

Since corroborative evidence is usually meager or lacking altogether as to the falseness of these kinds of accusations, the success of expert witnesses depends upon making a clear and convincing presentation of the way transferences from early developmental trauma typically operate in the therapeutic relationship. Then, drawing upon existing data in the case record (much as one might draw upon psychological test data), the expert witness must be able to show how the accusation in question bears the unmistakable mark of the client's character and/or personal developmental history and how similar accusations are documented in the record through prior interchanges with the therapist, with figures from the past, and with collateral others.

For example, the clinical records of a client accusing his/her therapist of sexual misconduct in an administrative law court may well demonstrate a series of similar documented accusations against previous therapists, hospital personnel, and high school teachers. Further, there are incidents and/or recovered memories of childhood molestation and an early history of, for example, premature birth necessitating intrusive and/or traumatic forms of infant care, infant adoption, and/or a fetal drug and alcohol syndrome. A profile can be drawn to demonstrate that the current allegation fits well within a highly idiosyncratic pattern of the client's previous history, pointing to the high likelihood of the allegation being

false. Indeed, the therapist may have inadvertently acted or failed to act in ways that stimulated the reexperiencing of the existing pattern (such as having been overly supportive or solicitous) so that the therapist became experienced in transference as seductive and/or emotionally abandoning. The allegation of sexual misconduct, however, may lack convincing evidence of exploitative or damaging behavior on the part of the therapist.

Administrative law judges who are familiar with the total case record, who have actually heard the testimony of both therapist and client, and then who have heard the argument about how specific accusations seem more likely to stem from primitive transference-countertransference exchanges rather than from negligence or exploitation are usually sympathetic to the plight of the accused therapist. However, it is my observation that licensing boards who are seldom familiar with the original record, who have usually not taken the time to hear personal testimony from either party, who have little or no knowledge of how deep transferences operate, and who have themselves not been educated in long-term, intensive, dynamic psychotherapy have been unmoved by the false accusation argument or by the administrative judges' opinions, voting often enough instead to discipline and sanction therapists without even the pretense of an open hearing or fair trial.

THE GENESIS OF FALSE ACCUSATIONS: A DEVELOPMENTAL/HISTORICAL PERSPECTIVE

First studied nearly a century ago by psychotherapists were the so-called Oedipal or neurotic transferences left over from dysfunctional family relationships experienced by four- to seven-year-old children (1). In the 1970s, therapists studied the narcissistic transferences left over from the three-year-old period in which needed affirming, confirming, and inspiring others failed in some way (2). During the 1970s and 1980s, therapists studied the borderline or symbiotic transferences left over from faulty or abusive relationships experienced during the character-forming period from 4 to 24 months of age (3).

Although studies of the transference psychosis have existed for many years, only in the last decade has it been possible to spell out in terms of transference development how significant emotional traumas dating from the months immediately preceding and following birth tend to live on in people's bodies, their personalities, and their relationships (4-7). These internalized primitive emotional experiences, which become lived out in later life in trust relationships, are referred to as organizing transferences,

psychotic transferences, or the transference psychosis—whether they are pervasive in the personality or exist only in small isolated pockets.

It is now clear that infantile traumata leave significant psychological scars that cannot be remembered in ordinary ways because the infant's capacities for visual and narrational forms of memory are yet in nascent stages of development (7-9). Remembering of infantile trauma is accomplished by experiencing in significant trust relationships of the present the destructive emotional experiences left over from the primeval past. What dynamic formulations can we call upon to grasp what seems to be happening?

THE PSYCHODYNAMICS OF FALSE ACCUSATIONS

An infant's primary task is to organize *physical* channels of connection to its intrauterine environment for nurturance, comfort, safety, and evacuation. In the months immediately preceding and following birth the infant is active in organizing *psychological* channels to the extrauterine environment, chiefly to the mind of the primary caregiver, the biological mother if she is available. On the basis of simple conditioning principles we can understand that when a baby physically or psychologically reaches out expecting satisfying response from the environment and no reinforcement is forthcoming that the reaching quickly withers or extinguishes. Likewise, when a baby reaches out to organize a satisfying channel of connection with environmental figures and instead encounters some kind of painful or traumatic jolt, the baby quickly learns not to reach in that way again.

Metaphorically, we can say that when early attempts on a baby's part to organize channels to its psychological environment are met either with traumatic under- or overresponsiveness that a sign is posted on that channel or neuronal pathway that says, "Never reach out in that way again." That cautionary imprint constitutes a primordial relationship memory, based on simple approach-avoidance conditioning principles. Babies can be seen to learn quickly what kinds of responsiveness can be expected from whom in their early environment, and their subsequent development proceeds according to basic approach-avoidance conditioning principles. The bottom line is that early trauma causes a terrifying anticipation of emptiness, pain, or agony to be conditioned to certain kinds of emotional relational experiences, thus systematically limiting subsequent learning opportunities that require relationships. Intimate relating itself, therefore, also becomes a source of terror.

Years later in the transference replay of psychotherapy, the client meets with the therapist, hoping for the gratification of primitive relational longings. When the critical moment of approaching the internalized infantile terror and physical constriction arrives, the conditioned response of pain, fear, and terror emerge to warn the client to avoid the therapist's relationship offering. Since this conditioned experience of pain and/or withdrawal has been systematically operating in relational experiences throughout the person's life, it is not surprising that these clients often present histories of various kinds of abuse and that their lives are frequently marked by many kinds of relational pain and withdrawal. There usually remain significant pockets of ego and superego deficit attributable to being unable to approach learning situations requiring relational involvements that the clients find intolerable. These wounded people have amassed a lifetime of experiences regarding what kinds of relational situations are alluring and what kinds are damaging. They have accumulated a lifetime of experiences in denying and projecting the blame onto those who would attempt to relate to them in emotionally connecting ways. The therapist is simply the next target for this lifetime experience of longing, fear, and blame.

At this very early time in their lives the primordial prohibition against future interpersonal emotional connections included for these people only a rudimentary sense of reality and extremely limited capacities for reality testing. Therefore, when the prohibition to interpersonal connection is later broken, the primitive body memory of the infantile trauma is reactivated and there is in transference an unrealistic and instantaneous confusion and fusion of the perpetrator of the past with the helping person of the present who has reached out and in some way succeeded in making emotional contact with the client. The sense of terror, panic, abuse, damage, and exploitation which was originally associated with the perpetrator in infancy is now associated with the perceived violator of the present—the well-intended helping professional.

Thus, the therapist or person in a helping, professional, or trust relationship is unwittingly set up long before the helping relationship even begins, i.e., set up to respond emotionally to the client's appeal for help. Further, the therapist is set up to struggle past adversity to provide a helping, holding, containing, and emotionally reassuring relationship for the person who is so desperately searching for help. Even worse, the psychotherapist is set up for transference-based false accusations by her or his training in empathy and by currently popular clinical theory and technique.

How Training and Clinical Theory Sets Therapists Up to Be Targets for False Accusations

Since the mid-1970s, virtually all approaches to long-term, depth psychotherapy have advocated techniques with features such as empathic attunement, holding and containing, reparenting, or a conjunction of subjective worlds. Emotionally connecting techniques are recommended on the supposition that lower-level narcissistic and borderline clients have experienced various kinds of emotional neglect, abuse, and/or abandonment in the structuring of their early psychological bonding or self-consolidation experiences. The "trust me, I can be there for you" approach therapists often take is generally effective when the internalized fear is of emotional abandonment or narcissistic injury because such fears can be soothed and worked through in an empathetically holding and containing atmosphere.

But the population that produces transference-based false accusations is not generally or primarily made up of those who experienced emotional or psychological abandonment during their bonding experiences or empathic breaches during their self-consolidation experiences. Rather, they are those who, at a yet earlier or more basic developmental level, encountered traumatic under- and/or overstimulation that was classically conditioned to primordial experiences of approach, reaching, connecting, and *organizing* relational channels. *Such people are terrified of emotional connections, not of emotional abandonment, despite the fact that emotional abandonment and empathy failure is what they most often find to clamor for and to complain about to the therapist. The deep terror is of forming and sustaining various kinds of emotional connections that are known from early experience to be traumatic.* All of the therapist's empathic attempts to connect, to relate, to "be there," and not to abandon the client paradoxically serve to escalate the terror and, eventually, to precipitate a wild and frantic escape attempt accompanied by loud cries of abuse. Most members of licensing boards simply do not at present have the knowledge base or expertise to know how to recognize transference psychosis that stems from early developmental trauma. As long as this knowledge gap exists, every therapist who sees clients with early childhood trauma is in potential jeopardy.

THE PREVENTION OF FALSE ACCUSATIONS

What are some measures that can be taken by the therapist to guard against his or her clients experiencing the therapeutic process as traumatic?

1. *Be cautious about whom you take on.* Is each client truly suitable for

once- or twice-a-week outpatient work? What forms of extra care is each client likely to need? Are you prepared to respond to that need? Remember, pulling out or deintensifying later will likely replicate the traumatic infantile experience that produced the initial prohibition against later intimacy, thereby increasing the danger of an accusation. Also remember that "going the second mile" or the third or fourth mile to try to be with or to rescue someone in a deep regression is very hazardous because the situation is likely to be reminiscent of some aspect of a desperate infancy. The client's plea is always for "more"; however, providing "more" runs the risk of forcing a connection to "save" the person when what she or he is running from is the possibility of an emotional connection that will precipitate regressive body-shaking memories of early trauma and abuse. When the client is regressed it may well be you who is accused of the intrusive abuse! This is the precise nature of the organizing transference, and potential disasters for therapists can be predicted.

2. *Remain mindful of the dangers of organizing transferences or transference psychosis* through extensive documentation, use of consultants, and a third party case monitor who also sees the client occasionally, conferences the work with you, and takes careful notes.[1]

3. *Document all peculiar actions and verbalizations that might contain primitive transference material,* and document any physical contact and any countertransference disclosures carefully in terms of the therapeutic context, intent, process, reaction, follow-up, and transference implications.[2]

4. *Avoid going "beyond the call of duty."* It invariably plays into the transference psychosis and creates unnecessary risks for the therapist without providing appreciable gains for the client. Don't be a detective helping your client dig up graveyards or search old dusty cellars for proof of "remembered" abuse. Stay in your consulting room, keep your hands basically to yourself when there is a danger that primitive transferences may be activated (even if you are trained and certified to do body work), and remain in a professional role at all times, regardless of how desperately you are petitioned to do otherwise![3] Carefully document any irregularities

[1]For a discussion of case management and how to set up a third-party case monitor see Hedges 1994, *Working the Organizing Experience: Transformation of Psychotic, Schizoid, and Autistic States* (Northvale, NJ: Jason Aronson).

[2]For helpful guidelines regarding the use and documentation of countertransference disclosures see Maroda, K., 1999, *Seduction, Surrender, and Transformation: Emotional Engagement in the Analytic Process* (Hillsdale, NJ: The Analytic Press) and Hedges, L. 2000, *Facing the Challenge of Liability in Psychotherapy: Practicing Defensively* (Northvale, NJ: Aronson).

[3]In Hedges, L., 1994, *Working the Organizing Experience* (Northvale, NJ: Jason Aronson) I specify certain kinds of token physical contact that may have an *interpretive* value. But any kind of physical

of your technique, explaining in your notes the reasons for your decisions, the client's reactions, your consultations, and your follow-up.[4]

5. *Do not collude with the resistance to transference remembering* by encouraging "recovered memories" and passively going along with acting out on the basis of them. Recovered memories are at best seen as dubious these days, and hypnosis or chemical interviews are risky even when conducted within strict protocols. Make sure that all unusual processes are carefully thought through, your thinking documented, experts obtained, third-party monitoring arranged, and that all questions are processed thoroughly with the client (7, 9, 10).

6. *Remember, borderline clients are afraid of abandonment. But people working in organizing or psychotic areas of personality—no matter how much advanced development they may have achieved—are terrified of interpersonal emotional connections.* Never allow emotional connection to occur without carefully working through the transference fears associated with that connection. Document the forms which resistance to contact takes and work on the transference-based terrors of connection.

7. *Be aware that countertransference reactions to organizing or psychotic transference include not only an irrational fear of the power of the client's psychotic reactions, but frightened confusion on the part of the therapist* when the client fails to reach out for the contact you offer.[5]

CASE CONSULTATIONS INVOLVING HIGH-RISK RELATIONSHIPS

What follows are three examples that illustrate the frequent helplessness of the therapist to effect change and how he or she has then suffered as a result of a negative therapeutic reaction that turned into an accusation. Each case is a therapist narrating his experience in consultation.[6]

CASE 1: MARGE

(As presented by a male therapist with fourteen years of clinical experience)

contact with people living in organizing experience is always dangerous because of their history of prior abuse and/or neglect.

[4]See Hedges, L., 2000, *Facing the Challenge of Liability: Practicing Defensively* (Northvale, NJ: Aronson) for detailed information on "practicing defensively" in order to limit liability—especially when primitive transferences may emerge in the course of therapy.

[5]The many forms taken by transference and countertransference to organizing experiences are studied in Hedges, L. *In Search of the Lost Mother of Infancy,* 1994; *Working the Organizing Experience: Transforming Psychotic, Schizoid, and Autistic States,* 1994; *Strategic Emotional Involvement,* 1996; and *Terrifying Transferences: Aftershocks of Childhood Trauma,* 2000 (all published by Aronson of Northvale, NJ).

[6]These cases are reprinted with modifications from Hedges, L. *Remembering, Repeating, and Working Through Childhood Trauma,* 1994 (Northvale, NJ: Aronson).

I saw Marge for two-and-a-half years ten years ago. She came to me after her children were grown and left home. She was a chronically depressed housewife in danger of alcoholism. A psychiatrist prescribed medication for her but she kept going downhill. Nothing I could do or say seemed to help. She did not want to go to work or school to bolster her skills. She belonged to a church, which was enough group for her. She worried whether her husband was having affairs on his sometimes week-long business trips. She mostly stayed home, watched television, ate, and slept.

On the day that later came into question, Marge was more depressed and despairing than I had ever seen her. Many times she spoke of having nothing to live for and of being despairing because she felt no one cared about her and that life was meaningless. The few friends she had she couldn't talk with. Marge said she was ready to end it all. Inside myself during the entire session I had to continually assess the seriousness of the suicide threat. It seemed serious. I could see that I was going to have to obtain a contract with her to call me before she did anything to hurt herself. But could I trust her even that far? Was I going to have to call the paramedics or police before I let her leave? *I tried everything I could think of but could achieve no connection.*

That day, Marge sat on the end of the couch further away from me than usual. *With ten minutes left, I asked her if I could sit on the couch with her for a few minutes, thinking that perhaps that might help.* She assented with some faint signs of life. A few minutes later, in desperation, I asked if it would help if I put my arm lightly around her. She thought she might like that and shortly perked up enough for me to let her leave safely. I have four children. I know what a father's reassuring arm can mean and what it feels like—and I swear to God that's the way it was. I also believe that was the way she received it at the time because we seemed to connect and she took heart. We continued therapy for some months and Marge began to get better, to relate to people more, and to take night classes.

Several years later, I closed my practice entirely and left the clinic where I had been seeing Marge to take a full-time job for a managed care company. She wanted to be seen again and found out how to contact me. I explained to Marge over the phone the reasons why I could not continue working with her; at that point I had no office, no malpractice insurance, no setup in which I could see her. She was enraged. She claimed I had always promised to love her and to see her no matter what. She wrote a threatening letter to the director of the clinic where I had worked. He asked if we three could meet together. She was insinuating I had behaved inappropriately with her, had hugged and kissed her and made all manner

of promises to her—none of which was true. All of it was apparently fabricated from that one incident and my lengthy commitment while working with her. This meeting with the clinic director settled her down a bit and she recanted the things she had said in the letter. He tried to arrange for her to see another therapist, which she refused to do. Shortly thereafter she caught her husband in what she was sure was a lie about some woman he was involved with at work. Again she demanded to see me. I spoke with her on the phone, and tried to assuage her rage that I could not see her. She unleashed a tirade over how I was abusing her. By this time she had been in an incest survivors' group for a while and she had gained plenty of validation for her rage at her parents, and so was much freer to rage at me. I gave her appropriate referrals.

The next thing I knew, an armed investigator from the state licensing board showed up at my work with an attaché case and a lot of questions. Marge had written a letter alleging sexual misconduct. But according to administrative law practices I was not allowed to see the letter. You know we do not have the same civil rights in administrative proceedings that we have in civil or criminal proceedings. We are basically presumed guilty until proven innocent.

Marge and I were doing good work and we both knew it. We got to many of the really terrible experiences she had undergone in childhood. I had her on her feet and moving in the world again, and I think I could have gotten her out of her deep and lifelong depression and low self-esteem if the insurance money had not run out. And now this.

Commentary on Marge

The most dangerous act for a therapist when working with an organizing transference is to connect successfully to the person without adequate working through of the resistance to emotional connection. Yes, this man saved the day and did not have to hospitalize his client. He succeeded in calling her back from the brink. But he is deluded in thinking that connection is experienced as good by people living organizing experience. It appears that she never forgave him for approaching and connecting when she wanted distance and that he then became fused into her psychotic fantasies as yet another infantile perpetrator. Her distress that she cannot have him further fuses him to the image of the perpetrator. Also, physical touching for the purpose of providing comfort or reassurance is never a good practice. Because, if it is not misunderstood as a seductive invitation, it will surely be seen as a replication of an abusive penetration. There is one certain, carefully defined and focused potential

use for *interpretive touching* in work with organizing or psychotic transferences (5, 6). But interpretive touch is a carefully calculated concretized communication given at a critical and anticipated point in time when the person is having a hard time sustaining a connection and clearly understands the nature of the interpretive communication. The licensing board will have no way of understanding that the therapy was going well until outside forces interrupted, plunging Marge into despair, with which her therapist successfully connected. The psychotic transference then operated to fuse his contact with her experiences of childhood abuse.

CASE 2: HORACE

(As presented by a male therapist with twelve years of clinical experience) We finally reached the psychotic transference. I had been trying unsuccessfully for months to bring some deep abuse into focus. Horace had a business presentation to make the next day and he was terrified of the challenge. It would be a reach for him and he might be questioned on some difficult issues. He did not know if he could cope. He was afraid. He went numb on the couch—actually experiencing a body paralysis for fifteen or twenty minutes. Had this not been a gradual descent into the psychotic pocket I had been hoping to explore, I might have been alarmed for medical reasons. In fact I did check with him to be sure he thought everything was okay. While he was in the trance, he experienced severe blows to his face and head accompanied by loud, startling, and frightening yelling. They came suddenly out of nowhere. He had never been able to cry, never been able to raise his voice in pain. Now he knew why. It seemed certain that his father had abused him as an infant for being a needy baby, for whimpering and crying. He was feeling whimpery and needy that night with me because of the presentation the next day. In transference he experienced me as abusing him for being needy.

That night his therapy basically ended though it was some time before I realized it. Horace ran a fast retreat from that frightening place that he never wanted to be in again. He had for a lifetime been running from this terrifying body memory and the total agony it represented to him. Retrospectively, I see that his setting me up began at that point. He began needing a great many concessions and unusual arrangements in our work, which I did my best to accommodate. These seemed interpretable in a variety of ways within the context of his life history. But it turns out, Horace was working behind the scenes collecting a list of variations in his professional relationship with me that could later be distorted in court to look as though they were inappropriate. *Knowing about a series of previous*

antisocial escapades in his life should have served to keep me alert, but I was so preoccupied with his fears and demands that I was lulled into inattentiveness.

Horace abruptly and aggressively terminated his work with me without ever successfully bringing the primitive transference into the analysis. When a subpoena for my records arrived, I was in a state of total shock. His manner of turning against me when I was least expecting it—harsh blows coming out of nowhere—replicated what I had seen him experience on the couch. He never wanted to go there again and shockingly arranged to turn the tables so that it was I who felt like a fool for trusting. In an alarming identification with the aggression he turned his primitive and violent trauma toward me.

Commentary on Horace

Never trust that someone in depth therapy will not attack you surprisingly, ragefully, and mercilessly when the psychotic transference has been mobilized. Primitive transferences cannot be fully assessed in advance and no reality limit is respected in their acting out. Trusting that this person would never sue you is to be a fool about the very problem your therapy seeks to bring out—madness, desperation, and sociopathic manipulations. We must never be lulled into inattentativeness when working an organizing transference.

CASE 3: TRULA

(As presented by a male therapist with twenty-two years of experience)

I know I did wrong and the worst part is that I knew it was wrong while I was doing it. It was horrifyingly uncanny. It was like a part of me was up on the ceiling looking down watching and knowing at the time that what I was doing was wrong. We had worked well together for three years but the challenge of a major promotion at work that was just beyond her grasp set off a major regression with fragmentation and depression. Trula became increasingly desperate and wanted to stop coming to see me. *Finances were an issue. I insisted we could not stop suddenly this way. I lowered my fee, and after some weeks of watching her desperately floundering just beyond my reach, I could not stand it any more.* I moved toward her, I embraced her to protect and reassure her. I held her, touched her, and gently kissed her. A part of me for a long time hoped she would sue me. Being punished would have been sweet relief. Instead, I had to experience the most agonizing regression imaginable in my own therapy.

My own mother was gravely disabled and could not care for me when I was born. I grew up in foster care and remember endless painful

Saturdays waiting on the porch steps for her to come. Sometimes she would, sometimes she would not, but I waited all day anyway, hoping. Even as an infant I must have somehow known she was fragmented, hurting, desperately needing help and reassurance. When my client entered this same despairing, unreachable place I could not bear it. I moved to rescue her, to try to give her the love, the containing, the touch she so desperately needed. And my client did respond favorably at the time. She pulled herself together and made a great success of her promotion. But when a devastating personal tragedy later hit her, I succumbed to financial blackmail to avoid public embarrassment.

Commentary on Trula

The psychotic transference always hooks us deeply. As the client continues to pull away, we are in danger of reliving our own infantile organizing period and feel the desperation that we may die if we cannot find mother. It is the client's successful connection with the primordial yearning that produces terror—thus replicating the original experience of the infant that foreclosed the possibility of emotional bonding and further development in selected areas of ego and superego functioning.

CONCLUSION

Hilton (11) points out that a three-part response to accusation arises almost instinctively from most of us: 1. denial—i.e., "I didn't do it," 2. defense—i.e., "I did the best I could," and 3. blame—i.e., "She knows better than this, this accusation is pathological." The real problem, says Hilton, is that an accusation often is aimed, somewhat successfully, at a core emotional wound of the accused, at a blind spot, or Achilles' heel. Until the accused is able to work through the core wound as it is active in the present relationship, it is unlikely that he will be able to give a satisfying response to the accuser who "knows" he or she is somehow right.

Hilton charts a course for us: 1. Avoid denial, defensiveness, and blame. 2. Use consultation to work through the core wound the accusation touches in you. 3. Show the person that you know how deeply he or she has been wounded by you or by the position you have taken. 4. Provide some reassurance that this particular kind of injury can somehow be averted or softened in the future—that is, that "this won't happen again to me or to someone else."

Hilton also believes that the most sensitive moment in the accusatory process is when the client first broaches the accusation with the therapist. First, she says, it takes a lot of courage to confront someone you believe is

or has been abusing you. Secondly, given that transference distortions are likely to be in operation and given the high probability that the accusation will be successfully aimed at a core wound of the accused, it is important to make every effort to "get it"— to grasp what the person is saying, to show an understanding of how they feel you have hurt them, and to acknowledge how determined they are to see to it that you do not hurt them or anybody else in this way again.

"Getting it" the first time correctly and extending deep empathy can save professionals a lot of time, expense, and grief. It's no skin off your back to acknowledge that you now see that what you did (or did not do) caused hurt and pain to them—and to make matters worse, *you* of all people who "should have known." Acknowledge that despite your best intentions, your judgment failed to show a full understanding of where they were coming from at the time. "No wonder this hurt so much." An acknowledgment of empathic failure does not constitute an admission of liability or of a wrongful act.

False accusations against therapists will not stop until therapists who conduct long-term, dynamic, depth-oriented psychotherapy become knowledgeable and skilled in working with primitive layers of the human mind. And unjust prosecutions will not stop until licensing boards and administrative law judges come to appreciate how transference from infantile trauma operates.

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