STRICT LIABILITY FOR PSYCHOTHERAPISTS-PATIENT SEX

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A woman enters psychotherapy for feelings of depression, sadness and frustration. Her marriage is failing. Her life has no meaning. She relates her troubled childhood with distant, preoccupied parents. She outlines her history of troubled, rejecting relationships. In therapy, she breaks down, weeping and overwhelmed. At the end of the session, the empathic therapist embraces her momentarily to show his support and concern for her. During the next session, she kneels down beside him seeking his embrace and comfort. After several sessions of embracing they kiss. Sexual touching and, finally, intercourse follows.

What began as a human gesture of comforting, developed into a personal, intimate relationship between a psychotherapist and his patient--a clear breech of his ethical and fiduciary duties. In spite of enormous media attention, frequent and public licensing board actions, and regular discussions in professional societies, this type of scenario repeats itself daily in psychotherapists' offices throughout the country. In an anonymous survey of psychologists and psychiatrists, nearly ten percent admitted to engaging in erotic contact with their patients.

Strikingly, in other surveys, almost 90 percent felt sexually attracted to their patients. Unanimously, the professional societies of psychiatrists, psychologists, social workers and counselors have ethical guidelines which prohibit psychotherapists-patient sex, and there is no professional psychotherapist who can legitimately say that he (or she) is not aware of them.

Today, more and more of these cases are also finding their way into the courtroom as a malpractice suit. The American Psychiatric Association's figures, for example, indicate that at least 15 percent of legal cases are related to sexual activities. In fact, the psychotherapist who has engaged in sexual contact with a patient, should almost expect a malpractice suit, especially if the relationship with that patient ends acrimoniously. For psychotherapists, there is tremendous risk both professionally and financially. Licensing boards have become intolerant of such behavior and routinely suspend or revoke the professional license to practice. And, malpractice insurance carriers will usually not cover damages that are a result of psychotherapists-patient sex (they may cover a limited portion of the legal defense).

Unfortunately, none of this seems to be a deterrent. From a litigation standpoint, regardless of the nature of the relationship or the relative contribution of either party, the evolving standard in these cases appears to be one of strict liability. The foundation for both the ethical guideline and professional duty to not engage in psychotherapists-patient sex lies in two principals: the fiduciary relationship and the concept of transference. The *fiduciary relationship* has been held by courts to be analogous to a guardian-ward relationship. As a consequence, there is public policy that demands protection of the patient from the deliberate and malicious abusive power and breech of trust by a psychotherapist, when that patient entrusts his or her body and mind. As professionals, psychotherapists have a duty of non-maleficence, i.e. to do no harm to the patient; a duty of beneficence, i.e. to further the patient's important and legitimate interests; and a duty of justice, i.e. to provide fair and equal treatment based on what the patient rightfully deserves.

Yet, those professional duties are not unique to psychotherapists but are part of every professional relationship. So, physicians of all specialties, attorneys, accountants, and other professionals should have similar obligations. How different is it, therefore, if surgeons or tax attorneys have sex with their patient or client? Is trusting of ones entrails or bank account

any less sensitive or vulnerable to exploitation? Some authors have written that the fiduciary duty in a psychotherapist-patient relationship precludes a patient from being able to consent to sex. Is that really different from a patient who just had her gallbladder removed? What about the client whose financial affairs have been entrusted to an attorney? Can they not consent?

The second principal governing the duty and prohibition against sex in the psychotherapist-patient relationship is *transference*. Transference is the psychoanalytic concept that basically says: when people interact with each other, they tend to interact with them in part as they have learned to interact with the earlier most important figures in their lives--usually parents or other authority figures during their rearing. Often, the psychological problems that people have today (especially in relationships) are based on earlier defects in relating, which the person now, unknowingly, brings into the current situation. For example, if a person was defensive and rebellious toward important authority figures in early life, that person may now have a tendency to be defensive and rebellious to any authority figures such as supervisors or bosses. As a consequence, there may be difficulty keeping a job.

What traditional analysts do, therefore, is to create a therapeutic situation in which they try not to reveal much of themselves in the analytic session, or to otherwise interact in a normal give-and-take fashion, but merely to listen and observe the patient. In this way, the analyst does not give the normal cues to which a patient would typical react during encounters in everyday life. The patient then begins imagining things about the analyst, and reacting to the analyst by projecting feelings onto the analyst, which are based primarily on his or her own learned early attitudes and needs. Without realizing it, the patient begins to think of the analyst as someone else from the past. In turn, the patient begins to behave towards the analyst as if the analyst was that other person. These attitudes, behaviors and needs are then pointed out during analysis and discussed, so that a better understanding of ones self and ones interactions with others can result.

In psychoanalytic psychotherapy, this is why a sexual or love relationship between an analyst and a patient is taboo, because the patient is not falling in love with the analyst at all, but with an image that the analyst allowed the patient to create by structuring the relationship in such a way that it could happen. Obviously, in these situations, this is not a level playing field. Patients are not dealing with the psychotherapist as a real person; they do not even know the psychotherapist as a real person. They are dealing with the position of care and concern, as well as the projections of their imagination onto that psychotherapist. It is very easy for a psychotherapist to become seduced by the admiration or affection of a patient, and to believe that it is for more than just the professional role. Or, after having a friendly relationship with the patient over many years, to forget that at the outset and through those years, it was the cloak of the profession to which that patient was reacting and not a friend they might otherwise have met at a social club.

Psychoanalytic theory is well aware of this potential--even if psychotherapists themselves too often fall into the same trap--and it designates a psychotherapist's problematic behavior with a patient into *boundary crossings* and *boundary violations*. Boundary crossings are behaviors that go beyond the strict nature of the professional relationship; but they are not, in and of themselves, necessarily inappropriate. However, they should be carefully noted since they can easily lead to inappropriate or unethical conduct. Boundary violations, on the other hand, are already inappropriate and unethical. For example, a psychotherapist may embrace a grieving mother who is mourning the recent loss of her son (a boundary crossing); but, a psychotherapist who has her sit on his lap while embracing her during the entire session is unethical (a boundary violation).

Although transference occurs to some extent in every psychotherapist-patient relationship, it also occurs, to some extent, between every professional and patient/client. From an ethical standpoint, the degree of transference does not matter--boundary violations are unethical anyway. The more troubling question, however, is that of the patient's ability to consent. Almost invariably in these malpractice cases patients are said to have been unable to consent because of transference. But, the model of the unrevealing psychotherapist is no more present in all forms of psychotherapy than it is in other nonpsychotherapeutic professional relationships. For example, what of the psychotherapist who has only seen a patient once or twice in consultation, or for medication management alone? Can the patient never consent in these situations? Is that really different from a dermatologist, ophthalmologist, or physical therapist? What about a psychotherapist whose professional relationship with the patient has ended, can that patient not consent to a sexual relationship three months later? Three years later? What if that psychotherapist and patient later married and lived out their years together? Is the patient in a perpetual nonconsenting union?

In malpractice cases of psychotherapists-patient sex, the issue of the patient's inability to consent has relevance not only for liability, but also spills over into damages. The nonconsenting patient is assumed to be more damaged, and since consent is never possible, the damage is always great. So, what has emerged is a strict liability standard in which the patient is always said to be powerless without regard to the circumstances. Interestingly, most malpractice suits are filed not when the sexual activity occurs, but when the "personal" relationship appears to be dissolving.

Neither the fiduciary duty nor the transference potential in a psychotherapist-patient relationship automatically means that a patient cannot consent to a sexual relationship with the psychotherapist. While in some instances, especially more analytically oriented psychotherapy, there may be a very strong power gradient that dulls the ability to consent, in modern psychotherapy that is more the exception than the rule. Defining all psychotherapy patients as powerless is dehumanizing and unrealistic. On the other hand, regardless of the patient's power to consent, sex by a psychotherapist with a patient or former patient is unethical. It may or may not be that damaging to the patient, depending on the circumstances, but it is always damaging to the integrity of the profession and to public trust. Licensing boards appropriately should take action against psychotherapists who engage in such behavior, and patients may have legitimate malpractice claims depending on their unique vulnerability. But, the degree of damage must be scrutinized more carefully in light of the complexities of the relationship and the relative involvement of the parties, and not just on the *de facto* strict liability standard.

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