

**Psychotherapist Malpractice**  
**Adapted from Ch. 55: *Sexual Abuse*, in ATLA LITIGATING TORT CASES**  
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**Introduction**

This paper will address psychotherapist malpractice in the context of boundary violations, where a psychotherapist engages in a personal or sexual relationship with a patient. The broader range of psychotherapist malpractice, involving misdiagnosis and treatment, will not be addressed. Such cases are more akin to medical malpractice cases.

**Claims Arising out of Boundary Violations**

Therapists routinely deal with troubled, vulnerable, suggestible patients. A known risk of psychotherapy is that the patient may become overly attached to the therapist and may consent to sexual contact without appreciating its damaging consequences. This attachment phenomenon is known as “transference,” a term that describes a patient’s displacing feelings about another person and redirecting them toward the therapist.<sup>1</sup> Through the intensity of the therapy, the patient “develops an intense, intimate relationship with her therapist and often ‘falls in love’ with him.”<sup>2</sup> Transference can be an important part of the therapeutic process; at the same time, it carries with it a tremendous potential for abuse.<sup>3</sup>

A related phenomenon is counter-transference, whereby the therapist projects his or her own experiences and relationships onto the patient.<sup>4</sup> While a therapist may use transference

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<sup>1</sup> See Barry Furrow, *Malpractice in Psychotherapy* 33 (1980).

<sup>2</sup> *Franklin v. Professional Risk Management Services, Inc.*, 987 F. Supp. 71, 73 (D. Mass. 1997), quoting *St. Paul Fire & Marine Ins. Co. v. Love*, 459 N.W.2d 698, 700 (Minn. 1990).

<sup>3</sup> Linda Jorgenson, Steven B. Bisbing, and Pamela K. Sutherland, *THERAPIST-PATIENT SEXUAL EXPLOITATION AND INSURANCE LIABILITY*, 3 *Tort & Ins. Law J.* 595, 597-598 (1992); Robert Simon, *WHEN BAD MEN DO WHAT GOOD MEN DREAM*, Ch. 6 (“The Ultimate Betrayal: Sexual Misconduct in the Helping Professions”), 111-142 (Washington, D.C. 1996); Ellen T. Luepker and Gary Richard Schoener, *Sexual Involvement and the Abuse of Power in Psychotherapeutic Relationships* in Gary Richard Schoener, et al., Eds., *PSYCHOTHERAPISTS’ SEXUAL INVOLVEMENT WITH CLIENTS: INTERVENTION AND PREVENTION* 65-79 (Minneapolis, MN 1989).

<sup>4</sup> *Doe v. Samaritan Counseling Center*, 791 P.2d 344 (Alas. 1990), overruled on other grounds by *Veco, Inc. v. Rosebrock*, 970 P.2d 906 (Alas. 1999); Robert Simon, *WHEN BAD MEN DO WHAT GOOD MEN DREAM*, Ch. 6 (“The Ultimate Betrayal: Sexual Misconduct in the Helping Professions”), 111-142 (Washington, D.C. 1996); Ellen T. Luepker and Gary Richard Schoener, *Sexual Involvement and the Abuse of Power in Psychotherapeutic Relationships* in *PSYCHOTHERAPISTS’ SEXUAL INVOLVEMENT WITH CLIENTS: INTERVENTION AND PREVENTION* 65-79 (Minneapolis, MN 1989).

for positive gain in therapy—to understand “what transference role the patient is forming, [to gain] understanding of what is being relived and re-experienced rather than being remembered . . . [and to regulate] the future course of therapy”<sup>5</sup>—misusing or exploiting transference or counter-transference to engage the patient in sexual activity is not only inappropriate, it can be harmful and damaging to the patient.<sup>6</sup>

Accordingly, ethics standards for psychotherapy prohibit all sexual contact between mental health professionals and their patients, and with former patients, usually for at least two years.<sup>7</sup> In the opinions of experts, a therapist owes his patient a professional duty to avoid sexual contact *even if the patient consents, or purports to*.<sup>8</sup> Consequently, sexual intimacies

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<sup>5</sup> Zipkin v. Freeman, 436 S.W.2d 753, 756 (Mo. 1968).

<sup>6</sup> Linda Jorgenson, Steven B. Bisbing, and Pamela K. Sutherland, THERAPIST-PATIENT SEXUAL EXPLOITATION AND INSURANCE LIABILITY, 3 Tort & Ins. Law J. 595, 597-598 (1992); Kenneth S. Pope, *Therapist-Patient Sex Syndrome: A Guide for Attorneys and Subsequent Therapists to Assessing Damage*, in Glen O. Gabbard, Ed., SEXUAL EXPLOITATION IN PROFESSIONAL RELATIONSHIPS 39-55 (Washington, D.C. 1989); Gary Richard Schoener, *The Assessment of Damages* in PSYCHOTHERAPISTS' SEXUAL INVOLVEMENT WITH CLIENTS: INTERVENTION AND PREVENTION 133-146 (Minneapolis, MN 1989). Gary Richard Schoener, Jeanette Hofstee, and John C. Gonsiorek, *Therapeutic Responses to Clients Who Have Been Sexually Abused by Psychotherapists*, in Gary Richard Schoener, et al., Eds., *Psychotherapists' Sexual Involvement with Clients: Intervention and Prevention* 95-112 (Minneapolis, MN, 1989). See also Carolyn M. Bates and Annette M. Brodsky, *SEX IN THE THERAPY HOUR: A CASE OF PROFESSIONAL INCEST* (New York, 1989); Lucy Freeman and Julie Roy, *BETRAYAL* (New York, 1976); Ellen Plasil, *THERAPIST* (New York, 1985); Evelyn Walker and Perry Deane Young, *A KILLING CURE* (New York, 1986).

<sup>7</sup> See American Assoc. of Marriage & Family Therapists, ETHICAL PRINCIPLES FOR FAMILY THERAPISTS §1.4 (“Sexual intimacy with clients is prohibited”), §1.5 (sexual intimacy with former clients prohibited for two years) (2001); American Assoc. of Sex Educators, Counselors and Therapists, AASECT CODE OF ETHICS (1993)(prohibition on sexual activity with client or former client); American Psychiatric Assoc., PRINCIPLES OF MEDICAL ETHICS & ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY §1(1) (“A psychiatrist shall not gratify his/her own needs by exploiting the patient”)§2(1) (“Sexual activity with a current or former patient is unethical”) (2001). American Psychoanalytic Assoc., PRINCIPLES AND STANDARDS OF ETHICS FOR PSYCHOANALYSTS, Principle VI (2001); American Psychological Assoc., ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT Standard 4.05 (1992)(“Psychologists do not engage in sexual intimacies with current patients or clients”; other standards discourage sexual contact with former patients except under “the most unusual circumstances” (4.07) or providing therapy to former sexual partners (4.06)(Draft 7 of the revision (April 15, 2002) contains the same provisions (Standards 10.05, -.07, -.08), strengthening to a prohibition the ban on sexual intimacies with former patients for at least two years (10.08), and adding a ban on intimacies with relatives or family of patients (10.06); Council on Ethical and Judicial Affairs, American Medical Association, *Sexual Misconduct in the Practice of Medicine*, 266 J.A.M.A. 2741 (1991); ASSOC. FOR THE TREATMENT OF SEXUAL ABUSERS PROFESSIONAL CODE OF ETHICS §7(e), -(f) (2001) (prohibitions on sexual intimacy with current and former clients); CLINICAL SOCIAL WORK FEDERATION CODE OF ETHICS §II.3.a (proper boundaries), -.b (no sexual relationships with current or former clients) (1997); Nat’l Assoc. of Social Workers, Inc., CODE OF ETHICS OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS, Standard 1.09 (1996, 1999)(prohibitions on intimacies with current and former patients or their family members, and on treating former sexual partners); National Board for Certified Counselors, Inc., NBCC CODE OF ETHICS §A(10) (1997) (prohibition on sexual relations with current clients and former clients for two years).

<sup>8</sup> Kenneth S. Pope, *Therapist-Patient Sex Syndrome: A Guide for Attorneys and Subsequent Therapists to Assessing Damage*, in Glen O. Gabbard, Ed., SEXUAL EXPLOITATION IN PROFESSIONAL RELATIONSHIPS 39-55 (Washington, D.C. 1989); Dan B. Dobbs, THE LAW OF TORTS § 102, at 238 nn. 9, 10 (2000). But see *Worsham v. United States*, 828 F.2d 1525, 1527 (11th Cir. 1987) (although sexual misconduct by a drug and alcohol counselor was unethical and improper, “no tort can be committed against a person consenting thereto if that consent if free, is not obtained by fraud, and is the action of a sound mind”).

between therapists and their clients are generally considered by experts to be malpractice, and in most jurisdictions will support a legal claim for damages based upon malpractice.<sup>9</sup> Indeed, a therapist's mishandling of transference leading to sexual involvement is such a serious violation of trust that some courts deem it gross negligence.<sup>10</sup>

Some states have enacted special statutes creating a cause of action for damages for psychotherapist sexual exploitation.<sup>11</sup> These statutes are a codification of professional standards and often contain special provisions specifically eliminating consent as a defense and in most circumstances prohibiting the discovery and use of a plaintiff's sexual history.<sup>12</sup>

Sexual contact is not necessarily a prerequisite for a malpractice claim based on inappropriate boundary violations by a therapist. It is generally accepted among psychotherapists that interaction between patient and therapist that transgresses professional boundaries is inappropriate and may be harmful even without blatant sexual contact.<sup>13</sup>

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<sup>9</sup> See, e.g., *Benavidez v. United States*, 177 F.3d 927 (10th Cir. 1999) (claim that psychologist encouraged client to use drugs and engaged him in homosexual sex was negligent malpractice not assault or battery for purposes of the FTCA); *Simmons v. United States*, 805 F.2d 1363 (9th Cir. 1986); *Doe v. Samaritan Counseling Center*, 791 P.2d 344 (Alas. 1990), overruled on other grounds by *Veco, Inc. v. Rosebrock*, 970 P.2d 906 (Alas. 1999); *Corgan v. Muehling*, 167 Ill. App.3d, 1093, 522 N.E.2d 153 (1988), aff'd, 143 Ill.2d 296, 574 N.E.2d 602 (1991); *Zipkin v. Freeman*, 436 S.W.2d 753 (Mo. 1968); *Marston v. Minneapolis Clinic of Neurology and Psychiatry, Ltd.*, 329 N.W.2d 306 (Minn. 1982); *MacClements v. Lafone*, 104 N.C. App. 179, 408 S.E.2d 898, discr. rev. denied, 330 N.C. 613, 412 S.E.2d 87 (1991); *Morgan v. Psychiatric Inst. of Wash.*, 692 A.2d 417 (D.C. 1997); *L.L. v. Medical Protective Co.*, 362 N.W.2d 174 (Wis.1984) (quoting from Davidson, *Psychiatry's Problem with No Name: Therapist-Patient Sex*, 37 Am. J. Psychoanalysis 43, 48-49 (1977) and Stone, *The Legal Implications of Sexual Activity Between Psychiatrist and Patient*, 133 Am. J. Psychiatry 1138, 1139 (1976)). *But see* *Roe v. Wisconsin Patients Compensation Fund*, 229 Wis.2d 250, 599 N.W.2d 665 (1999) (because state law criminalized sexual contact by a therapist with a client, no coverage existed under either state fund providing coverage for excess liability or insurance policy, both of which excluded payments or coverage for intentional, criminal acts).

<sup>10</sup> See *Simmons v. U.S.*, 805 F.2d 1363 (9th Cir. 1986). In *Simmons*, the plaintiff's expert psychologist explained that through the transference phenomenon, a therapist-client relationship comes to symbolize a parent-child relationship. For a therapist to become sexually involved with a client "would be replicating at a symbolic level the situation in which a parent would be sexual with a child. The kind of harm that can flow from those sorts of violations of trust are very similar." *Simmons v. U.S.*, 805 F.2d 1363, 1365 (9th Cir. 1986).

<sup>11</sup> See e.g., Cal. Civ. Code § 43.93; 740 Comp. Ill. Stat. Ann. 140/0.01 to 140/7; Minn. Stat. Ann. §§148A.01-148A.06; N.H. Rev. Stat. Ann. §330-A:25; N.C. Gen. Stat. §90-21.41-21.48; Tex.Civ. Prac. & Rem. Code Ann. § 81.002; Wis. Stat. Ann. §§893.585, 895.70.

<sup>12</sup> See, e.g., Minn. Stat. Ann. §148A.01 (applies to sexual contact "whether or not occurring with the consent of a patient or former patient"), §148A.04 & -.05 (limited discovery and admissibility of evidence of sexual history); N.C. Gen. Stat. §90-21.45 ("Admissibility of evidence of sexual history") & §90-21.46 ("Prohibited defense").

<sup>13</sup> See Richard Epstein & Robert Simon, *The Exploitation Index: An Early Warning Indicator of Boundary Violations in Psychotherapy*, 54 BULL. MENNINGER CLIN. 450 (1990); Glenn Gabbard, *Psychodynamics of Sexual Boundary Violations*, 21 PSYCHIATRIC ANNALS 651 (1991); Thomas G. Gutheil, M.D. and Glen O. Gabbard, M.D., *The Concept of Boundaries in Clinical Practice: Theoretical Risk-Management Dimensions*, 150 AM. J. PSYCHIATRY 188 (Feb. 1993); Robert Simon, *Sexual Exploitation of Patients: How It Begins Before It Happens*, 19 PSYCHIATRIC ANNALS 104 (1989). Robert Simon identifies the following "precursor boundary violations": "(1) Failing to maintain therapist neutrality and treatment boundaries; (2) Failure to obtain a proper psychiatric history; (3) Failure to properly evaluate a vulnerable patient; (4) Failure to manage the transference-countertransference; (5) Failure to

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diagnose a dependent personality disorder; (6) Failure to render appropriate treatment; (7) Improper use of psychotropic drugs; (8) Using alcohol with the patient; (9) Contributing to the patient's drug and alcohol use; (10) Failure to monitor drug therapy; (11) Failure to consult; (12) Failure to refer; (13) Treating outside of the psychiatrist's expertise; (14) Infantilizing the patient; (15) Abandoning the patient . . . (16) Confidentiality violations; (17) Deception; (18) Exploitative use of hypnosis; (19) Improper use of somatic therapies; (20) Encouraging acting out; (21) Use of drugs with patient; (22) Using patients to perform work for the therapist; (23) Failure to obtain informed consent to 'innovative procedures'; (24) Failure to set limits on the patient's behavior; (25) Advising against education, training, and professional advancement; (26) Exploiting the patient's financial assets; (27) Use of regressive techniques; (28) Terrorizing the patient; (29) Instructing patients to engage in potentially harmful activities outside of therapy." Robert Simon, *Psychological Injury Caused by Boundary Violation Precursors to Therapist-Patient Sex*, 21 *PSYCHIATRIC ANNALS* 614, 617 (1991). See also Steven B. Bisbing, Linda Mabus Jorgenson, and Pamela K. Sutherland, *SEXUAL ABUSE BY PROFESSIONALS: A LEGAL GUIDE* § 12-5(c), at 478-480 (1995 & Cum. Supp. 2000). Bisbing identifies a number of common boundary violations, many of which, while not actionable in themselves, may nevertheless establish a context for actionable misconduct. These include: (a) a therapist's changing his customary procedures to accommodate a client—for example, having lax appointment schedules, exceeding allotted appointment times, or not charging fees; (b) failing to deal with inappropriate client behavior, such as missed or late appointments or payments; (c) discussing personal problems with the client, or disclosing personal information in an effort to impress or influence the client; (d) attempting to influence the client's philosophical or political positions; (e) having contact with the client outside the office for nonprofessional purposes; and (f) failing to terminate the relationship when the client no longer needs therapy.

Misconduct that stops short of sexual contact thus may be actionable if it otherwise transgresses professional boundaries. Some courts have recognized that therapist malpractice may arise out of such boundary violations as socializing, gift-giving, and even telephoning, notwithstanding the lack of sexual contact.<sup>14</sup> Such boundary violations often set the stage for sexual misconduct; in fact, experts observe that claims against therapists for sex abuse are generally more believable in the context of other boundary violations.<sup>15</sup> Other non-sexual acts of malpractice—for example, overmedicating a client or otherwise misusing medication, breaching confidentiality, offering treatment beyond the therapist’s expertise, failing to refer or obtain consultations as appropriate, practicing while under the influence of alcohol or drugs, abandoning a client—may likewise lend credence to a claim of abuse. For this reason, and also to maximize the potential for coverage under the therapist’s liability insurance, the plaintiff should include in her complaint all deviations from the standard of care.<sup>16</sup>

In any claim for malpractice seeking damages from a therapist arising out of inappropriate sexual activities or boundary violations, expert testimony is required to establish that the conduct is a violation of the applicable standard of care.<sup>17</sup>

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<sup>14</sup> See, e.g., *Zipkin v. Freeman*, 436 S.W.2d 753 (Mo. 1968); Linda Jorgenson, Steven B. Bisbing, and Pamela K. Sutherland, *Therapist-Patient Sexual Exploitation and Insurance Liability*, 27 TORT & INS. LAW J. 595, 609-611 & nn 114-118. (Spring 1992).

<sup>15</sup> {FN See Thomas G. Gutheil, M.D. and Glen O. Gabbard, M.D., *The Concept of Boundaries in Clinical Practice: Theoretical Risk-Management Dimensions*, 150 AM. J. PSYCHIATRY 188 (Feb. 1993).

<sup>16</sup> Likewise, a plaintiff should be very careful in alleging and describing sexual acts as the basis for a claim, in order to maximize coverage potential.

<sup>17</sup> *McCracken v. Walls-Kaufman*, 717 A.2d 346 (D.C. App. 1998) (applicable standard of care and causation not “within the ken of the average lay juror”).

If the claim is brought pursuant to a special statute, expert testimony might not be required to prove a *prima facie* case.<sup>18</sup> In any case, however, expert testimony that is thorough and detailed is critical in overcoming the juror bias that inevitably exists against sexual abuse plaintiffs who apparently “consented” to sexual contact with a therapist, and in identifying and describing the injuries caused by the conduct.<sup>19</sup> Such testimony is immensely important in educating jurors about why such conduct and its consequences cannot be viewed as just a romantic relationship that failed, and in explaining why such a relationship is abusive and damaging, even to a patient who first came to the psychotherapist with pre-existing psychiatric problems.

A therapist who knows of a plaintiff’s particular sensitivity has a duty to act with regard for that condition.<sup>20</sup> Under the “thin skull” rule, a defendant takes his plaintiff as he finds her: if his conduct would create liability for injury to a person of normal sensibilities, he is liable for all damages to an unusually susceptible plaintiff.<sup>21</sup>

In addition to malpractice claims, therapists have been held liable under claims for intentional and negligent infliction of emotional distress,<sup>22</sup> breach of fiduciary duty,<sup>23</sup> and breach of contract.<sup>24</sup>

### **Profile of the Offending Psychotherapist**

The relationship between a patient and any health care provider, especially a psychotherapist, is inevitably intimate. It is a relationship of unequal power, of dependence, and of vulnerability. All helping professionals are trained to recognize the danger of boundary

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<sup>18</sup> See e.g., Cal. Civ. Code § 43.93; 740 Comp. Ill. Stat. Ann. 140/0.01 to 140/7; Minn. Stat. Ann. §§148A.01–148A.06; N.H. Rev. Stat. Ann. §330–A:25; N.C. Gen. Stat. §90-21.41–21.48; Tex.Civ. Prac. & Rem. Code Ann. § 81.002; Wis. Stat. Ann. §§893.585, 895.70.

<sup>19</sup> For a detailed summary of expert testimony on these and related matters, see *Morgan v. Psychiatric Inst. of Wash.*, 692 A.2d 417, 422-423 (D.C. 1997) (expert testimony regarding transference phenomenon and client’s resulting inability to consent to physical touching).

<sup>20</sup> *Coran v. Muehling*, 143 Ill.2d 296, 574 N.E.2d 602, 158 Ill.Dec. 489 (1991)(sexual abuse by therapist will support a claim for negligent infliction of emotional distress).

<sup>21</sup> *Poole v. Copland, Inc.*, 348 N.C. 260, 498 S.E.2d 602 (1998)(where sexual harrassment by co-worker would have harmed a person of ordinary sensibilities who did not have plaintiff’s prior history of sexual abuse, “thin skull rule” applied, subjecting defendant employer to liability for full extent of plaintiff’s damages).

<sup>22</sup> E.g., *Corbett v. Morgenstern*, 934 F. Supp. 680 (E.D. Pa. 1996) (intentional infliction claim by client whose psychologist had engaged in a 12-year sexual relationship with her); *Richard H. v. Larry D.*, 198 Cal. App. 3d 591, 243 Cal. Rptr. 807 (1988) (negligent infliction claim by client whose therapist had engaged in sexual relationship with client’s wife); *Morgan v. Psychiatric Inst. of Wash.*, 692 A.2d 417 (D.C. 1997).

<sup>23</sup> E.g., *Roy v. Hartogs*, 85 Misc. 2d 891, 381 N.Y.S.2d 587 (1976); *Omer v. Edgren*, 38 Wash. App. 376, 685 P.2d 635 (1984).

<sup>24</sup> See *Anclote Manor Foundation v. Wilkinson*, 263 So.2d 256 (Fla. App. 1972) (husband of client who committed suicide after being sexually abused by her therapist sued hospital that employed therapist for breach of contract and recovered costs of wife’s treatment). *But see Lackey v. Bressler*, 86 N.C. App. 486, 358 S.E.2d 560 (1993) (no breach of contract claim for acts constituting malpractice).

transgressions, and the harm that comes to a patient when sexual boundaries are crossed, and have ethical and professional guidelines addressing proper boundaries.<sup>25</sup> In therapy, particularly, the essential concept is that the appropriate professional “boundaries” of treatment are set by the therapist, not the patient.<sup>26</sup> Crossing of these boundaries is not, then, something that is done without awareness, but the transgression itself ranges from impulsive to blatantly predatory.

Which patients are most vulnerable to sexual exploitation? Although it is *always* the responsibility of the therapist to maintain boundaries, certain characteristics of vulnerability have been identified as placing the patient at greater risk of exploitation:

- depressed patients or patients who have lost a loved one;
- dependent personalities;
- patients who have a history of child sexual and physical abuse;
- patients with serious psychiatric illness or substance abuse problems;
- patients with impaired mental and personality function (low self-esteem, dependent,

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<sup>25</sup> See references to various professional ethical rules at Note 7, *supra*. Physicians have promised to avoid sexual contact with patients for 2000 years. The Hippocratic Oath states:

I will use my power to help the sick to the best of my ability and judgment; I will abstain from harming or wronging any man by it. . . .  
Whenever I go into a house, I will go to help the sick and never with the intention of doing harm or injury. I will not abuse my position to indulge in sexual contacts with the bodies of women or of men, whether they be free men or slaves.

G.E.R. Lloyd, (Ed.), *Hippocratic Writings* at 67 (London 1978).}

<sup>26</sup> Robert Simon, *BAD MEN DO WHAT GOOD MEN DREAM*, Ch. 6 at 128 (American Psychiatric Press, Inc., Washington, D.C. 1996).

difficulty with reality, self-destructive, or impulsive);

- physically attractive patients with low self-esteem;
- patients with low intelligence;
- patients with a history of chronic illness as children.<sup>27</sup>

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<sup>27</sup> Robert Simon, *BAD MEN DO WHAT GOOD MEN DREAM*, Ch. 6 at 135-136 (American Psychiatric Press, Inc., Washington, D.C. 1996), *citing* K.S. Pope & J.C. Bouhoutsos, *SEXUAL INTIMACY BETWEEN THERAPISTS AND PATIENTS*. (New York: Praeger, 1986).

Within this professional context and knowledge, experts have identified characteristics of the psychotherapist and health care provider who crosses boundaries and sexually abuses a patient or client. One commentator identifies three broad categories of sexually-abusing psychotherapists: the *psychotic*, the truly mentally ill and representing the smallest group; the *antisocial*, a somewhat larger group who “are ruthless, are without remorse or empathy for their victims, and are the most frankly exploitative”; and the *lovesick*, a large group including “‘normals,’ neurotics, and assorted personality disorders,” who “fall in love” with patients “to whom [they portray themselves] as lonely, vulnerable, and needy.”<sup>28</sup>

Another commentator postulates nine categories of offending professionals.<sup>29</sup>

1. *Naive*—these providers are simply untrained and are “naive about the trajectory of their behavior and start down the ‘slippery slope.’” Their prognosis is variable, depending on their ability to understand and be rehabilitated.

2. *Normal and/or mildly neurotic*—all health care providers and clergy are potentially in this group. They are reasonably well-trained, but at a “bad spot” in their lives, begin blurring boundaries and fall in love with patients. These are the “lovesick.” These perpetrators usually have only one victim, and their prognosis is generally good.

3. *Severely neurotic and/or socially isolated*—this group is like the previous group, but have more ongoing problems of depression, feelings of inadequacy, low self-esteem, and social isolation. They rationalize their behavior more, and are less able to terminate their violations. They tend to be “superprofessionals” who are dedicated and hardworking. Their prognosis is “mixed” and “guarded.”

4. *Impulsive character disorders*—this group has chronic problems with impulse control, and have problem behaviors in other areas, such as insurance or tax fraud, sexual harassment, and other inappropriate or criminal behaviors. They don’t conceal their conduct well, and are easily caught. These individuals are “unrehabilitatable” and should be removed from positions of trust.

5. *Sociopathic or narcissistic character disorders*—these individuals have a long history of difficulty with impulse and behavior controls, but are less detectable because they are more planful and deliberate. They are credible and “cunning” enough to manipulate situations as well as colleagues. They have support among other professionals, and confess to inappropriate behaviors they believe others know about. These individuals are not rehabilitatable and should be removed from positions of trust.

6. *Psychotics*—these individuals have impaired reality testing and are significantly impaired. They are not rehabilitatable.

7. *“Classic” sex offenders*—chronic pedophiles and physically aggressive sex offenders.

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<sup>28</sup> Stuart W. Twemlow, & Glen O. Gabbord, *The Lovesick Therapist*, in Glen O. Gabbord, Ed., *SEXUAL EXPLOITATION IN PROFESSIONAL RELATIONSHIPS* 71, 72-73 (Washington, D.C., 1989).

<sup>29</sup> John C. Gonsiorek, *Assessment for Rehabilitation of Exploitative Health Care Professionals and Clergy*, in John C. Gonsiorek, ed., *BREACH OF TRUST: SEXUAL EXPLOITATION BY HEALTH CARE PROFESSIONALS AND CLERGY* 145,147-154 (Sage Publications, London 1995).

These individuals should be removed from the health care professions.

8. *Medically disabled*—this group includes those who are neurologically impaired and have “true bipolar mood disorder.” This group is unpredictable and of mixed prognosis.

9. *Masochistic/self-defeating individuals*—this group is varied. Their problems “run deep” and their prognosis “guarded.”<sup>30</sup>

Physicians who sexually abuse their patients would tend to fall into similar categories. The more extreme cases—or perhaps the cases that come to the attention of the public—involve physicians who are deviant and predatory.<sup>31</sup> In all cases, the sexual exploitation of a patient is an abuse of power, a manipulation of the patient’s trust and vulnerability and, in its extreme, predatory.

### Causation and Damages

A damage evaluation should include an assessment of the overall treatment, not just the boundary violations and sexual contact.<sup>32</sup> There may be a number of other deficiencies in the treatment that caused harm to the patient. In fact, the boundary violations themselves will often lead to other violations of the standard of care, either because the therapist is seeking to avoid outside knowledge and intervention in the care or because the therapist is blind to the client’s treatment needs by reason of the non-therapeutic relationship.<sup>33</sup> Other areas of standard of care violations to investigate are: failure to diagnose other problems (“underpathologizing” or “overpathologizing”); inadequate treatment of the presenting complaints (e.g., substance abuse, depression, relationship problems, etc.); failure to refer (for medications, physical problems, family interventions, substance abuse, etc.); treatment outside area of expertise; confidentiality violations; improper use of medications, hypnosis, or electroshock therapy; use of drugs or

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<sup>30</sup> John C. Gonsiorek, *Assessment for Rehabilitation of Exploitative Health Care Professionals and Clergy*, in John C. Gonsiorek, ed., *BREACH OF TRUST: SEXUAL EXPLOITATION BY HEALTH CARE PROFESSIONALS AND CLERGY* 145, 147-154 (Sage Publications, London 1995).

<sup>31</sup> See, e.g., Marilyn Beck & Lori Long, *Gynecologist-Patient Sexual Abuse: I. A Medical Board's View*, in Anne W. Burgess and Carol R. Hartman, *SEXUAL EXPLOITATION OF PATIENTS BY HEALTH PROFESSIONALS* 66-73 (New York, 1986); Ann W. Burgess, *Gynecologist-Patient Sexual Abuse: II An Evaluation of Victims*, in Anne W. Burgess and Carol R. Hartman, *SEXUAL EXPLOITATION OF PATIENTS BY HEALTH PROFESSIONALS* 74-83 (New York, 1986); Audrey W. Mertz, *Sexual Abuse of Anesthetized Patients*, in Anne W. Burgess and Carol R. Hartman, Eds., *SEXUAL EXPLOITATION OF PATIENTS BY HEALTH PROFESSIONALS* 61-65 (New York, 1986); Carolyn Moore Newberger & Eli H. Newberger, *When the Pediatrician is a Pedophile*, in Anne W. Burgess and Carol R. Hartman, *SEXUAL EXPLOITATION OF PATIENTS BY HEALTH PROFESSIONALS* 99-106 (New York, 1986); Barbara Noel, with Kathryn Watterson, *YOU MUST BE DREAMING*. (New York: Poseidon Press, 1992); Jack Olsen, *DOC: THE RAPE OF THE TOWN OF LOVELL*. (New York: Atheneum, 1989).

<sup>32</sup> Gary Richard Schoener, *The Assessment of Damages*, in Gary Richard Schoener, et al., Eds., *PSYCHOTHERAPISTS' SEXUAL INVOLVEMENT WITH CLIENTS: INTERVENTION AND PREVENTION* 133, 135 (Minneapolis, MN 1989).

<sup>33</sup> Id.

alcohol with a client; or inappropriate advice about family, career or educational advancement.<sup>34</sup>

Specific harm resulting from the violations may include: psychological disorder (depressive reaction, post-traumatic stress disorder, atypical dissociative disorder); exacerbation of pre-existing disorder; problems in marital or family relationships; difficulty trusting professionals; psychosomatic symptoms; difficulty concentrating; impaired social functioning; mood disorders; lack of self-confidence, anger, or resentment; loss of employment; or emotional breakdown.<sup>35</sup>

There may be significant pre-existing injury. Patients who are sexually abused and exploited by psychotherapists are usually the classic “thin-skull” plaintiffs. They have sought psychotherapy because of existing, significant psychic injury, and that in turn makes them vulnerable to exploitation. With respect to psychiatric harm, these cases present the classic double-edged sword, and it is typical for the defense to argue that while the psychotherapist may have been negligent, no harm was caused as the plaintiff’s injuries all preexisted the exploitation. Such arguments are dangerous, because they trigger a juror’s natural distrust of anyone with psychiatric problems, and invoke current anti-plaintiff biases. These cases are bitterly fought, and viciously defended. Every sexual abuse plaintiff is injured again by the litigation.

It is extremely important to understand and articulate for the jury the significance of the pre-existing injuries, and to differentiate and articulate the injuries caused by the abuse. The transference that makes the abuse possible in the first place is the key to understanding the injury: crossing of boundaries by a trusted therapist who has been placed (by transference) in the role of a parent for purposes of the therapy is a violation nearly identical to incest.<sup>36</sup> The injuries that result from the abuse itself, then, are similar to those that result from incest: a victim may have “overwhelming feelings of depression, fear, anxiety, guilt, and shame.”<sup>37</sup> In addition to the harms listed above, victims may also develop difficulty in intimate relationships, including communication, blurred boundaries, identity of self, and sexual intimacy.<sup>38</sup>

It is critical to have an independent psychiatric evaluation of the plaintiff by an expert knowledgeable about the kind of psychic injury that occurs from boundary violations by a psychotherapist. This expert may also explain to the jury the nature of the abusive relationship and how the patient’s apparent consent is obtained by exploiting the transference and the power differential in the relationship.

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<sup>34</sup> Id., at 135-142.

<sup>35</sup> Id., at 142-143.

<sup>36</sup> See Ellen T. Luepker, *Sexual Exploitation of Clients by Therapists: Parallels With Parent-Child Incest*, in Gary Richard Schoener, et al., Eds., *PSYCHOTHERAPISTS’ SEXUAL INVOLVEMENT WITH CLIENTS: INTERVENTION AND PREVENTION* 73-81 (Minneapolis, MN, 1989); Peter Rutter, *SEX IN THE FORBIDDEN ZONE* 100 (New York, 1991).

<sup>37</sup> Peter Rutter, *SEX IN THE FORBIDDEN ZONE* 101 (New York, 1991).

<sup>38</sup> Id.