Boundary Violations Between Therapist and Patient

By MICHAEL H. STONE, M.D.

The temptation for male physicians to engage in sexual relations with their female patients is apparently as old as medicine itself; Hippocrates warned against such conduct in the oath he fashioned 2,500 years ago. To succumb to this temptation is to take advantage of one's professional position, and constitutes a very serious ethical violation. This is of course true in any realm of medicine, but such breaches are all the more serious in psychiatry, where patients often seek help specifically within the area of intimate relationships. A surgeon who has a sexual encounter with a woman whose gallbladder he has recently removed may at least have performed successful surgery. But a psychiatrist who permits such an encounter is subjecting his patient to a betrayal of trust precisely where she was most troubled to begin with and where she is most vulnerable.

Since sexual encounters between psychiatrist and patient are — at least in the beginning — a voluntary matter, it is fair to inquire whether special characteristics (on both sides) may enhance susceptibility to what Medlicott¹ has delicately described as "professional indiscretion."

THE HIGH-RISK FEMALE PATIENT

The thrust of transference will incline any female patient towards experiencing affectionate as well as erotic feelings for her therapist, and the more the treatment approaches the length and intensity of psychoanalysis, the more likely the tendency is to manifest itself.²,³ Since the tendency is acted out literally in relatively few patients, some women are obviously more susceptible than others.

The more fragile a woman's ego structure, the more vulnerable she is. A patient who approaches a borderline or psychotic level of func-
tion has a correspondingly greater emotional neediness and readiness to endow her therapist with strong transference feelings. Such women may also be more openly seductive as they attempt to promote what they view as a lifesaving attachment to a helping figure. Dahlberg studied a series of therapist-patient sexual contacts and found that the more clinging and dependent and depressed women, as opposed to the assertive and paranoid, were the most willing to engage in sex with their therapists. A delusional or otherwise frankly psychotic woman is particularly vulnerable because the therapist knows that she is less likely to turn against him; if she does, the extent of her illness will seriously damage her credibility.

Although a number of psychiatrists have rationalized sexual advances towards their patients as “therapeutic” maneuvers to overcome frigidity or other inhibitions, it has yet to be recorde
d that any male psychiatrist has directed this therapeutic zeal towards sexual unresponsiveness housed in someone old or ugly. The high-risk patient is a pretty woman in her 20s or 30s, and it should be obvious that rationalizations about overcoming frigidity are in no way therapeutic but merely self-serving.

A very important factor is the history of an incestuous or at least highly eroticized relationship between the patient and her father. When this element is present, the woman has been witness and participant to flagrant disregard of a barrier (the incest taboo) of which the psychiatrist-patient boundary is an analogue. As the transference is mobilized in the psychotherapeutic setting, she will attempt, predictably and with regularity, to duplicate the situation that existed between herself and her father. The relationship with her father may also have engendered markedly ambivalent attitudes toward men, one aspect of which is a high degree of suspicion that “men are out for only one thing.” Part of her sexual provocative-ness constitutes an effort to humiliate the therapist, as well as a general test of a man’s capacity to withstand her charms. Should her psychiatrist join her father in succumbing, she may feel momentarily triumphant, but this readily gives way to a quite justified sense of betrayal.

There is also a group of women at intermediate risk: patients who are better integrated, attractive without being particularly seductive, and appealing but not so grossly dependent as those in the first group. A number of them move their therapists to feelings of what seems like genuine love. These are the women whom therapists occasionally feel disposed to marry, after terminating treatment and waiting what they imagine to be a decent interval. Some women in this category have kept their heads even after the doctor has lost his. Others, perhaps influenced by the powerful regressive forces mobilized in the transference, have gone along with such proposals and later married their therapists — sometimes with disastrous results.

A final group comprises female patients whose susceptibility to physical involvement with their therapists rests on the absence of a father, either through death or divorce or

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through psychologic aloofness in an otherwise present father. Girls in this situation are prone to form quick, intense attachments to men whom they hope to make over into father substitutes. This appeared to be a factor in the patient who was eventually emboldened to sue her psychiatrist in a celebrated lawsuit in New York in 1975.

CLINICAL ILLUSTRATIONS

A series of clinical vignettes from my experience illustrates these points and the severe risks to the patient and, at times, the psychiatrist.

1. An attractive stewardess in her mid-20s was admitted, acutely psychotic, to a general-hospital emergency ward. Although there were features of paranoid schizophrenia, she also exhibited confusion and had a prominent tachycardia. There were scratches on her forehead in the shape of a tic-tac-toe diagram that seemed too neat to be accidental, despite her claims that they had resulted from a fall on the pavement. With conservative management and phenothiazines, she recovered quickly and admitted having taken a large amount of amphetamines in a suicide gesture.

As her condition stabilized, she was able to relate that she had been having an affair with her psychiatrist, whom she had originally consulted for depression. He had become uneasy and told her that they must not continue the relationship; it was after this rejection that she made her suicide gesture. The forehead marks were self-inflicted, as part of a wish to mar her beauty, which she felt had got her into all this trouble to begin with. Psychiatric consultation in the hospital revealed that she was chronically schizophrenic and that during her teens she had engaged in sexual play with her father.

2. A married woman of 33, whose personality organization had been characteristically border-line, sought psychiatric help because of mounting depression within the context of feeling trapped in her marriage. She had married in late adolescence, in part to escape an incestuous relationship with her father that had continued since early childhood. Shortly before marrying she told her mother of what had taken place, whereupon her mother left her father. The patient was relieved but at the same time felt guilty over what she perceived as her role in breaking up her parents' marriage. She grew fearful that she would meet the same fate as her mother and lose her husband because of infidelity. Her fears soon reached panic proportions, and suicidal ruminations preoccupied her mind; it was at this point that she consulted a psychiatrist. By the second visit a sexual relationship had developed between them, and it continued for two or three additional sessions.

This woman, who was stunningly attractive, had elaborated the fantasy before seeing the psychiatrist that if he at least could resist her charms, there existed one man whom she could trust and perhaps her worst fears need not come true. But after this trust was betrayed, "suicide with dignity" seemed preferable to a life in which, as now seemed confirmed, one man after another would take advantage of her. She fell into a psychotic depression that required several months of intensive hospital treatment to subdue her determination to kill herself; her hold on life is still precarious.

3. Not so fortunate was a 24-year-old woman admitted to a psychiatric hospital after a serious suicide attempt following the death of her father. He had shown considerable erotic interest in her, kissing and fondling her and calling her "my little wife" even while his real wife was dying of a chronic illness. During her hospitalization, her behavior and dress were often highly seductive.

After a number of months, her intense preoccupation with suicide seemed to have lifted and she was permitted to engage in hospital activities off the service to which she had been admitted. One of these activities was directed by an occupational therapist with whom she quickly became sexually involved. After a few weeks she
turned his attentions to another female patient. At this point she took an overdose of sleeping pills, and two days later was found dead in the workshop that the therapist had directed.

4. A divorced woman of 35, a fairly well-compensated schizophrenic who worked as a librarian, left her psychiatrist after they had become involved in a brief sexual affair. She had originally entered therapy because of a psychotic break after her husband left her. She also complained of insatiable sexual desires and tended to feel rejected unless her partner made love to her several times daily. Although very aware of having tried to seduce her psychiatrist, she felt cheapened afterwards, as though this were one more proof that men appreciated her only for her physical attributes.

This patient had been involved in incestuous relationships with both parents. She and her father had engaged in mutual masturbation to orgasm, and her mother, under the guise of inspecting her for possible gynecologic problems, performed frequent "examinations" in which she stimulated her daughter's clitoris.

5. An attractive married woman in her mid-30s entered analysis because of dissatisfaction with her marriage. Several months later, as various erotic aspects of the transference began to unfold, the analyst (a well-respected man in his mid-50s) expressed love towards her and terminated the analysis in favor of an "actual" relationship. Each obtained a divorce, and a year and a half later they were married. The analyst was ostracized by the psychoanalytic community in which he had worked, and the couple moved to a more secluded area. But he fell into a deep depression and committed suicide three years after the marriage.

6. A fairly attractive divorced schizophrenic woman of 27 was admitted to a psychiatric hospital following a year and a half's relationship with her psychologist that was characterized by kissing and petting. This patient came from a particularly chaotic background. When she was six her father died suddenly, and her mother killed herself the next day, several hours before the funeral. There followed many years of indifferent care from her half-brother, wandering alone in Greenwich Village, and living in semi-vagabondage that was the more poignant because, at the age of 11, she lost her only remain-ing grandparent and all her uncles in quick succession.

After some years of sexual promiscuity she impulsively married an unsuitable man when she was 22, and it was the dissolution of this marriage that led her to seek help. Her psychologist professed to be moved by her tragic story, desiring to "make up" to her what she had missed while growing up. She was told to come every day except Sunday; sessions were of varying lengths; eventually he stopped charging her for them. At this point she realized that she was not in therapy at all but in some kind of morbid relationship from which she could not seem to extricate herself. She made a serious suicide attempt and had to be hospitalized.

THE HIGH-RISK THERAPIST

Psychiatrists who have engaged in sex with their female patients are difficult to characterize; most of them have not been in psychotherapy at precisely the time the unethical behavior was occurring, so very few members of the profession have direct experience with these men. While the high-risk patients seem very similar to each other, their psychiatrists, to judge from anecdotal descriptions, seem to fall into one of several categories.

In Dahlberg's series, the therapists had been men in their 40s and 50s, divorced or separated from their wives, and in the midst of a depression. Two psychiatrists mentioned by Stone were in their late 20s and had become enveloped in pathologic rescue fantasies towards particularly seductive patients. They were "disturbed and disturbing"; one was borderline, the other was sociopathic, and both were considered mavericks by their group of colleagues. In common with Dahlberg's profile, both men continued
were experiencing dissolution of a love relationship at the time.

Of the psychiatrists alluded to in the clinical illustrations above, one was in a stable marriage but was characterologically sociopathic (#2). He was in his 40s. Two (#3, #5) were psychoanalysts in their 50s; the other (#1) was a general psychiatrist in his 30s. Factors in both these sectors of psychiatry predispose towards engaging in sexual activities with patients. The analyst often has a longer and deeper relationship with his patient, of a kind that may foster the illusion that "sex with a patient is generally not permissible, but with this patient it is different." The affair that ensues is often the only such ethical breach during the particular analyst's professional lifetime.

Psychiatrists without analytic training, especially those with special interest in pharmacotherapy and other noninterpersonal modes of treatment, often see their patients less frequently and for shorter periods. This may reduce the intensity of the doctor-patient relationship and keep temptation under control. But at the same time, some of their patients may be substantially sicker than those in analysis. It is with these fragile, often chronically psychotic women that "quickie" sexual relationships are often so tempting.

The maverick therapist who believes that sex with his patients is a valid new "treatment" represents an especially great risk to his patients, because he will not even be susceptible to feelings of guilt. Certain psychotic and psychotic practitioners are equally dangerous because they lack built-in restraints.

One of the interesting findings to emerge from the survey conducted by Kardener and colleagues concerns the higher degree of permissiveness expressed by medical students as compared with older practitioners. Twenty-five per cent of the students questioned felt that intercourse might be beneficial "under the right circumstances," whereas only 5 per cent of physicians expressed a similar view (though 19 per cent felt that some erotic contact might be of benefit). It is not known whether the students will change their views as they mature, but the authors may be correct in speculating that the younger generation of physicians (including psychiatrists) may exhibit a less absolute set of values than their predecessors. High-risk therapists may include not only those in midlife crisis but also a number of much younger colleagues just beginning their professional careers.

Since Kardener and co-workers studied only the responses of physicians, we do not know how therapists who lack medical training compare with those who have a medical background. The vignettes above include two nonmedical therapists (#3, #6), but these cases were not collected systematically to shed light on this question. At present, only physicians are required to take an oath not to engage in

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sexual acts with their patients; whether this oath serves to reduce the comparative incidence of such behavior is a question deserving further study.

**DISCUSSION**

In addition to characteristics of ego fragility, physical attractiveness, sexual seductiveness, and disturbed father-daughter relations, Medicott has stressed the presence of a hysterical character structure and strong homosexual trends existing alongside the heterosexual promiscuity. Some of the "victims" in his series had a penchant for seducing professional men, one after the other, as part of their life-style; the hostility toward men was as prominent as the dependency. As in the series enumerated above, impulsivity was a regular feature. Many of the women are of borderline personality organization, with an ever-present desire to actualize rather than verbalize transference.

Women who have experienced a prolonged erotic relationship with their fathers (cf. cases 1 through 4) typically respond to this overstimulation with marked inability to postpone impulse gratification. This is true for sexual im-

*continued*
pulses particularly, since for these women sex often becomes the channel in which all feelings are diverted. Some of these women were brought up with specific injunctions against expression of anger, so that as they grow older they develop the habit of expressing anger by withholding sexual favors or by leading men on and subsequently disappointing them. All life’s struggles become recast in the mold of a sexual drama. These women rarely have independent careers or interests; they stand or fall in accordance with their capacity to dominate via sexuality. With only one asset between them and the abyss, it is small wonder that betrayal of trust may precipitate overt suicidal behavior.

It cannot be overemphasized that, however much the high-risk patient wants to seduce her therapist, as much or more of her desire lies in testing whether the therapist, in contrast to all the other men she has known, can actually be trusted to safeguard her rights and allow her to grow and mature unmolested. Medicott and Kardener have both drawn the parallel between the incest taboo and professional privilege, both systems that have been established to allow a dependent relationship during the long period when the child or patient is struggling to achieve an adult level of autonomy. Even if the privileged person hopes to legitimize his own unethical behavior by marrying his patient, he should be reminded of the not-so-fictional psychiatrist in Tender Is the Night, whose marriage ended in disaster.

In the Kardener survey, psychiatrists came off reasonably well in comparison with other specialists: 5 per cent engaged in erotic behavior short of intercourse (as against 11 per cent among gynecologists) and 5 per cent had had intercourse with a patient (as against 9 per cent of general practitioners). This survey was done in the Los Angeles area, and it is not known to what extent the results can be generalized for the country as a whole; but the total figure of 10 per cent means that possibly 2,000 or 3,000 psychiatrists throughout the country have an ethical value system shaky enough to permit this sort of activity. This figure does not even begin to consider the large numbers of nonmedical therapists whose licensure is not even predicated on taking the Hippocratic Oath.

It is interesting that the percentage of women who have had incestuous relationships with their fathers is, according to Woodbury and Schwartz, at about the same level as the percentage of psychiatrists who have had sex with their patients. Ideally, a woman seeking psychiatric help for problems that are largely due to an eroticized relationship with her father should be treated by a male therapist, if only to learn that at least some men can be trusted not to take advantage of her. With a female therapist she might feel more relaxed and get superficially better, but the doubt would still linger. It cannot be very reassuring for these women to realize that they have something like a one-in-10 chance of being improperly treated. The risk may be substantially greater for the women whose portraits we have limned here; it is clear that erotic contact between therapist and patient is not randomly distributed over the whole range — young and old, beautiful and plain — of female patients.

Although we seem to be entering an era of ethical relativism, it is my opinion that the matter of therapist-patient sexual contact lies well outside even the shifting and expanding boundaries of contemporary values. These patients play for high stakes. They can be treated successfully only by a therapist who is incorruptible yet also capable of relating empathically to this type of patient. If he finds himself becoming exaggeratedly aloof in reaction to the temptation or if, on the other hand, he feels his self-control slipping, he must be wise enough to refer the patient to someone else. And once such a step is taken, he must remember that there is no such thing as a “decent interval” where professional ethics are concerned. Once the patient has crossed the office threshold, she has established herself as

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someone willing to expose the secrets of her life to a person specially trained to hear and deal with them. This is the essence of "privilege," and it does not cease on termination of therapy.

Taken together, these requirements constitute a difficult assignment, but I believe they represent an irreducible minimum.

As matters stand now, the advantages are all with the therapist. In the case of psychiatry, local branches of the A.P.A. each have an ethics committee to whom the victimized patient can complain. But remarkably few complaints are ever lodged, and when members of the committee do investigate a complaint, it is frequently

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the old story of "his word against hers." The "her" is often a borderline or psychotic woman whose credibility may be easy to undermine, leaving the offending therapist free to do the same thing with some other patient in the future. It is rare for him to be censured, unless his dossier is filled with numerous complaints, and rarer still for him to lose his license to practice. Even that measure may not put a stop to unethical conduct, as in the case of the psychiatrist mentioned in the book by Freeman and Roy. I have personally seen a woman in consultation to whom this psychiatrist made sexual advances several months after he had lost his license. If psychiatry has been relatively powerless to police its membership even though a structure for peer review exists, the nonmedical disciplines must be in an even sorrier state. Sexually abused patients have the right to retain counsel and to sue, as Miss Roy ultimately did, but this avenue has been pursued on pitifully few occasions.

When a serious boundary violation between patient and therapist occurs, the subsequent treatment is jeopardized and sometimes ruined altogether. The patient has to interrupt treatment and look to someone else for help, and her capacity for trust is by now seriously compromised. The woman in the second vignette, for example, was extremely reluctant to enter the hospital because she suspected that I was in league with the psychiatrist who seduced her and that I was planning to give her shock treatment in order to eradicate her memory of what had transpired.

Although women are becoming more vocal, they are still reluctant to complain. The more willing a female patient may have been to enter a sexual affair, the more guilty she feels about subsequently bringing the matter to the attention of either an ethics committee or the legal profession. This is true despite legal rulings that since the doctor-patient relationship is essentially a fiduciary one, even women who engage willingly in sex with their therapists have the right to consider themselves victims.

Ethics committees are relatively weak in their ability to investigate and weaker still in their capacity to punish. Since courts have much more power than ethics committees, women might be well advised to seek redress directly from the law. Masters and Johnson have expressed a view with which I heartily concur:

We feel that when sexual seduction of patients can be firmly established by due legal process, regardless of whether the seduction was initiated by the patient or by the therapist, the therapist should initially be sued for rape rather than for malpractice; i.e., the legal process should be criminal rather than civil.

If the psychiatric profession becomes aware that sexual contact with a patient is more likely to provoke a potentially ruinous lawsuit than a mere remonstrance from an ethics committee, practitioners will experience a salutary bolstering of their capacity for self-restraint.

Ultimately, there can be no substitute for an enlightened public. It is important to educate women about the nature of the therapist-patient relationship, its proper boundaries, and their right to have these boundaries held inviolate. The efforts of women's groups have already met with some success; the popular press and the media will be required to complete the task.
Finally, psychiatrists and therapists from other disciplines must not overlook one of their most powerful weapons in the maintenance of proper ethical standards: ostracism. The British are apparently more inclined to apply this measure against a colleague once there is compelling evidence of a serious breach. Professional ostracism, including the refusal to refer patients, means a much stricter application of an intramural honor code than one customarily sees in these cases. All too often, clinicians will express outrage or dismay but do little more than shrug their shoulders. Ostracism, on the other hand, may fail to affect the conscience of an offending colleague directly but will surely affect his pocketbook. In time this may very well exert a corrective influence upon the conscience as well.

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