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# THE FUROR OVER PSYCHOTHERAPIST-PATIENT SEXUAL CONTACT: NEW SOLUTIONS TO AN OLD PROBLEM\*

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## I. INTRODUCTION

In a growing response to psychotherapist-patient sexual relations, the major mental health organizations have universally condemned sexual contact in therapeutic relationships as exploitative, proclaiming, "It's [n]ever O.K."<sup>1</sup> The Code of Ethics adopted by the American Psychiatric Association states emphatically that "sexual contact with the patient is unethical."<sup>2</sup> The American

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1. In 1984, the Minnesota legislature appointed a task force to study the problem of sexual exploitation by counselors and therapists. See MINN. STAT. § 631 (1984). The task force produced three publications. See THE STATE TASK FORCE ON SEXUAL EXPLOITATION BY COUNSELORS AND THERAPISTS, *It's NEVER O.K.: SEXUAL EXPLOITATION BY COUNSELORS AND THERAPISTS* (1987) [hereinafter MINN. TASK FORCE, *It's NEVER O.K.*]; MINNESOTA PUB. EDUC. WORK GROUP OF THE TASK FORCE ON SEXUAL EXPLOITATION BY COUNSELORS AND THERAPISTS, *It's NEVER O.K.: A HANDBOOK FOR VICTIMS AND VICTIM ADVOCATES ON SEXUAL EXPLOITATION* (1988) [hereinafter MINN. TASK FORCE, *It's NEVER O.K.: A HANDBOOK FOR VICTIMS*]; MINNESOTA TASK FORCE ON SEXUAL EXPLOITATION BY COUNSELORS AND THERAPISTS, *It's NEVER O.K.: A HANDBOOK FOR PROFESSIONALS ON SEXUAL EXPLOITATION BY COUNSELORS AND THERAPISTS* (B. Sanderson ed. 1989) [hereinafter MINN. TASK FORCE, *It's NEVER O.K.: PROFESSIONAL HANDBOOK*]; see also G. SCHOENER, J. MILGROM, J. GONSIOREK, E. LUEPKER, & R. CONROE, *PSYCHOTHERAPISTS' SEXUAL INVOLVEMENT WITH CLIENTS: INTERVENTION AND PREVENTION* (1989) [hereinafter G. SCHOENER & J. MILGROM].

2. AMERICAN PSYCHIATRIC ASS'N, *THE PRINCIPLES OF MEDICAL ETHICS WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY* § 2, at 4 (1985).

Psychological Association's Rules of Ethics provide that "sexual intimacies with clients are unethical."<sup>3</sup> The National Association of Social Workers' Code of Ethics proclaims that "social worker[s] should under no circumstances engage in sexual activities with clients."<sup>4</sup> The American Psychoanalytic Association has issued a similar prohibition.<sup>5</sup>

Even the Hippocratic oath<sup>6</sup> prohibits sexual contact and has found its way into the common law. In *Andrews v. United States*,<sup>7</sup> the United States Court of Appeals for the Fourth Circuit determined that the defendant exceeded the boundaries of the oath when he had a sexual relationship with his client during counseling sessions<sup>8</sup> and stated:

The Hippocratic oath states, "In every house where I come, I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction, and especially from the pleasures of love with women and men." Although not a basis for liability in this case, the Hippocratic oath is indicative of the medical profession's historic knowledge of and concern about the potential for sexual abuse of the physician-patient relationship.<sup>9</sup>

Despite its historic prohibition, psychotherapists' sexual contact with patients occurs. Before 1975, psychotherapist malpractice suits were rare.<sup>10</sup> A plaintiff brought the first known civil action concerning a therapist's improprieties with a patient in a

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3. AMERICAN PSYCHOLOGICAL ASS'N, ETHICAL PRINCIPLES OF PSYCHOLOGISTS 6(a) (1980).

4. NATIONAL ASS'N OF SOCIAL WORKERS, INC., CODE OF ETHICS OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS 5 (1980).

5. See AMERICAN PSYCHOANALYTIC ASS'N, PRINCIPLES OF ETHICS FOR PSYCHOANALYSIS AND PROVISIONS FOR IMPLEMENTATION OF THE PRINCIPLES OF ETHICS FOR PSYCHOANALYSIS (1983).

6. STEADMAN'S MEDICAL DICTIONARY 579 (3d ed. 1972).

7. 732 F.2d 366 (4th Cir. 1984) (patient sued therapist for malpractice after a sexual relationship with the therapist).

8. *Id.* at 368.

9. *Id.* at 368 n.2 (citing STEADMAN'S MEDICAL DICTIONARY 579). For further discussion of the prohibitions imposed by the Hippocratic oath, see Campbell, *The Oath: An Investigation of the Injunction Prohibiting Physician-Patient Sexual Relations*, 32 PERSP. BIO. & MED. 300 (1989).

10. See *Roy v. Hartogs*, 81 Misc. 2d 350, 366 N.Y.S.2d 297 (N.Y. Civ. Ct. 1975) (patient sued prominent psychiatrist for malpractice and assault for engaging her in sexual relationship). This case made front page news and brought the issue of psychotherapist-patient sexual exploitation to the public's attention. The case also resulted in the publication of a book and a made-for-television movie. See L. FREEMAN & J. ROY, *BETRAYAL* (1976).

1961 English case, *Landau v. Werner*.<sup>11</sup> From this landmark case until the mid-1970's, few cases were reported.<sup>12</sup> The 1980's, however, brought a flood of cases and much publicity.<sup>13</sup> Now, psychotherapists' sexual involvement with patients is a leading cause of psychotherapist malpractice claims<sup>14</sup> and, between 1976 and 1986, was the most frequent source of litigation against psychologists insured under the American Psychological Association.<sup>15</sup>

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11. 105 Sol. J. 1008 (1961) (psychiatrist found negligent for pursuing social relationship with client, even though relationship did not involve sexual relations).

12. See *Roy*, 81 Misc. 2d 350, 366 N.Y.S.2d 297; Annotation, *Civil Liability of Doctor or Psychologist for Having Sexual Relationship with Patient*, 33 A.L.R.3d 1393 (1970).

13. See, e.g., *Simmons v. United States*, 805 F.2d 1363 (9th Cir. 1986); *Horak v. Biris*, 130 Ill. App. 3d 140, 474 N.E.2d 13 (1985). In 1981, a jury awarded a patient-plaintiff \$4.6 million, the highest damage award to date in a psychotherapist malpractice case. *Walker v. Parzen*, 24 ATLA L. REP. 295 (1981). Victims of sexual abuse have written several books. See, e.g., C. BATES & A. BRODSKY, *SEX IN THE THERAPY HOUR* (1989); E. PLASIL, *THERAPIST* (1985); E. WALKER & P.D. YOUNG, *A KILLING CURE* (1986).

14. Perr, *Medicolegal Aspects of Professional Sexual Exploitation*, in *SEXUAL EXPLOITATION IN PROFESSIONAL RELATIONSHIPS* 211, 212 (G. Gabbard ed. 1989).

15. G. SCHOENER & J. MILGROM, *supra* note 1, at 538. "From 1976 to 1986, sexual intimacy with clients was the most frequent cause of suits against psychologists insured under the American Psychological Association's policy; the suits accounted for 44.8% of all monies (\$7,019,165) paid in response to claims." *Id.* (citation omitted).

Although insurers have attempted to exclude sexual contact from coverage, they have not been successful under policy language that reads "arising out of the performance of professional services rendered or which should have been rendered, during the policy period, by the Insured." See, e.g., *Saint Paul Fire & Marine Ins. Co. v. Mitchell*, 164 Ga. App. 215, 217, 296 S.E.2d 126, 127 (1982) (emphasis omitted); see also *Vigilant Ins. Co. v. Employers Ins.*, 626 F. Supp. 262, 264 (S.D.N.Y. 1986) (construing an identical insurance policy clause); *Mazza v. Medical Mutual Ins. Co.*, 319 S.E.2d 217, 219 (N.C. 1984) (same provision); *Aetna Life & Casualty Co. v. McCabe*, 556 F. Supp. 1342, 1344 (E.D. Pa. 1983) (identical clause). In *Saint Paul Fire & Marine Ins. Co. v. Love*, 447 N.W.2d 5 (Minn. Ct. App. 1989), the court reversed a motion for summary judgment that the trial court granted and held that the liability policy did not per se exclude coverage when the therapist became emotionally and sexually involved with a patient. *Id.* at 10. The plaintiff's expert, Gary Schoener, concluded that the therapist's rendering of services was negligent in the following ways:

- (1) improper and non-therapeutic disclosure of the therapist's personal problems to the patient; (2) therapist's failure to adequately recognize and deal with emotional transference and countertransference; (3) therapist's failure to monitor his personal health, preventing effective therapy; (4) therapist's attempting to personally counsel client to "fix" the results of therapist's sexual involvement; and (5) failure to provide outside therapeutic intervention for problems arising from the sexual involvement.

*Id.* at 7.

The court distinguished cases involving medical doctors from those involving mental health therapists who become sexually involved with their patients. *Id.* at 9. The court stated that in therapist cases, "[t]here is no clear dichotomy between the professional purpose and all of the alleged tortious acts. Alleged breaches of the professional obligation, if proved, are departures related to the therapy itself. . . . The sexual acts are an incidental outgrowth of the primary malpractice, not the proximate cause." *Id.* at 9-10.

Recognizing the unique nature of the therapist-patient relationship and its potential for sexual abuse, state legislatures and licensing boards have altered their handling of these cases.<sup>16</sup> Since 1983, several states have specifically proscribed psychotherapists' sexual contact with their patients through criminal, civil, and licensing regulations.<sup>17</sup> Other states are now considering these types of regulations.<sup>18</sup>

This Article examines the unique nature of the psychotherapist relationship, which potentially leads to sexual abuse, and it analyzes the relevant criminal, civil, and licensing board statutes enacted throughout the United States. Section II discusses the problem of sexual contact in the therapeutic relationship. This Section discusses the therapist's role as fiduciary and the relational power imbalance between the parties and provides an overview of the psychological phenomena of transference and countertransference. Section II also reviews empirical data on psychotherapist-patient sexual exploitation and presents the types of injuries that victims suffer. Through a review of criminal laws,

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The court noted, however, that insurers did have the right to exclude specifically certain types of malpractice claims from the terms of their policies. *Id.* at 10 (citing *Govar v. Chicago Ins. Co.*, 879 F.2d 1581 (8th Cir. 1989)).

In *Govar*, the therapist's insurance policy contained the following language:

This insurance does not apply to claims arising out of any sexual act or acts performed or alleged to have been performed by the named insured. However, notwithstanding the foregoing, the insured shall be protected under the terms of this policy for any claim upon which suit may be brought against him, for any such alleged act or acts by the Insured unless a judgment or final adjudication adverse to the Insured shall establish that such act or acts occurred as an essential element of the cause of action so adjudicated.

*Govar*, 879 F.2d at 1582. The court held that this clause barred the patient's claim against the therapist's insurance company, as the patient's "entire case centered on sex." *Id.* at 1583 (emphasis added).

In another sexual exploitation case, however, a court allowed a patient to recover from the malpractice insurer even though the insurance policy specifically excluded sexual misconduct. *Cranford Ins. Co. v. Allwest Ins. Co.*, 645 F. Supp. 1440, 1442 (N.D. Cal. 1986). The court recognized the patient's argument that concurrent proximate causes led to her injuries, specifically, the therapist's mishandling of transference, which the policy excluded, and the therapist's abandonment of the patient, which the policy did not exclude. *Id.* at 1444. The court noted that, under California law, when an insured risk and an excluded risk constitute concurrent proximate causes of an injury, a liability insurer is liable if the policy covers one of the causes. *Id.*

16. Seven states have passed criminal statutes proscribing therapist-patient sexual contact. See *infra* notes 156-66 and accompanying text. Four states have enacted civil causes of action. See *infra* notes 386-426 and accompanying text. Several states have modified their licensing and disciplinary procedures. For a more extensive discussion, see *infra* notes 470-547.

17. See *id.*

18. See *infra* note 164 and accompanying text.

Section III examines trends in the criminalization of sexual exploitation, including an analysis of seven recent statutes proscribing psychotherapist-patient sexual exploitation. Section IV explores the common law and four state statutes addressing psychotherapist-patient sexual exploitation, as well as such ancillary concerns as statutes of limitations, employer liability, and civil "victim shield" provisions. Section V provides an overview of current administrative statutes and exposes the features of board regulation, the scope of power, and the range of sanctions available. This Section also discusses related issues, including burden of proof, statutes of limitations, mandatory reporting, and victim shield provisions within the context of board regulations. Section VI concludes that no existing remedy adequately protects patients from the growing problem of psychotherapist sexual exploitation and that a combination of remedies within a comprehensive legal scheme is therefore necessary.<sup>19</sup>

## II. UNIQUE NATURE OF THE THERAPEUTIC RELATIONSHIP

### A. *Therapist as Fiduciary*

Because he possesses special expertise, a professional often owes a fiduciary duty to his clients.<sup>20</sup> A fiduciary relationship "arises whenever confidence is reposed on one side, and domination and influence result on the other."<sup>21</sup> A fiduciary is never

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19. Throughout this Article, the authors refer to the psychotherapist as "he" and the victim as "she." These references are a reader's aid and are not intended to imply that sexual exploitation of male patients is somehow less important than sexual exploitation of females. The vast majority of sexual exploitation cases reported, however, involve a male therapist and a female patient. See *infra* notes 81-83 and accompanying text (surveys by representatives of psychiatric, psychological, and social work organizations indicate that almost 90% of offenders are male and a similar percentage of the victims are female).

20. See, e.g., *Horak v. Biris*, 130 Ill. App. 3d 140, 145, 474 N.E.2d 13, 17 (1985) (social worker is fiduciary to clients and must refrain from harmful actions); *Plaquemines Parish Comm'n Council v. Delta Dev. Co.*, 502 So. 2d 1034, 1039-40 (La. 1987) (relationships between attorney and client and between public official and his constituency are fiduciary); *Merkley v. Beaslin*, 778 P.2d 16, 19 (Utah App. Ct. 1989) (attorneys and doctors are fiduciaries because of special expertise).

21. BLACK'S LAW DICTIONARY 626 (6th ed. 1990); see also *Erickson v. Christenson*, 99 Or. App. 104, 108, 781 P.2d 383, 386 (1989). In reversing the dismissal of a claim against a clergyman for sexual exploitation in a counseling relationship, the court stated, "Because he was plaintiff's pastor and counselor, a special relationship of trust and confidence developed." *Id.* (emphasis omitted). The court stressed that the breach of fiduciary duty was a breach of a confidential relationship. *Id.*



a coequal in a relationship with a client;<sup>22</sup> by virtue of his special skill or status, the fiduciary is a more powerful figure in the relationship.<sup>23</sup> This asymmetry in power requires the trusted professional to act with utmost care and good faith.<sup>24</sup>

In a landmark case, *Roy v. Hartogs*,<sup>25</sup> the court explicitly found that a psychotherapist is a fiduciary to his client.<sup>26</sup> A therapist's sexual exploitation of his client is one of the most outrageous breaches of fiduciary duty.<sup>27</sup> Unfortunately, the nature of psychotherapy makes sexual contact both tempting and destructive.<sup>28</sup>

### *B. Client Dependence Engenders Client Vulnerability*

The patient often enters a professional relationship with the psychotherapist in a vulnerable emotional condition.<sup>29</sup> The individual seeks professional help because of painful, unresolved problems, and she relies on the therapist's expertise to reduce her suffering.<sup>30</sup> In order to form a constructive alliance, the

22. See *Barbara A. v. John G.*, 145 Cal. App. 3d 369, 383, 193 Cal. Rptr. 422, 432 (1983) (essence of fiduciary relationship is that parties do not deal on equal terms).

23. See *id.*; *Toombs v. Daniels*, 361 N.W.2d 801, 809 (Minn. 1985) ("fiduciary relationship exists 'when confidence is reposed on one side and there is resulting superiority and influence on the other'"); see also T. GUTHEIL & P. APPELBAUM, *CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW* 153 (1982); *infra* notes 29-36 and accompanying text. See generally Frankel, *Fiduciary Law*, 71 CALIF. L. REV. 795 (1983) (discussing how fiduciary relations may lead to an abuse of power); Sealy, *Fiduciary Relationships*, 1962 CAMBRIDGE L.J. 69 (describing the trust and confidence inherent in a fiduciary relationship).

24. See *Destefano v. Grabrian*, 763 P.2d 275 (Colo. 1988), in which the court stated:

[A] fiduciary is a person having a duty, created by his undertaking, to act primarily for the benefit of another in matters connected with the undertaking. A fiduciary has a duty to deal "with utmost good faith and solely for the benefit" of the beneficiary. A fiduciary's obligations to the beneficiary include, among other things, a duty of loyalty, a duty to exercise reasonable care and skill, and a duty to deal impartially with beneficiaries.

*Id.* at 284 (citations omitted).

25. 81 Misc. 2d 350, 366 N.Y.S.2d 297 (N.Y. Civ. Ct. 1975).

26. *Id.* at 352, 366 N.Y.S.2d at 299.

27. See Feldman-Summers, *Sexual Contact in Fiduciary Relationships*, in *SEXUAL EXPLOITATION IN PROFESSIONAL RELATIONSHIPS* 193, 197-203 (G. Gabbard ed. 1989) (case studies illustrate that many clients feel powerlessness toward their therapists).

28. The intimacy of the treatment setting and the phenomena of transference and countertransference create forces that make sexual involvement tempting to both therapist and patient. See *infra* notes 37-50 and accompanying text.

29. R. SIMON, *CLINICAL PSYCHIATRY AND THE LAW* 289 (1987). This statement may not be true for those who seek professional help to break a habit or to change a particular behavior, such as smoking, or for those within the field of psychopharmacology. Nevertheless, the therapist in these conditions remains a fiduciary and must act with utmost good faith and concern only for the patient's needs.

30. See Feldman-Summers, *supra* note 27, at 195-96.

patient must trust the therapist enough to participate in treatment with him. For effective therapy, in most situations the patient must share her fears, wishes, conflicts, fantasies, and feelings.<sup>31</sup> The psychotherapist must assure confidentiality and create a private, secure, and intimate process.<sup>32</sup> The exchanges between patient and therapist are not social discourse, and ideally the therapist should orient them around the patient's therapeutic issues.

The patient's self-revelation reinforces the power imbalance between the parties, which some have likened to the relationship between a benevolent parent and a child.<sup>33</sup> Like a child depends upon a parent, a patient often depends upon a therapist. At times, this dependence becomes extreme. For example, the plaintiff in *Greenberg v. McCabe*<sup>34</sup> testified that she became so dependent on her therapist that he "became a God" to her and that she would not question the therapy he prescribed because she so feared displeasing him.<sup>35</sup> Experts have maintained that this behavior is attributable in part to the phenomenon of transference.<sup>36</sup>

### C. *The Phenomena of Transference and Countertransference*

Recounting the details of one's personal life evokes a series of typical reactions in a psychotherapy patient.<sup>37</sup> Partly or wholly

31. See Marmor, *Some Psychodynamic Aspects of the Seduction of Patients in Psychotherapy*, 36 AM. J. PSYCHOANALYSIS 319, 320 (1976).

32. *Id.*; see A. Stone, *Commentary, Sexual Misconduct by Psychiatrists: The Ethical and Clinical Dilemma of Confidentiality*, 140 AM. J. PSYCHIATRY 195, 196 (1983) ("Confidentiality has merited special consideration in psychiatry, not only because it is necessary to protect the privacy of patients but also because an expectation of privacy is essential to protect the process of psychotherapy itself, particularly the intimate process of psychoanalytic therapy."); M. Stone, *Boundary Violations Between Therapist and Patient*, 6 PSYCHIATRIC ANNALS 670, 675-76 (1976) ("Once the patient has crossed the office threshold, she has established herself as someone willing to expose the secrets of her life to a person specially trained to hear and deal with them.").

33. See Feldman-Summers, *supra* note 27, at 200. The vulnerability accompanying either low self-esteem or high dependency is compounded if the patient reveals these underlying feelings to the fiduciary. The fiduciary who acquires such information is then in a position to misuse or exploit these weaknesses of the trusting client. Enhanced vulnerability due to revelation is virtually inevitable in the therapist-client situation because the client is encouraged to "tell all." *Id.*; see M. Stone, *supra* note 32, at 675.

34. 453 F. Supp. 765 (E.D. Pa.), *aff'd*, 594 F.2d 854 (3d Cir. 1978), *cert. denied*, 444 U.S. 840 (1979).

35. *Id.* at 771.

36. *Id.*

37. See generally R. GREENSON, *THE TECHNIQUE AND PRACTICE OF PSYCHOANALYSIS* 1345-46 (1967). Gratitude at being listened to, feelings of support and protection, and a sense

operating outside the patient's sphere of awareness, ideas and feelings that are attributes of earlier relationships are "transferred" onto the relationship with the psychotherapist—hence the term "transference."<sup>38</sup> The psychotherapist brings to the therapeutic relationship a counterpart set of feelings, wishes, and fears. Psychotherapists refer to this phenomenon as countertransference, and it arises in part from the therapist's own early experiences and in part from his response to the patient's transference.<sup>39</sup>

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of personal importance to another individual arouse a constellation of feelings drawn from past experiences. These memories, yearnings, wishes, and fears often reflect relationships with important figures from childhood, and their content recapitulates in the present time childlike modes of relating. These modes of relating come to the fore and layer onto the relationship with the therapist. Even though they are derived from the past and may have nothing to do with the therapeutic interaction, they are present and influential determinants of behavior. Dependent yearnings, strivings for childlike sensual gratification, efforts to attain "special" status in the eyes of the therapist, strategies to avoid abandonment and loss, and wishes to be loved are frequent, if not universal, characteristics of the patient's contribution to the therapeutic relationship. Hateful or destructive residues of early relationships also may be present.

38. *Id.* The court in *Simmons v. United States*, 805 F.2d 1363 (9th Cir. 1986), discussed transference and the mishandling of transference:

Transference is the term used by psychiatrists and psychologists to denote a patient's emotional reaction to a therapist and is "generally applied to the projection of feelings, thoughts and wishes onto the analyst, who has come to represent some person from the patient's past." Transference "is perhaps regarded as the most significant concept in psychoanalytical therapy, and one of the most important discoveries of Freud."

*Id.* at 1364 (citations omitted). Dr. Laura Brown, the clinical psychologist who treated Ms. Simmons, testified at trial:

What the notion of transference assumes is that as therapy develops, and if therapy is working, the client comes to either consciously or unconsciously, or both, regard the therapist as a child might regard the parent. This is important because in order for a therapist to have positive powerful impact in helping the client to change and heal, the therapist has to have the same kind of authority power in a positive way with the client that the parents once had, or the parental figures once had in a negative way with the client while the client was growing up. And, so what happens when therapy is working . . . is that this transference relationship grows so that the client comes to experience the therapist as a powerful, benevolent parent figure. And, what that means is that you've got a symbolic, sometimes conscious sometimes not, parent-child relationship existing in the therapy setting, even though you have two adults there.

*Id.* at 1364-65.

39. Stewart, *Psychoanalysis and Psychoanalytic Psychotherapy*, in 2 H. KAPLAN & B. SADOCK, *COMPREHENSIVE TEXTBOOK OF PSYCHIATRY* 1345-46 (4th ed. 1985). Stewart explains that although Freud coined the term "countertransference," he wrote little about the phenomenon. *Id.* at 1345. Stewart adds, "Just as the term 'transference' has often been used to encompass the patient's total range of feelings for and against the analyst, countertransference connotes a broad spectrum of reactions in the analyst. These reactions

Transference and countertransference are a powerful admixture. The paramount difference between the patient's and the therapist's contributions to this interaction lies in their relative awareness of it.<sup>40</sup> Through education, training, and often personal psychotherapy of his own, the qualified therapist is able to monitor consciously and to assess the effect of countertransference on his behavior. Indeed, he has the responsibility to do so.<sup>41</sup> The patient, however, may have little awareness of her own transference. This differential in awareness and knowledge of the transference/countertransference phenomenon is another facet of the power asymmetry in the therapeutic relationship. The psychotherapist has a special responsibility to use this power constructively.<sup>42</sup>

If properly managed, transference/countertransference interaction provides a focal point for the major task of psychotherapy.<sup>43</sup> Treatment becomes difficult when either the patient or the

may be regarded as analogues of the patient's transferences." *Id.* at 1346.

Therapists carry their own residual childhood wishes to be cared for and loved. Like their patients, they wish to be valued and treated as special. They also bring their own grievances and destructive impulses. In addition, just as patients respond to a therapist's willingness to listen with acceptance, therapists are affected by their patients' idealizations, wishes for special closeness, and sensual yearnings.

40. See M. TANSEY & W. BURKE, UNDERSTANDING COUNTERTRANSFERENCE: FROM PROJECTIVE IDENTIFICATION TO EMPATHY 133-50 (1989); D. WINNICOTT, *Hate in the Countertransference*, in THROUGH PAEDIATRICS TO PSYCHO-ANALYSIS: THE COLLECTED PAPERS OF D.W. WINNICOTT 194 (2d ed. 1974).

41. See Ginsberg, *Diagnosis and Psychiatry: Examination of the Psychiatric Patient*, in 2 COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 482 (4th ed. 1985) (noting the psychiatrist's responsibility to be aware of countertransference behavior and explaining that, absent sufficient understanding of his own motives, the psychiatrist may attribute "to the patient feelings and attitudes that stem from experiences in the psychiatrist's life that do not properly involve the patient").

42. See generally D. DAWIDOFF, THE MALPRACTICE OF PSYCHIATRISTS: MALPRACTICE IN PSYCHOANALYSIS, PSYCHOTHERAPY AND PSYCHIATRY (1973).

43. Transference is crucial to the therapeutic process because the patient "unconsciously attributes to the psychiatrist or analyst those feelings which he may have repressed towards his own parents. . . . [I]t is through the creation, experiencing and resolution of these feelings that [the patient] becomes well." *L.L. v. Medical Protective Co.*, 122 Wis. 2d 455, 459, 362 N.W.2d 174, 177 (Wis. Ct. App. 1984) (quoting D. DAWIDOFF, *supra* note 42, at 6). "Inappropriate emotions, both hostile and loving, directed toward the physician are recognized by the psychiatrist as constituting . . . the transference. The psychiatrist looks for manifestations of the transference, and is prepared to handle it as it develops." *Id.* (quoting Heller, *Some Comments to Lawyers on the Practice of Psychiatry*, 30 TEMP. L.Q. 401, 401-02 (1957)). "Understanding of transference forms a basic part of the psychoanalytic technique." *Zipkin v. Freeman*, 436 S.W.2d 753, 755 n.1 (Mo. 1968) (quoting BLAKISTON'S NEW GOULD MEDICAL DICTIONARY 1260 (2d ed. 1956)).

Transference is a rich source of information about the genesis of emotional conflicts and behavior patterns that generally troubles the patient and leads her to seek treatment.

therapist takes action based on transference or countertransference.<sup>44</sup> When a psychotherapist permits a patient to "act out" transference wishes and feelings, he deprives her of the opportunity to explore them and to understand their significance in the larger context of her life. Based on infantile ideas and emotions, the patient's behavior is painful because it is false and humiliating once its source is revealed.<sup>45</sup>

*Simmons v. United States*<sup>46</sup> addressed these issues in a legal context. In *Simmons*, psychiatrists testified that the patient suffered overwhelming guilt, shame, and anxiety because of her sexual relationship with her therapist.<sup>47</sup> The court discussed the effects of transference:

The impacts of sexual involvement with one's counselor are more severe than the impacts of merely "having an affair" for two major reasons: first, because the client's attraction is based on transference, the sexual contact is ordinarily akin to engaging in sexual activity with a parent, and carries with it the feelings of shame, guilt and anxiety experienced by incest victims. Second, the client is usually suffering from all or some of the psychological problems that brought him or her into therapy to begin with. As a result, the client is especially vulnerable to the added stress created by the feelings of shame, guilt and anxiety produced by the incestuous nature of the relationship, and by the sense of betrayal that is felt when the client eventually learns that she is not "special" as she had been led to believe, and that her trust has been violated.<sup>48</sup>

Confusion about appropriate boundaries between the patient and therapist inevitably results when therapists "act out" transference/countertransference feelings. Such boundary violations

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The clinician's ability to be aware of his countertransference as a reaction to the patient enables his understanding of the nature of the patient's transference. See D. WINNICOTT, *supra* note 40, at 194, 203; Ginsberg, *supra* note 41, at 485. Empathetic response to transference communications reduces the demoralization of patients and enhances the treatment alliance. See *id.* (explaining that the psychiatrist's contribution to the therapeutic alliance with the patient "is determined by his professional behavior and personal attitudes, including sensitivity, tolerance, and the ability to respect the patient's rights and integrity"); Stewart, *supra* note 39, at 1346.

44. See R. GREENSON, *supra* note 37, at 1345-46; M. TANSEY & W. BURKE, *supra* note 40, at 39-64.

45. See Freud, *Further Recommendations in the Technique of Psycho-Analysis: Observations on Transference-Love*, in 2 COLLECTED PAPERS 377 (J. Riviere trans. 1959).

46. 805 F.2d 1363, 1365 (9th Cir. 1986); see *supra* note 38 and accompanying text.

47. *Simmons*, 805 F.2d at 1367.

48. *Id.* (quoting district court opinion).

are unilateral alterations of the treatment contract and are almost always done without the informed consent of the patient, who may have little awareness of the significance or consequences of what is happening.<sup>49</sup> When the acting out is of a sexual nature, the problems for which the patient originally sought counseling may be brushed aside and sexual issues emphasized.<sup>50</sup>

The therapist who acts out his countertransference rather than objectively monitoring it loses a valuable source of information about his patient. He violates an agreement that the therapeutic relationship exists solely to serve the patient's needs. By stepping out of his role, the therapist betrays the patient's trust and fractures the structure of continuity and constancy essential to accomplishing the therapeutic task.

#### *D. Studies of Psychotherapist-Patient Sexual Contact*

The relationship between a therapist and a client is intimate and may lead to intense emotional closeness.<sup>51</sup> Listening intently and caringly is seductive to both parties.<sup>52</sup> The literature in the field indicates that a majority of therapists have felt sexually

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49. Generally, "boundaries" are the behavioral rules expected of people in a given role. One authority has defined boundaries as "limits on behavior—rules for how people in various roles ought to behave, and statements from each individual as to what kinds of behaviors she can accept or tolerate without feeling violated." Disch, *Sexual Abuse by Psychotherapists*, 14(8) SOJOURNER: THE WOMEN'S FORUM 20, 21 (1989). She contends that clear boundaries in the therapy relationship allow a client to express herself with more freedom and decrease the chances of becoming mired in an exploitative relationship. Clear boundaries include sessions that occur at scheduled times, beginning and ending as arranged; no interruptions ordinarily occurring during therapy hour; a clear fee arrangement; set treatment goals, changed only through negotiation; focusing the therapy session solely on the client; clarity by the therapist concerning his values and their impact on the therapy; a definite contract concerning confidentiality; no sexual involvement with patients or social contacts with the client, except when overlapping circles of acquaintances demand it. If social contact occurs, the therapist should define the rules of contact and closely monitor any effects. *Id.*

Disch contends that unclear boundaries lead to harmful boundary violations, including sex, or to client inhibitions and distrust of the therapist. Both limit the effectiveness of therapy. *Id.*

50. Luepker & Retsch-Bogart, *Group Treatment for Clients who have been Sexually Involved with their Psychotherapists*, in MINN. TASK FORCE, IT'S NEVER O.K.: PROFESSIONAL HANDBOOK, *supra* note 1, at 40-42.

51. See R. SIMON, *supra* note 29, at 284-87.

52. "Further, the necessary intensity of the therapeutic relationship may tend to activate sexual and other needs and fantasies on the part of both patient and therapist, while weakening the objectivity necessary for control." AMERICAN PSYCHIATRIC ASS'N, *supra* note 2, § 2, at 4.

attracted to some of their clients.<sup>53</sup> Studies by representatives of psychological,<sup>54</sup> psychiatric,<sup>55</sup> and social work organizations<sup>56</sup> indicate that between four and thirteen percent of all therapists actually engage in sexual contact with their clients.<sup>57</sup> Furthermore, the studies reveal that a large number of offending therapists repeatedly exploit their patients.<sup>58</sup> This Section reviews the studies evaluating the prevalence of sexual misconduct and explores other data concerning repeat offenders and damages.

### 1. *Psychologists*

Researchers conducted three major surveys in the past decade to determine the prevalence of psychologist-patient sexual contact.<sup>59</sup> In 1977, one study revealed that 12.1 percent of male psychologists and 2.6 percent of female psychologists admitted to sexual intimacies with their clients.<sup>60</sup> A 1979 study yielded similar results: twelve percent of the responding male psychologists and three percent of the responding female psychologists admitted having had sexual contact with patients.<sup>61</sup> The statistics were similar almost a decade later, despite the American Psychological Association's public education campaigns.<sup>62</sup>

53. See, e.g., Pope, Keith-Spiegel, & Tabachnick, *Sexual Attraction to Clients: The Human Therapist and the (Sometimes) Inhuman Training System*, 41 AM. PSYCHOLOGIST 147, 151-52 (1986) (95% of the male psychologists responding to a national survey admitted feeling sexual attraction toward their clients).

54. See *infra* notes 59-62 and accompanying text.

55. See *infra* notes 63-66 and accompanying text.

56. See *infra* notes 67-73 and accompanying text.

57. Feeling amorous toward a patient is a natural by-product of the countertransference phenomenon. As long as the therapist deals constructively with these feelings, the feelings may contribute to the process, and no harm will come from the attraction. Acting on these feelings is exploitative, however, and usually harmful. See generally Kardener, *Sex and the Physician-Patient Relationship*, 131 AM. J. PSYCHIATRY 1134, 1135 (1974) (discussing the adverse effects of therapist as "parent surrogate" or as "caretaker").

Data is available concerning other groups, including clergy and marriage and family counselors. For a complete review of the literature, see G. SCHOENER & J. MILGROM, *supra* note 1, at 11-64.

58. See *infra* notes 79-80 and accompanying text.

59. See Holroyd & Brodsky, *Psychologists' Attitudes and Practices Regarding Erotic and Nonerotic Physical Contact with their Patients*, 134 AM. J. PSYCHIATRY 843 (1977); Pope, Levenson, & Schover, *Sexual Intimacy in Psychology Training: Results and Implications of a National Survey*, 34 AM. PSYCHOLOGIST 682, 686 (1979); Pope, Keith-Spiegel, & Tabachnick, *supra* note 53, at 152.

60. See Holroyd & Brodsky, *supra* note 59, at 843-49.

61. See Pope, Levenson, & Schover, *supra* note 59, at 686.

62. See Pope, Keith-Spiegel, & Tabachnick, *supra* note 53, at 152 (nearly 10% of the male psychologists and 2.5% of the female psychologists responding to a national survey admitted sexual contact with clients).

## 2. *Psychiatrists*

Researchers have conducted two significant studies concerning psychiatrist sexual exploitation. The first was a random sampling of male psychiatrists in Los Angeles in 1973.<sup>63</sup> This study concluded that ten percent of the local psychiatrists responding had engaged in sexual contact with their clients.<sup>64</sup> A nationwide study in 1984 and 1985 found a similar incidence.<sup>65</sup> It reported that 7.1 percent of the male and 3.1 percent of the female psychiatrists responding admitted to sexual involvement with patients.<sup>66</sup> The results of the studies of psychiatrists are therefore nearly identical to those of the studies of psychologists.

## 3. *Social Workers*

In 1985, a national survey of 1000 social workers found that 3.8 percent of the male social workers responding to the study had erotic contact with clients during therapy or within three months of termination.<sup>67</sup> No female social workers reported engaging in this conduct.<sup>68</sup>

Statistical data reveal that the percentage of social workers who sexually exploit patients is substantially smaller than the percentages of offending psychologists and psychiatrists.<sup>69</sup> The explanations for this disparity are twofold. First, nearly seventy-five percent of all social workers are women,<sup>70</sup> who, statistically, are less likely than men to abuse clients sexually.<sup>71</sup> Second,

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63. See Kardener, Fuller, & Mensh, *A Survey of Physicians' Attitudes and Practices Regarding Erotic and Nonerotic Contact with Patients*, 130 AM. J. PSYCHIATRY 1077 (1973).

64. *Id.* at 1080.

65. Gartrell, Herman, Olarte, Feldstein, & Localio, *Psychiatrist-Patient Sexual Contact: Results of a National Survey, I: Prevalence*, 143 AM. J. PSYCHIATRY 1126 (1986) [hereinafter Gartrell & Herman]. This study surveyed one-fifth of all psychiatrists under the age of 65, but the response rate was only 26%. *Id.* at 1127. Although the return rate was low, the profile of the respondents was consistent with the profile of the professional population in the American Medical Association Masterfile. *Id.* A significantly larger proportion of board-certified psychiatrists answered the survey, however. *Id.*

66. *Id.* at 1128.

67. Gechtman, *Sexual Contact Between Social Workers and Their Clients*, in *SEXUAL EXPLOITATION IN PROFESSIONAL RELATIONSHIPS* 27, 30 (G. Gabbard ed. 1989).

68. *Id.*

69. *Id.* at 32.

70. *Id.* The percentage of women in the other two fields is nearly reversed. *Id.*

71. See *infra* notes 81-83 and accompanying text; see also Gechtman, *supra* note 67, at 32.



eighty-nine percent of social workers are employed by agencies.<sup>72</sup> The closer supervision and more clearly delineated boundaries in institutions lower the incidence of sexual exploitation of patients by social workers.<sup>73</sup>

#### 4. *Reconciliation*

Every study cited used similar methodology: researchers gathered statistics through confidential surveys.<sup>74</sup> Given the inherent limitations of this method of data collection, it is important to note that the occurrence of sexual abuse may be much higher than these studies indicate.<sup>75</sup> Some have suggested that one in five psychotherapists sexually exploits his patients.<sup>76</sup> The Gartrell study indicated that sixty-five percent of responding psychiatrists had counseled at least one patient who had been sexually involved with a prior therapist,<sup>77</sup> yet only approximately ten percent of

72. Gechtman, *supra* note 67, at 33. Pope and Bouhoutsos reported that only 14% of psychologist-patient sexual involvement occurs in an agency setting. K. POPE & J. BOUHOUTSOS, *SEXUAL INTIMACY BETWEEN THERAPISTS AND PATIENTS* 152 (1986).

73. Gechtman, *supra* note 67, at 33. Comparison figures should not be interpreted to mean that any professional group as a whole is more or less likely to abuse therapy patients sexually. G. SCHOENER & J. MILGROM, *supra* note 1, at 60.

74. See Bouhoutsos, Holroyd, Lerman, Forer, & Greenberg, *Sexual Intimacy Between Psychotherapists and Patients*, 14 PROF. PSYCHOLOGY RES. & PRAC. 185 (1983) [hereinafter Bouhoutsos & Holroyd]; Gartrell & Herman, *supra* note 65, at 1126-28; Gechtman, *supra* note 67, at 28; Holroyd & Brodsky, *supra* note 59, at 843; Kardener, Fuller, & Mensh, *supra* note 63, at 1077; Pope, Levenson, & Schover, *supra* note 59, at 684. For a discussion of the methodologies researchers used, see Comment, *How Vagueness Can Ruin a Survey: Comment on Pope, Tabachnick, and Keith-Spiegel and Reply to Koltko*, 44 AM. PSYCHOLOGIST 845 (1989).

75. Gartrell, Herman, Olarte, Feldstein, & Localio, *Reporting Practices of Psychiatrists Who Knew of Sexual Misconduct by Colleagues*, 57(2) AM. J. ORTHOPSYCHIATRY 287, 292-93 (1987) [hereinafter Gartrell & Herman].

Our data further suggest that the prevalence of psychiatrist-patient sexual contact might be substantially higher than earlier reports indicated. Respondents in this survey indirectly knew of 1316 cases of psychiatric sexual violations, yet acknowledged direct sexual contact with only 144 patients. How can we account for this discrepancy between the number of directly acknowledged patient contacts and the number of psychiatric violations reported to respondents? Perhaps many psychiatrists who did not return the questionnaire were offenders. It is also possible that a substantial number of respondents falsely denied their sexual involvement with patients or under reported the number of patients with whom they had been involved.

*Id.*

76. Moisan, *Sins of the Secular Priesthood: Civil Liability for the Sexual Seduction of Patients*, 33 MED. TRIAL TECH. Q. 440, 444 (1986-87) (citing 1977 unpublished study demonstrating that as many as 20% of psychiatrists and psychologists were intimate with their patients).

77. Gartrell & Herman, *supra* note 75, at 289, 293.

psychiatrists admitted to such conduct.<sup>78</sup> The disparity in these figures suggests that the group admitting to sexual contact contains many repeat offenders, that those failing to respond to the survey had a higher incidence of abuse than those who responded, or that not all respondents were truthful.

### 5. Repeat Offenders

Given the disparity in the statistics between psychotherapists who admit to exploiting their patients and psychotherapists who have treated exploited clients, logic dictates that many therapists abuse more than one patient. Indeed, three studies indicate that many abusive therapists are repeat offenders.<sup>79</sup>

Although many single offenders have encountered situational difficulties that could have been alleviated through education, supervision, personal therapy, or rehabilitation, multiple offenders may have characterological defects that further therapy is not likely to solve.<sup>80</sup>

### 6. Patients

The victims of psychotherapist abuse have little in common except that they are mostly women who are younger than their abusers.<sup>81</sup> Gartrell found that eighty-eight percent of the patients exploited were female,<sup>82</sup> whereas Bouhoutsos reported that ninety-two percent were women.<sup>83</sup> The female victims varied widely in

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78. Gartrell & Herman, *supra* note 65, at 1126 (7.1% of male and 3.1% of female psychiatrists admitted to sexual contact with patients).

79. Holroyd and Brodsky found that 80% of those who sexually exploited their patients admitted to engaging in erotic practices more than once. Holroyd & Brodsky, *supra* note 59, at 843-49. The Gartrell study of psychiatrists found that 20% of sexually abusive therapists had sexual intimacies with two clients and 13% were involved with more than three patients. Gartrell & Herman, *supra* note 65, at 1128. One psychiatrist reported sexual involvement with 12 clients. *Id.* Pope's study found that 86% of those who became sexually intimate with patients did so only once or twice. K. POPE & J. BOUHOUTSOS, *supra* note 72, at 44. Ten percent of abusive therapists became sexually intimate with their clients between 3 and 10 times. *Id.*

80. K. POPE & J. BOUHOUTSOS, *supra* note 72, at 44.

81. See, e.g., G. SCHOENER & J. MILGROM, *supra* note 1, at 23 (describing study's findings that female victims of psychotherapist sexual exploitation were an average of sixteen and a half years younger than their therapist).

82. Gartrell & Herman, *supra* note 65, at 1128.

83. Brodsky, *Sex Between Patient and Therapist: Psychology's Data and Response*, in *SEXUAL EXPLOITATION IN PROFESSIONAL RELATIONSHIPS* 19 (G. Gabbard ed. 1989) (quoting Bouhoutsos & Holroyd, *supra* note 74); see also G. SCHOENER & J. MILGROM, *supra* note 1, at 95. The Minneapolis Walk-In Counseling Center has treated more than 1,500 victims. *Id.* at iii. Most victims have been women, and male therapists have exploited over 80% of them. *Id.*

occupation, socioeconomic status, and level of functioning.<sup>84</sup>

### *E. Damage Caused by Sexual Exploitation*

Surveys and studies have documented the extensive damage caused by therapists' sexual abuse.<sup>85</sup> Therapists who treated sexually exploited patients reported that ninety percent of the abused patients suffered negative consequences, including difficulty resuming therapy, hospitalization, and suicide.<sup>86</sup> Counselors at the Minnesota Walk-In Counseling Center found that abused clients displayed common symptoms, including feelings of guilt and shame, grief, rage, depression, loss of self-esteem, ambivalence, confusion, fear, and massive distrust.<sup>87</sup> A study of fifteen patients hospitalized at the Menninger Foundation after sexual contact with psychotherapists concluded that subsequent treatment was prolonged and of limited success, and the incidence of suicide was markedly elevated.<sup>88</sup> Pope has described a syndrome consisting of ambivalence, guilt, emptiness and isolation, sexual confusion, impaired ability to trust, identity and role reversal, emotional lability or dyscontrol, suppressed rage, increased suicidal risk, and cognitive dysfunction.<sup>89</sup> In addition to these descriptive syndromes, therapist-patient sex may produce a number of formal diagnostic disorders.<sup>90</sup> Therapist-patient sex may also

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84. J. Wohlberg, *The Psychology of Therapist Sexual Misconduct: A Victim's Perspective*, Presentation at Boston Psychoanalytic Society (Feb. 10, 1990); see Schoener & Hofstee-Milgrom, *Helping Clients Who Have Been Sexually Abused by Therapists*, in *INNOVATIONS IN CLINICAL PRACTICE: A SOURCEBOOK* 408 (P. Keller & S. Heyman eds. 1987).

85. See, e.g., Bouhoutsos & Holroyd, *supra* note 74, at 190-95 (questionnaire was sent to all licensed psychologists in California); Gartrell & Herman, *supra* note 75, at 289 (87% of respondents who treated sexually abused patients assessed sexual contact as always harmful).

86. Bouhoutsos & Holroyd, *supra* note 74, at 190-91.

87. See G. SCHOENER & J. MILGROM, *supra* note 1, at 159; Luepker & Retsch-Bogart, *Group Treatment for Clients Who Have Been Sexually Involved with Their Psychotherapists*, in *MINN. TASK FORCE, IT'S NEVER O.K.: PROFESSIONAL HANDBOOK*, *supra* note 1, at 35.

88. See Collins, Mebed, & Mortimer, *Patient-Therapist Sex: Consequences for Subsequent Treatment*, 3 *MCLEAN HOSP. J.* 24, 28 (1978).

89. See Pope, *Therapist-Patient Sex Syndrome: A Guide for Attorneys and Subsequent Therapists to Assessing Damage*, in *SEXUAL EXPLOITATION IN PROFESSIONAL RELATIONSHIPS* 39, 40-45 (G. Gabbard ed. 1989). One authority noted the similarity to the damage that incest victims suffer. Gabbard, *Introduction*, in *SEXUAL EXPLOITATION IN PROFESSIONAL RELATIONSHIPS* xi (G. Gabbard ed. 1989). Both groups of victims often suffer shame, intense guilt, a feeling of responsibility for the exploitation, isolation, poor self-esteem, suicidal behavior, and denial, and both often face familial rejection and disbelief. *Id.*

90. The disorders include major depression (single episode or recurrent), dysthymia (a less severe form of depression), generalized anxiety disorder, posttraumatic stress dis-

exacerbate preexistent dissociative disorders and personality disorder symptoms.<sup>91</sup>

Psychotherapy ends when patient-therapist sex begins, thereby depriving sexually exploited patients of the opportunity for continued consultation with their therapist. Long after the formal termination of effective psychotherapy, many patients report having imaginary conversations with former therapists in order to assess their own feelings, to come to decisions, or to self-evaluate important attitudes.<sup>92</sup> This internal dialogue can be an extremely valuable residual benefit of therapy and may endure for years after the resolution of transference and the termination of actual psychotherapy meetings.<sup>93</sup> The ambivalence and rage stemming from sexual exploitation destroys this dialogue. The benevolent, internalized figure is no longer available for consultation. Prior therapeutic work is often undone, and a patient's ability to trust is destroyed.<sup>94</sup>

#### F. Summary

Through the unique nature of the psychotherapist-patient relationship, the patient seeks to bring about personal change that she cannot accomplish by herself. Patient and therapist form an alliance for the exercise of power on the patient's behalf.<sup>95</sup> Powerful forces of transference and countertransference create a ten-

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order, somatoform, psychosomatic disorders, sexual disorders, sleep disorders, and adjustment disorders. See K. POPE & J. BOUHOUTSOS, *supra* note 72, at 63-66; G. SCHOENER & J. MILGROM, *supra* note 1, at 142-43, 166-68; Pope, *supra* note 89, at 40-45. See generally AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (3d ed. 1987) (containing a categorization and description of each diagnostic disorder).

91. See generally Helzer, Robins, & McEvoy, *Post-Traumatic Stress Disorder in the General Population*, 317 NEW ENG. J. MED. 1630, 1632 (1987).

92. Pfeffer, *The Meaning of the Analyst after Analysis*, 11 J. AM. PSYCHOANALYTIC A. 229, 243 (1962).

93. *Id.* "The vividness of the representation and the use of the representation for the purpose of continuing the therapeutic dialogue are significantly correlated with self-perceived improvement." Geller, Cooley, & Hartley, *Images of the Psychotherapist: A Theoretical and Methodological Perspective*, in 1 IMAGINATION, COGNITION, AND PERSONALITY 123 (1981).

94. Reactivation of transference wishes and feelings, accompanied by their distortion of interpersonal relationships, is a common regressive phenomenon. The therapist leaves the exploited patient in the miserable position of having her conflicts reactivated at a time when she can neither effectively continue psychotherapy with her former therapist nor trust anyone else to do the necessary psychological work. See Pope, *Research and Laws Regarding Therapist-Patient Sexual Involvement: Implications for Therapists*, 40 AM. J. PSYCHOTHERAPY 564, 566-67 (1986).

95. M. TANSEY & W. BURKE, *supra* note 40, at 4.

dency to act out rather than resolve pathological forms of relating.<sup>96</sup> To counter this tendency, the effective functioning of the therapeutic alliance depends upon careful maintenance of treatment structure and boundaries.<sup>97</sup> Therapists who engage in sexual activity with their patients breach these boundaries.<sup>98</sup> This activity renders psychotherapy ineffective and causes severe and long lasting damage to patients.<sup>99</sup>

The remainder of this Article explores the issues surrounding the legal prohibition of psychotherapist-patient sexual exploitation. Because sex in the therapeutic relationship causes severe damage, many therapists advocate criminalization of this behavior.

### III. CRIMINALIZATION OF PSYCHOTHERAPIST-PATIENT SEX

#### A. *The Call for Criminalization*

In 1975, Masters and Johnson addressed the American Psychiatric Association concerning the prevalence of sexual exploi-

96. See *St. Paul Fire & Marine Ins. Co. v. Love*, 459 N.W.2d 698, 701 n.4 (Minn. 1990) (quoting AMERICAN PSYCHIATRIC ASS'N, *THE PRINCIPLES OF MEDICAL ETHICS WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY* § 2.1 (1985)) ("Further, the necessary intensity of the therapeutic relationship may tend to activate sexual and other needs and fantasies on the part of both patient and therapist, while weakening the objectivity necessary for control.").

97. See generally Disch, *supra* note 49 (thorough discussion of boundaries).

98. See *id.* at 21.

99. See A. Stone, *supra* note 32, at 196 (a psychotherapist's misuse of his power for the purpose of sexual favors often causes the same type of mental injury that incest victims suffer); see also T. Gutheil, *Insights: Patient-Therapist Sexual Relations: The Search for Clarity in Complexity* (1989) (unpublished manuscript). Gutheil notes:

In a comparable manner, the physician is involved in a "special" relationship of trust in which deep confidences, intimacy of conversation and privacy are shared, and close ties may develop. The physician who then sexually exploits his patient may be considered to be taking unfair advantage of the special properties of the relationship. The literature clearly portrays the emotional harm this causes, both acutely to the patient and to the process of future therapy.

*Id.* at 4-5; see also Dagish, *Many Legal Pitfalls and Ethical Dilemmas Exist in Psychiatry*, *PSYCHIATRIC TIMES*, Feb. 1989, at 8.

The American Psychiatric Association (APA) has determined that, for psychiatrists, sex with patients is never ethically acceptable. The underlying principle is the undue influence that therapists may have over their patients.

The physician-patient relationship is supposed to be a fiduciary one, geared entirely to the welfare of the patient . . . .

*Id.*; see also Milgrom, *Secondary Victims of Sexual Exploitation by Counselors and Therapists: Some Observations*, in G. SCHOENER & J. MILGROM, *supra* note 1, at 235-40 (secondary victims of a psychotherapist's sexual exploitation include spouses, children, parents, and siblings); K. POPE & J. BOUHOUTSOS, *supra* note 72, at 68 (the emotional distance created by a patient's or therapist's sexual involvement also affects coworkers, employers, roommates, and friends).

tation by psychotherapists.<sup>100</sup> They were outraged by numerous incidents of sexual exploitation and urged criminalization of this behavior:

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 the therapist, the therapist should initially be sued for rape rather than malpractice, i.e., the legal process should be criminal rather than civil. Few psychotherapists would be willing to appear in court on behalf of a colleague and testify that the sexually dysfunctional patient's facility for decision making could be considered normally objective when he or she accepts sexual submission after developing extreme emotional dependence on the therapist.<sup>101</sup>

Although supporters have widely hailed their moral umbrage, this blanket recommendation has been extremely controversial within legal and mental health circles.<sup>102</sup> Making all therapist-patient sexual contact a criminal offense regardless of consent is a wide deviation from traditional notions of criminal rape.<sup>103</sup>

By presenting seven states' criminal statutes on psychotherapist-patient sexual exploitation, this Section examines the changes in traditional criminal rape statutes and explores the modern trend toward criminalizing sexual abuse by therapists.

### *B. Evolution of Traditional Criminal Rape*

Traditional criminal rape statutes are very narrow. At common law, rape is "[u]nlawful sexual intercourse with a female without her consent."<sup>104</sup> Rape prosecutions focus on the issue of consent, and some courts require the victim's utmost resistance, unless such resistance would have been futile, in order for a judge or jury to find the perpetrator guilty.<sup>105</sup>

Common law rape does include some situations in which a physician engages in intercourse with a patient in unusual cases of sexual exploitation. These cases have generally involved the

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100. See Masters & Johnson, *Principles of the New Sex Therapy*, 133 AM. J. PSYCHIATRY 548 (1976).

101. *Id.* at 553.

102. See Appelbaum, *Statutes Regulating Patient-Therapist Sex*, 41 HOSP. & COMMUNITY PSYCHIATRY 15, 15-16 (1990); Coleman, *Sex Between Psychiatrist and Former Patient: A Proposal for a "No Harm, No Foul" Rule*, 41 OKLA. L. REV. 1, 20-22 (1988).

103. See *infra* notes 104-15 and accompanying text.

104. BLACK'S LAW DICTIONARY 1260 (6th ed. 1990).

105. See, e.g., *People v. Taylor*, 48 Ill. 2d 91, 98, 268 N.E.2d 865, 868 (1971).

administration of drugs to minimize resistance to the physician's advances.<sup>106</sup> A most outrageous case concerned a doctor who used electroconvulsive shock therapy, combined with medication, to render his patients helpless while he sexually assaulted them.<sup>107</sup> The physician was convicted of rape and incarcerated.<sup>108</sup> In *Eberhart v. State*,<sup>109</sup> the court ruled that intercourse with a patient against her objections, albeit feeble, was rape.<sup>110</sup> Additionally, courts have upheld convictions in which the therapist committed the act when the patient was unaware of the nature of the act.<sup>111</sup> These cases share a common theme—lack of consent.

In cases in which a therapist or physician misleads his patient into sexual contact under the guise of treatment, courts have not uniformly applied traditional criminal rape doctrine. Although some states forbid fraud as a means of gaining consent,<sup>112</sup> some courts have held that such a situation does not constitute rape,<sup>113</sup> reasoning that the patient had the ability to resist or consent if the therapist did not use force.<sup>114</sup> Traditionally, rape has been such a narrowly defined offense that it leaves unprotected many victims of nonconsenting sexual relations and sexual contact.<sup>115</sup>

### C. Modern Trends

Modern understandings of rape issues recognize that some forms of sexual contact offend public policy and should be pro-

106. See, e.g., *Ballard v. Superior Court*, 64 Cal. 2d 159, 410 P.2d 838, 49 Cal. Rptr. 302 (1966) (physician charged with rape of a patient after an alleged administration of drugs to prevent resistance); *People v. Middleton*, 38 Ill. App. 3d 984, 350 N.E.2d 223 (1976) (physician convicted of deviant sexual assault for oral copulation with a patient who was under the influence of drugs).

107. A. Stone, *The Legal Implications of Sexual Activity Between Psychiatrist and Patient*, 133 AM. J. PSYCHIATRY 1138 (1976).

108. *Id.*

109. 134 Ind. 651, 34 N.E. 637 (1893).

110. *Id.* at 655, 34 N.E. at 638.

111. See *State v. Ely*, 114 Wash. 185, 194 P. 988 (1921) (physician convicted of raping a woman during a physical examination while she was unconscious); *Pomeroy v. State*, 94 Ind. 96 (1883) (physician had intercourse with a woman afflicted with epileptic fits).

112. See *infra* notes 145-48 and accompanying text.

113. See *Don Moran v. People*, 25 Mich. 355, 365 (1872) (under the applicable rape statute, if the defendant did not deceive the victim as to the nature of the act, it was not rape even if he misrepresented the purpose or "medical value" of the act of intercourse); *State v. Murphy*, 6 Ala. 765, 768-72 (1844) (defendant not guilty of rape when he fraudulently led victim and her parents to believe that defendant and victim were legally married); see also *Regina v. Barrow*, L.R. 1 C.C. 156, 11 Cox 191 (1868) (defendant not guilty of rape when he impersonated woman's husband); W. CLARK & W. MARSHALL, A TREATISE ON THE LAW OF CRIMES 757-58 (7th ed. 1967) (discussing conflicting results on whether fraud vitiates consent).

114. *Don Moran*, 25 Mich. at 355.

115. See A. Stone, *supra* note 107, at 1138-39.

hibited, regardless of victim consent.<sup>116</sup> Statutory rape provisions designed to protect children embody these concerns.<sup>117</sup> Laws protect other classes as well. As of 1986, thirty-seven states had passed legislation criminalizing sexual acts with a person suffering from serious mental impairment.<sup>118</sup>

### 1. *Mental Defect—Mental Disability*

Maine's sexual assault statute offers a typical example of these statutes.<sup>119</sup> Derived from the Modern Penal Code, it prohibits sexual intercourse or sexual acts with one who the actor knows or, if reasonably apparent, should know is mentally disabled and substantially incapable of understanding the nature of the act.<sup>120</sup> This statute protects the severely mentally ill or mentally retarded from sexual abuse by their guardians, caretakers, or others in a position to know of their handicap.<sup>121</sup> This narrow exception to the traditional requirement of forced sexual contact is based on the premise that certain classes of victims are unable to give full consent due to lack of maturity or intelligence or because of another disability.<sup>122</sup>

On its face, the "mentally disabled" or "incapacitated" language of these statutes appears broad enough to include therapist exploitation. Courts, however, have applied these statutes to only the most egregious of therapist-patient sexual situations.<sup>123</sup> Aside from the mentally retarded or institutionalized mental patients, these statutory exceptions to common law do not cover the typical case of therapist-patient sexual contact and, indeed, do not extend any more protection to this class of victims than does traditional criminal rape doctrine.<sup>124</sup> Nevertheless, a few states have passed

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116. *E.g.*, HEALTH SERVICES INVESTIGATION DIV., MICH. STATE DEP'T OF LICENSING & REGULATION, SEXUAL EXPLOITATION BY THERAPISTS: CRIMINAL, CIVIL & ADMINISTRATIVE REMEDIES 12-13 (1986) [hereinafter MICHIGAN, SEXUAL EXPLOITATION BY THERAPISTS].

117. *See, e.g.*, CAL. PENAL CODE § 261.5 (West 1988).

118. MICHIGAN, SEXUAL EXPLOITATION BY THERAPISTS, *supra* note 116, at 13.

119. *See* ME. REV. STAT. ANN. tit. 17-A, § 253(2)(C) (1986 & Supp. 1989); *see also* MODEL PENAL CODE § 213.1(2)(b) (Proposed Official Draft 1962).

120. ME. REV. STAT. ANN. tit. 17-A, § 253(2)(C).

121. *See id.*

122. *See* Note, *Psychiatric Malpractice: Exploitation of Women Patients*, 11 HARV. WOMEN'S L.J. 83, 100-02 (1988).

123. *See, e.g.*, State v. Chabot, 478 A.2d 1136 (Me. 1984) (affirming conviction for gross sexual misconduct for sexual relations with nursing home resident).

124. Consent may be a defense if the mental disability is not known or reasonably apparent to the defendant. Thus, the protection afforded is very minimal. *See, e.g.*, ME. REV. STAT. ANN. tit. 17-A, § 253(2)(C) (crime occurs only if mental disability is "reasonably apparent or known to the actor" and the victim was "incapable of appraising the nature of the contact").



statutes criminalizing sexual contact or assault by physicians in the course of medical treatment.<sup>125</sup>

## 2. *Sexual Assault During Medical Treatment*

Five states have defined sexual contact or assault under the guise of treatment as rape, thus filling a gap in common law rape doctrine.<sup>126</sup> Under each statute, physicians who engage in sexual contact during medical treatment or examination are guilty of a felony.<sup>127</sup> In New Hampshire, it is a felony to engage in sexual penetration with another person "[w]hen the actor engages in the medical treatment or examination of the victim in a manner or for purposes which are not medically recognized as ethical or acceptable."<sup>128</sup> Michigan's statute is virtually identical to the New Hampshire prohibition.<sup>129</sup> Colorado's and Wyoming's statutes similarly prohibit sexual intrusion inconsistent with reasonable medical practice.<sup>130</sup> These statutes have essentially criminalized the

125. See *infra* notes 126-44, 156-66 and accompanying text.

126. See COLO. REV. STAT. §§ 18-3-403(h), -404(g) (1986); MICH. COMP. LAWS ANN. § 750.520b(1)(f)(iv) (West Supp. 1990); N.H. REV. STAT. ANN. § 632-A:2(VII) (1986); R.I. GEN. LAWS § 11-37-2(D) (Supp. 1989); WYO. STAT. § 6-2-303(a)(vii) (1988). All five states have replaced their traditional rape statutes, which required a female victim and a male perpetrator, with gender-neutral sexual assault statutes.

127. See sources cited *supra* note 126.

128. N.H. REV. STAT. ANN. § 632-A:2(VII).

129. See MICH. COMP. LAWS ANN. § 750.520b(1)(f)(iv), which provides:

(1) A person is guilty of criminal sexual conduct in the first degree if he or she engages in sexual penetration with another person and if any of the following circumstances exists . . . [t]he actor causes personal injury to the victim and force or coercion is used to accomplish sexual penetration. Force or coercion includes but is not limited to any of the following circumstances . . . [w]hen the actor engages in the medical treatment or examination of the victim in a manner or for purposes which are medically recognized as unethical or unacceptable.

130. See COLO. REV. STAT. § 18-3-403(h) ("(1) Any actor who knowingly inflicts sexual penetration or sexual intrusion on a victim commits sexual assault in the second degree if . . . [t]he actor engages in treatment or examination of a victim for other than bona fide medical purposes or in a manner substantially inconsistent with reasonable medical practices"); *id.* § 18-3-404(g) ("(1) Any actor who knowingly subjects a victim to any sexual contact commits sexual assault in the third degree if . . . [t]he actor engages in treatment or examination of a victim for other than bona fide medical purposes or in a manner substantially inconsistent with reasonable medical practices"); see also WYO. STAT. § 6-2-303(a)(vii).

Any actor who inflicts sexual intrusion on a victim commits sexual assault in the second degree if, under circumstances not constituting sexual assault in the first degree . . . [t]he actor inflicts sexual intrusion in treatment or examination of a victim for purposes or in a manner substantially inconsistent with reasonable medical practices.

*Id.*

failure to meet the standard required under civil malpractice actions.<sup>131</sup> All of these states require expert testimony.<sup>132</sup>

Rhode Island takes a slightly different approach<sup>133</sup> to this type of statute. It makes sexual penetration a felony if the actor "engages in the medical treatment or examination of the victim for the purpose of sexual arousal, gratification or stimulation."<sup>134</sup> Sexual contact is a lesser included offense.<sup>135</sup> This statute differs in that it requires proof of the defendant's subjective intent at the time of the alleged offense;<sup>136</sup> the practice that the medical community generally follows is not determinative. Thus, this statute may not require expert testimony to obtain a conviction.<sup>137</sup>

Textually, none of these statutes covers the psychotherapist-patient relationship, although a recent decision seems to indicate that courts will apply similar statutes to psychotherapists as well as physicians.<sup>138</sup> In *State v. vonKlock*,<sup>139</sup> a New Hampshire court held that New Hampshire's sexual assault statute is not limited to physicians.<sup>140</sup> The court found that the defendant psychologist had engaged in "medical practice" and committed aggravated sexual assault while counseling his patient.<sup>141</sup> The court quoted New Hampshire's definition of "medical practice": "Any person shall be regarded as practicing medicine . . . who shall diagnose, operate on, prescribe for or otherwise treat any human ailment,

131. See *infra* notes 276-79 and accompanying text (explaining civil standard of care). By adopting the "reasonable medical practice" standard, these states seem to be allowing the medical community's standard for professional behavior to determine criminal liability.

132. Cf. D. HARNEY, MEDICAL MALPRACTICE § 22.4, at 424 (1987) (discussing the need for expert testimony on the causation issue); M. ZAREMSKI & L. GOLDSTEIN, MEDICAL & HOSPITAL NEGLIGENCE § 24.09, at 22 (1990) ("Expert testimony is generally required to establish the standard of care applicable to the conduct of the medical practitioner . . . . The rationale . . . is that a jury . . . would find it difficult, without assistance, to determine what constitutes reasonable practice in the health care community."). In civil cases in which even a lay jury would find it obvious that conduct violated professional standards, courts may not require expert testimony. See S. PEGALIS & H. WACHSMAN, AMERICAN LAW OF MEDICAL MALPRACTICE § 11:2, at 267-77 (1981) (using the example of *res ipsa loquitor* in the medical malpractice area). A therapist's seduction of a patient may be such a clear-cut violation. See D. LOUISELL & H. WILLIAMS, 1 MEDICAL MALPRACTICE § 8.12 (1990).

133. R.I. GEN. LAWS § 11-37-2(D) (Supp. 1989).

134. *Id.*

135. *Id.* § 11-37-4(C).

136. *Id.* § 11-37-4(D).

137. See *supra* note 132.

138. See *State v. vonKlock*, 121 N.H. 697, 700-01, 433 A.2d 1299, 1302 (1981), *rev'd on other grounds*, *State v. Smith*, 127 N.H. 433, 503 A.2d 774 (1985).

139. 121 N.H. 697, 433 A.2d 1299.

140. *Id.* at 700-01, 433 A.2d at 1302.

141. *Id.*

physical or mental."<sup>142</sup> Under this reasoning, the other four statutes also would include psychotherapists.<sup>143</sup>

All of these statutes are similar to fraud statutes in that they punish physicians for engaging in sexual contact or sexual penetration under the guise of medical treatment.<sup>144</sup>

### 3. *Misrepresentation*

At least two state statutes that may apply to the therapist-patient setting make sexual contact a crime when the contact results from misrepresentation.<sup>145</sup> Alabama, for example, finds one guilty of sexual misconduct if, "[b]eing a male, he engages in sexual intercourse with a female without her consent . . . or with her consent where consent was obtained by the use of any *fraud or artifice*."<sup>146</sup> Although Alabama courts have not yet applied this statute to therapeutic deception, such conduct should fall within its terms when a psychiatrist induces a patient to have sex under the artifice of therapy.

A Michigan statute similarly criminalizes sexual intercourse through misrepresentation, providing that one who medically treats a female and represents to her that her health depends upon her having sexual intercourse with a man who is not her husband, and who thereby induces her to have intercourse, is guilty of a felony.<sup>147</sup> This narrowly written statute seems to cover only instances in which a doctor tells a patient that she can get well by having intercourse with him or some other man who is not the patient's husband. On its face, the statute appears gender-biased and may be constitutionally suspect.<sup>148</sup> Assuming it is

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142. *Id.* (emphasis omitted) (quoting N.H. REV. STAT. ANN. § 329:1 (1955)).

143. *But see* G. SCHOENER & J. MILGROM, *supra* note 1, at 547 (noting that a Michigan court "specifically rejected" an application of the Michigan sexual assault statute to "nonphysician psychologists") (citation omitted).

144. The phrase "under the guise of treatment" assumes deception on the part of the health care professional. Compare N.H. REV. STAT. ANN. § 632-A:2(VII) (1986) (a felony occurs when the sexual penetration is not medically recognized, ethical, or acceptable) with ALA. CODE § 13A-6-65 (1982) (plaintiff establishes guilt when professional obtains consent by any fraud or artifice).

For a general discussion of fraud as it relates to psychiatry, see J. SMITH, *MEDICAL MALPRACTICE: PSYCHIATRIC CARE* §§ 8.20-8.23 (1986).

145. See ALA. CODE § 13A-6-65; MICH. COMP. LAWS ANN. § 750.90 (West 1968).

146. ALA. CODE § 13A-6-65 (emphasis added).

147. MICH. COMP. LAWS ANN. § 750.90.

148. Sexual exploitation of male patients does occur, although statistics indicate that a female therapist's abuse of a male patient is rare, as is a male therapist's abuse of a male patient. See *supra* text accompanying notes 81-83. This evidence alone, however,

constitutional, however, this type of statute may impose criminal liability against offending therapists. These statutes thus vitiate consent obtained fraudulently and once again make consent the prosecution's focus.

#### 4. *Position of Authority*

One may find a more sensitive legal approach in Wyoming, whose statute establishes sexual assault when an actor in a position of authority abuses his power and causes a victim to submit sexually.<sup>149</sup> Wyoming defines "position of authority" as "that position occupied by a parent, guardian, relative, household member, teacher, employer, custodian or any other person who, by reason of his position, is able to exercise significant influence over a person."<sup>150</sup>

The Supreme Court of Wyoming upheld this statute in *Scadden v. State*.<sup>151</sup> Scadden, a teacher and girls' volleyball coach, was found guilty of sexual assault in the second degree under this statute on the theory that he used his position of authority to cause a seventeen-year-old student to submit to sexual intercourse.<sup>152</sup> Scadden argued that the student consented.<sup>153</sup> The court explained, however, that this statute obviated consent because the defendant possessed authority over the victim.<sup>154</sup> The court noted that if society gives one person the right to exercise control over another, the controlling person should not use that position

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may not salvage the statute from such an attack. See *Califano v. Goldfarb*, 430 U.S. 199, 210-11 (1977) (to withstand constitutional challenge, classifications by gender must serve important governmental objectives and must be substantially related to the achievement of those objectives).

149. See WYO. STAT. § 6-2-303(a)(vi) (1988).

150. *Id.* § 6-2-301(a)(iv).

151. 732 P.2d 1036 (Wyo. 1987).

152. *Id.* at 1039.

153. *Id.* at 1040.

154. The court in *Scadden* declared:

In the exercise of its governmental police power, the legislature has thrown out the protecting arm of the law to guard those persons who are vulnerable to the powers and influence of one in a position of authority. This legislative act permits the State to show that the victim did not consent, by demonstrating that the perpetrator occupied a position of authority over the victim and used that position to impose his sexual will. The consensual status of the conduct can be disproved by establishing the participants' relationship, and the defendant's use of that relationship to compel the victim to succumb. This statute is neither unreasonable nor arbitrary, and is within the police power of the state to enact laws for the general welfare of the people.

*Id.* at 1040-41.

of power to exploit sexually those under his influence.<sup>155</sup> Given the similar power asymmetry between patient and therapist, a sexually exploitative psychotherapist should fall within the ambit of this statute so that the state may pursue him criminally.

5. *Legislation Specifically Prohibiting Psychotherapist-Patient Sexual Exploitation*

Since 1983, legislators have advocated a new statutory scheme whereby the government will prosecute psychotherapists for sexually exploiting their clients.<sup>156</sup> The new statutes specifically define psychotherapy, sexual contact, and the class of potential defendants treated as psychotherapists.<sup>157</sup>

Wisconsin first enacted a criminal statute making psychotherapist-patient sexual exploitation a criminal offense in 1983, when the state made sexual exploitation a misdemeanor.<sup>158</sup> Minnesota passed the first felony statute<sup>159</sup> and was soon followed by the

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155. *Id.* at 1042-43. In its argument, the State did not rely separately on Scadden's position as a teacher, but only on his ability to exercise influence over the girl. *Id.* at 1042.

In construing the statute, the court explained the type of status an individual must possess in order to have sufficient authority over another to vitiate consent. The court stated:

One in a position of authority is a person who acquires that status by virtue of society and its system of laws granting to him the right of control over another. For example, society grants to a jailer power over his prisoner, and, therefore, the jailer is in a position of authority over the prisoner. Likewise, the teacher or coach is vested with power by a grant from society. The legislature enacted the statute to prohibit persons in such positions of authority from using those positions to cause any individual who might be subject to authoritative power to submit to sexual acts.

*Id.* at 1042-43. The court concluded, "A person of ordinary sensibilities in [Scadden's] position clearly should have known that his conduct was forbidden." *Id.* at 1043.

156. See *infra* notes 157-211 and accompanying text. Following the passage of Wisconsin's misdemeanor statute, Minnesota conducted a comprehensive study of this area. See TASK FORCE ON SEXUAL EXPLOITATION BY COUNSELORS AND THERAPISTS, MINN. DEP'T OF CORRECTIONS, REPORT TO THE MINN. LEGISLATURE (1985) [hereinafter MINNESOTA, REPORT OF TASK FORCE]. California and Massachusetts have also initiated task forces. See CALIFORNIA SENATE RULES COMM., REPORT OF THE SENATE TASK FORCE ON PSYCHOTHERAPIST AND PATIENTS SEXUAL RELATIONS (1987) [hereinafter CALIFORNIA, REPORT OF TASK FORCE]; ACT ESTABLISHING HOUSE COMM. ON SEXUAL MISCONDUCT BY PHYSICIANS, THERAPISTS AND OTHER HEALTH CARE PROFESSIONALS, Mass. H.R. 5437, 174th Leg., 2d Sess., 176 Gen. Court (1989).

157. See sources cited *supra* note 156.

158. See WIS. STAT. § 940.22(2) (1983), amended by WIS. STAT. ANN. § 940.22(2) (West Supp. 1989).

159. See 1985 Minn. Laws ch. 297.

legislatures of Wisconsin, North Dakota, and Colorado.<sup>160</sup> California<sup>161</sup> passed a criminal bill in September 1989, followed by Maine<sup>162</sup> in October 1989 and Florida<sup>163</sup> in June 1990. Other states have considered or are considering this type of criminal sanction.<sup>164</sup> When drafting these statutes, legislators must carefully define the critical terms so as to cover adequately the types of prohibited behavior<sup>165</sup> and to forestall attack under the void for vagueness doctrine.<sup>166</sup>

(a) *Psychotherapy*

Minnesota defines "psychotherapy" as "the professional treatment, assessment, or counseling of a mental or emotional illness, symptom, or condition,"<sup>167</sup> as do California<sup>168</sup> and Florida.<sup>169</sup> North Dakota similarly defines "psychotherapy" as "the diagnosis or treatment of a mental or emotional condition, including alcohol or drug addiction."<sup>170</sup> Under Wisconsin law, psychotherapy involves "the use of learning, conditioning methods and emotional reactions in a professional relationship to assist persons to modify feelings, attitudes and behaviors which are intellectually, socially or emotionally maladjustive or ineffectual."<sup>171</sup> Colorado's lengthy definition of "psychotherapy" provides that "[p]sychotherapy means the treatment, diagnosis, or counseling in a professional relationship to assist individuals or groups to alleviate mental disorders, understand unconscious or conscious motivation, resolve emotional, relationship, or attitudinal conflicts, or modify behaviors which interfere with effective emotional, social, or intellectual functioning."<sup>172</sup> Each of these statutes should ade-

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160. See 1988 Colo. Sess. Laws 88, § 1; 1987 N.D. Laws ch. 169, § 1; WIS. STAT. ANN. § 940.22(2).

161. 1989 Cal. Stat. ch. 795, § 1.

162. 1989 Me. Laws ch. 401, pt. A, § 4.

163. 1990 Fla. Sess. Law Serv. ch. 90-70 (West).

164. For example, Pennsylvania has a bill pending concerning sexual exploitation. See H.R. 151, 1989 Sess. (Pa. 1989). Massachusetts is in the task force process. See H.R. 976, 2d Sess., 176 Gen. Court, 1989.

165. For a discussion and comparison of the types of behavior these states proscribe, see *infra* notes 216-49 and accompanying text.

166. See *infra* notes 192-209 and accompanying text (discussing void for vagueness doctrine as applied to the acts prohibited).

167. MINN. STAT. ANN. § 609.341(18) (West 1987).

168. CAL. CIV. CODE § 43.93 (West Supp. 1990).

169. 1990 Fla. Sess. Law Serv. ch. 90-70, § 1(4)(a) (West).

170. N.D. CENT. CODE § 12.1-20-06.1(1) (Supp. 1989).

171. WIS. STAT. ANN. § 455.01(6) (West 1988).

172. COLO. REV. STAT. § 18-3-405.5(4)(c) (Supp. 1989).

quately cover psychotherapists, whether licensed or unlicensed. Maine's statute, however, is not as forthright.<sup>173</sup>

Maine defines "mental health therapy" as "treatment modalities intended to change behavior, emotions or attitudes."<sup>174</sup> Maine's definition, however, includes only therapy that "is based upon an intimate relationship involving trust and dependency."<sup>175</sup> The state also must prove that a "substantial potential for vulnerability and abuse" arises from the relationship.<sup>176</sup> Because the state must prove each element beyond a reasonable doubt,<sup>177</sup> conviction of a psychotherapist is not likely to occur under this statute. Proving trust and dependency beyond a reasonable doubt will be very difficult, but establishing a potential for abuse and vulnerability beyond the fact of abuse in a given case may be impossible.

These varied definitions are similar in that they outline the relationship that the statute protects, although Maine is the most rigid in its requirements. Because no reported cases specifically apply these definitions to a particular fact pattern, their workability is untested. The vague requirements that Maine imposes, however, will likely render the statute unusable, if not unconstitutional.<sup>178</sup>

(b) *Therapist*

Although "psychotherapy" delineates the protected relationships, each statute demarcates the class of defendants it intends to reach through its definition of "therapist" or "psychotherapist." Wisconsin categorizes as a therapist a "physician, psychologist, social worker, nurse, chemical dependency counselor, member of the clergy or other person, whether or not licensed by the state, who performs or purports to perform psychotherapy."<sup>179</sup> Minnesota's definition of "therapist" adds to this list a marriage and family therapist, as well as a mental health service provider.<sup>180</sup> North Dakota specifically includes "psychiatrist" in its class of

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173. See ME. REV. STAT. ANN. tit. 17-A, § 253(2)(I) (Supp. 1990).

174. *Id.*

175. *Id.*

176. *Id.*

177. See MCCORMICK ON EVIDENCE § 341 (E. Cleary ed. 3d ed. 1984).

178. Although this statute's imprecise wording raises constitutional concerns, such a discussion exceeds the scope of this Article.

179. WIS. STAT. ANN. § 940.22(1)(i) (West Supp. 1989).

180. MINN. STAT. ANN. § 609.341(17) (West Supp. 1990).

defendants.<sup>181</sup> Florida's provision includes licensed therapists, as well as any person who provides psychotherapy.<sup>182</sup> Colorado defines a "psychotherapist" as "any person who performs or purports to perform psychotherapy, whether or not such person is licensed by the state."<sup>183</sup> California's criminal statute includes in its proscription against psychotherapist sexual exploitation "any person holding himself or herself out to be a psychotherapist."<sup>184</sup> This language seems to broaden the class of criminal law defendants to include persons unlicensed by the State, whereas California's civil statute enumerates certain professionals in its "psychotherapist" definition.<sup>185</sup>

These statutes attempt to bridge the gaps often found in license revocation and other administrative proceedings.<sup>186</sup> Each statute includes not only licensed professionals but also clergy, unlicensed therapists, and "quacks" who are otherwise not amenable to board supervision.<sup>187</sup> Only Maine restricts the class of defendants to those who hold themselves out to be psychiatrists, psychologists, or licensed social workers.<sup>188</sup> Consequently, Maine exempts most unlicensed therapists from its class of defendants.<sup>189</sup> The

181. N.D. CENT. CODE § 12.1-20-06.1(2) (Supp. 1989).

182. 1990 Fla. Sess. Law Serv. ch. 90-70, § 1(4)(a) (West).

183. COLO. REV. STAT. § 18-3-405.5(4)(b) (Supp. 1990).

184. CAL. BUS. & PROF. CODE § 729(a) (West Supp. 1990).

185. Compare CAL. BUS. & PROF. CODE §§ 729(a), (c)(1) (criminal code) with CAL. CIV. CODE § 43.93(a)(2) (West Supp. 1990) (civil provision). Unlike the criminal definition of "psychotherapist," the civil definition includes "educational psychologist." See CAL. CIV. CODE § 43.93(a)(2).

186. For a discussion of the weaknesses of administrative proceedings, see *infra* text accompanying notes 543-47.

187. See, e.g., COLO. REV. STAT. § 18-3-405.5(4)(b) ("any person . . . whether or not such person is licensed by the state") (emphasis added). The Colorado Business and Occupations Code for Mental Health Professionals specifically excludes clergy from the statute's operation. See *id.* § 12-43-215(1).

Any person engaged in the practice of religious ministry shall not be required to comply with the provisions of this article; except that such person shall not hold himself out to the public by any title incorporating the terms "psychologist," "licensed clinical social worker," "clinical social worker," "LCSW," "licensed marriage and family therapist," "LMFT," "licensed professional counselor," "certified school psychologist," or "CSP" unless that person has been licensed pursuant to this article or certified as a certified school psychologist.

*Id.* The criminal code applies to all psychotherapists, whether or not licensed by the state pursuant to title 12. See *id.* § 18-3-1405.5(4)(b). The clergy will likely argue that they are exempt from the criminal statute, but the criminal statute appears to be broader; it includes *any person* who performs psychotherapy in the statutory class.

188. ME. REV. STAT. ANN. tit. 17-A, § 253(2)(I) (Supp. 1990).

189. The legislature's oversight in this regard could lead to the anomalous result that an offender whose license was revoked for sexual misconduct but who was not criminally prosecuted might be shielded from prosecution for any further violations because he would no longer be licensed.



legislature's failure to include unlicensed therapists is a critical shortcoming in Maine's statute, leaving the victims of unlicensed therapists without any real recourse through the criminal process or board proceedings. Civil actions also may be difficult to maintain.<sup>190</sup>

(c) *Sexual Contact—Sexual Act*

In an attempt to meet constitutional requirements of specificity, the states define in a variety of ways the behavior that these statutes prohibit. Five of the seven states prohibit touching for the purpose of sexual arousal or other similar conduct.<sup>191</sup> Litigants have attacked some of these statutes as void for vagueness.<sup>192</sup> To determine whether a statute is void for vagueness, a court must examine "whether the statute forbids the doing of an act in terms so vague that persons of ordinary intelligence must necessarily guess as to its meaning and differ as to its application."<sup>193</sup>

North Dakota defines "sexual contact" as "any touching of the sexual or other intimate parts of the person for the purpose of arousing or satisfying sexual or aggressive desires."<sup>194</sup> In *State v. Jenkins*,<sup>195</sup> a North Dakota appellate court held that the trier of fact may infer sexual or aggressive desires from the facts surrounding the touching.<sup>196</sup> Wisconsin prohibits a similar range of behavior, but defines "sexual contact" in more detail than does North Dakota.<sup>197</sup> Even with the additional detail, however, Wisconsin's provision has faced vagueness challenges.<sup>198</sup>

190. Malpractice civil suits require proof of the standard of care *in the profession*. See *infra* notes 274-300 and accompanying text. This standard may be very difficult to prove with regard to unlicensed therapists who, by definition, operate outside of the profession. *Id.* Thus, the statute may exclude from civil liability the perpetrators who are the least amenable to criminal accountability.

191. See CAL. BUS. & PROF. CODE § 729(b)(2) (West Supp. 1990) ("for sexual gratification"); COLO. REV. STAT. § 18-3-401(4) (1986) (for "the purposes of sexual arousal, gratification, or abuse"); MINN. STAT. ANN. § 609.341(11)(b) (West 1987 & Supp. 1990) ("with sexual or aggressive intent"); N.D. CENT. CODE § 12.1-20-02(4) (1985) ("satisfying sexual or aggressive desires"); WIS. STAT. ANN. § 940.225(5)(b) (West Supp. 1990) (for "sexually arousing or gratifying the defendant"). But see ME. REV. STAT. ANN. tit. 17-A, § 251(1)(c) (1983 & Supp. 1989) ("sexual act" more narrowly defined than "sexual contact").

192. See, e.g., *People v. West*, 724 P.2d 623, 627 (Colo. 1986); *State v. Bicknese*, 285 N.W.2d 684, 685 (Minn. 1979).

193. *West*, 724 P.2d at 626.

194. N.D. CENT. CODE § 12.1-20-02(4).

195. 326 N.W.2d 67 (N.D. 1982).

196. *Id.* at 72.

197. See WIS. STAT. ANN. § 940.225(5)(b) (West Supp. 1990), which provides:

Defendants have similarly challenged Colorado's provision on vagueness grounds. In *People v. West*,<sup>199</sup> the defendant argued that Colorado's statutory definition of "sexual contact" was unconstitutionally vague in violation of the due process clause of the Colorado and United States Constitutions.<sup>200</sup> Colorado defines "sexual contact" as

knowingly touching . . . the victim's intimate parts by the actor, or . . . the actor's intimate parts by the victim, or . . . knowingly touching . . . the clothing covering the immediate area of the victim's or actor's intimate parts if that sexual contact can reasonably be construed as being for the purposes of sexual arousal, gratification, or abuse.<sup>201</sup>

The defendant argued that the phrase "can reasonably be construed as being for the purposes of sexual arousal, gratification, or abuse" denied him the right to have the plaintiff prove that element beyond a reasonable doubt.<sup>202</sup> Nevertheless, the court upheld the constitutionality of the definition and the trial court's application of it because the trial court had instructed the jury that the State had to prove this element beyond a reasonable doubt.<sup>203</sup> The court suggested, however, that failure to so instruct the jury might be fatal to the prosecution.<sup>204</sup>

The Supreme Court of Minnesota used the same reasoning in two cases that upheld the constitutionality of a similar statutory definition of "sexual contact."<sup>205</sup> Shortly thereafter, the Minnesota legislature amended its definition, making the Minnesota statute the most detailed in its definition of "sexual contact."<sup>206</sup> The

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"Sexual contact" means any intentional touching by the complainant or defendant, either directly or through clothing by the use of any body part or object, of the complainant's or defendant's intimate parts if that intentional touching is either for the purpose of sexually degrading; or for the purpose of sexually humiliating the complainant or sexually arousing or gratifying the defendant or if the touching contains the elements of actual or attempted battery under § 940.19(1).

198. See *State v. Nye*, 105 Wis. 2d 63, 312 N.W.2d 826 (1981).

199. 724 P.2d 623 (Colo. 1986).

200. *Id.* at 623-24.

201. COLO. REV. STAT. § 18-3-401(4) (1986).

202. *West*, 724 P.2d at 627.

203. *Id.* at 627-29.

204. See *id.* at 629.

205. *State v. Tibbets*, 281 N.W.2d 499, 501 (Minn. 1979); *State v. Bicknese*, 285 N.W.2d 684, 685-86 (Minn. 1979).

206. See MINN. STAT. ANN. § 609.341(11) (Supp. 1990), which defines sexual contact:

deletion of the "reasonably construed" language from the intent requirement seems to have corrected constitutional infirmities without the need for a corrective instruction.<sup>207</sup> For similar reasons, California incorporates "sexual gratification" language into its statute, prohibiting the touching of a patient's intimate parts if such contact exceeds the scope of medical treatment or is for sexual gratification.<sup>208</sup>

The statutes of Maine and Florida differ from other statutes in that they prohibit the specific sexual acts of intercourse, fellatio, cunnilingus, and sodomy, rather than general contact for sexual gratification.<sup>209</sup> Other types of sexual touching apparently are not sexual acts, but may be punishable as "sexual contact,"<sup>210</sup> which includes "any touching of the genitals or anus, directly or through clothing, other than as would constitute a sexual act, for the purpose of arousing or gratifying sexual desire or for the purpose of causing bodily injury or offensive physical contact."<sup>211</sup>

(a) "Sexual contact," for the purposes of sections 609.343, subdivision 1, clauses (a) to (f), and 609.345, subdivision 1, clauses (a) to (e), and (h) to (k), includes any of the following acts committed without the complainant's consent, except in those cases where consent is not a defense, and committed with sexual or aggressive intent:

(i) the intentional touching by the actor of the complainant's intimate parts, or

(ii) the touching by the complainant of the actor's, the complainant's, or another's intimate parts effected by coercion or the use of a position of authority, or by inducement if the complainant is under 13 years of age or mentally impaired, or

(iii) the touching by another of the complainant's intimate parts effected by coercion or the use of a position of authority, or

(iv) in any of the cases above, the touching of the clothing covering the immediate area of the intimate parts.

(b) "Sexual contact," for the purposes of sections 609.343, subdivision 1, clauses (g) and (h), and 609.345, subdivision 1, clauses (f) and (g), includes any of the following acts committed with sexual or aggressive intent:

(i) the intentional touching by the actor of the complainant's intimate parts;

(ii) the touching by the complainant of the actor's, the complainant's, or another's intimate parts;

(iii) the touching by another of the complainant's intimate parts; or

(iv) in any of the cases listed above, touching of the clothing covering the immediate area of the intimate parts.

*Id.*

207. *See id.*

208. CAL. BUS. & PROF. CODE § 729(b)(2) (West 1990).

209. *See* 1990 Fla. Sess. Law Serv. 491.0112 § 1(4)(c) (tentative assignment) (West); ME. REV. STAT. ANN. tit. 17-A, §§ 251(1)(C), 253(2)(I) (Supp. 1989).

210. ME. REV. STAT. ANN. tit. 17-A, § 255.

211. *Id.* § 251(1)(D).

(d) *Statutes Compared*

Of all the statutes passed to date, Minnesota's statute is the most widely known.<sup>212</sup> The Minnesota statute has influenced many of the states that have proposed or enacted criminal laws on this subject.<sup>213</sup>

In 1984, Minnesota appointed a task force to study the problem of psychotherapist sexual exploitation.<sup>214</sup> Following the task force's proposals,<sup>215</sup> Minnesota established criminal sexual conduct in the third degree when one engages in sexual penetration with another and

(h) the actor is a psychotherapist and the complainant is a patient of the psychotherapist and the sexual penetration occurred during the psychotherapy session. Consent by the complainant is not a defense;

(i) the actor is a psychotherapist and the complainant is a patient or former patient of the psychotherapist and the patient or former patient is emotionally dependent upon the psychotherapist; or

(j) the actor is a psychotherapist and the complainant is a

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212. Minnesota published an extensive task force report making recommendations for actions in cases involving sexual exploitation by psychotherapists. See MINNESOTA, REPORT OF TASK FORCE, *supra* note 156. In addition, the coordinator of the task force, Barbara Sanderson, edited an informative book, *It's NEVER O.K.: PROFESSIONAL HANDBOOK*. See MINN. TASK FORCE: *It's NEVER O.K.: PROFESSIONAL HANDBOOK*, *supra* note 1. This and other task force publications have been widely distributed. See *supra* note 1. Minnesota also has acquired comprehensive data on the victims of psychotherapist sexual abuse because Minnesota is the home of the Walk-In Counseling Center, which has to date seen more than 1,500 such victims. See G. SCHOENER & J. MILGROM, *supra* note 1, at 3-10; see also *supra* note 206.

213. See, e.g., MICHIGAN, SEXUAL EXPLOITATION BY THERAPISTS, *supra* note 116, at 6 ("As a result of the serious issues raised by the Minnesota Task Force report and the increasing occurrence of therapist sexual misconduct allegations, the existence and adequacy of available remedies under Michigan law were examined"); Letter from Senator Diane E. Watson, Cal. 28th District, regarding the history and origin of the California Task Force ("In 1983, I introduced to the Legislature a bill criminalizing sexual involvement of psychotherapists with their patients. . . . [T]he measure was based on Wisconsin and Minnesota statutes and equated this offense with rape.").

Gary Schoener, Executive Director of the Minnesota Walk-In Counseling Center, and Barbara Sanderson, Coordinator of the Minnesota Task Force, gave a two-day presentation in Boston, Massachusetts, on September 24-25, 1989, to the Massachusetts Special House Committee on Physician and Therapist Sexual Misconduct. Bills resulting from the Minnesota Task Force are now on file and pending before the legislature. See *supra* note 159.

214. Task Force on Sexual Exploitation by Psychotherapists Act ch. 631, 1984 Minn. Laws 45.

215. MINNESOTA, REPORT OF TASK FORCE, *supra* note 156.

patient or former patient and the sexual penetration occurred by means of therapeutic deception. Consent by the complainant is not a defense; or

(k) the actor accomplishes the sexual penetration by means of false representation that the penetration is for a bona fide medical purpose by a health care professional. Consent by the complainant is not a defense.<sup>216</sup>

Sexual contact, in contrast with sexual penetration, is a lesser offense that constitutes a felony in the fourth degree.<sup>217</sup>

This statute may extend indefinitely, provided that the former patient can prove that she was emotionally dependent upon the therapist at the time of sexual contact or that the sexual exploitation occurred as a result of therapeutic deception.<sup>218</sup> Its protection is greater than that provided by Minnesota's civil statute, which limits the time in which a former patient may bring a civil action to within two years of the sexual contact.<sup>219</sup> North Dakota's statute is the narrowest of the new statutes. It provides that sexual contact will be criminally prosecuted only if the contact occurred during a treatment session; the statute therefore excludes sexual exploitation occurring outside the therapy session.<sup>220</sup>

Maine's statute is broader in scope because it protects the victim as long as she is a patient or client of the psychotherapist, rather than just during treatment sessions.<sup>221</sup> The range of behavior that Maine's statute prohibits, however, is much narrower than other statutes because the State can prosecute only licensed psychotherapists<sup>222</sup> and the statute prohibits only certain forms of touching.<sup>223</sup> In addition, Maine does not eliminate the consent defense,<sup>224</sup> and if the victim cannot prove beyond a reasonable

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216. MINN. STAT. ANN. § 609.344(1)(h-j) (West 1987 & Supp. 1990); *id.* § 609.344(1)(k) (West Supp. 1990).

217. *See id.* § 609.345(h) (West Supp. 1990).

218. *See id.* § 609.345(1)(i)-(j).

219. *See id.* § 148A.01(3) (West 1989).

220. N.D. CENT. CODE § 12.1-20-06.1 (Supp. 1989). The statute provides that "[a]ny person who is or who holds oneself out to be a therapist and who intentionally has sexual contact . . . with a patient or client during any treatment, consultation, interview, or examination is guilty of a class C felony. Consent by the complainant is not a defense under this section." *Id.*

221. ME. REV. STAT. ANN. tit. 17-A, § 253(2)(I) (Supp. 1990).

222. *See supra* notes 188-90 and accompanying text.

223. *See supra* notes 210-11 and accompanying text.

224. ME. REV. STAT. ANN. tit. 17-A, § 253(2)(I) (consent not specifically excluded as a defense).

doubt that she was "dependent" and "vulnerable," the statute mandates the defendant's acquittal.<sup>225</sup>

Florida's statute covers sexual contact of a psychotherapist's client both in and out of the office.<sup>226</sup> The range of prohibited behavior is similar to that in Maine's statute.<sup>227</sup> The class of persons covered, however, is broader in that the covered class includes any person who provides psychotherapy.<sup>228</sup> Furthermore, consent is not a defense to sexual contact.<sup>229</sup> The statute also covers former clients if the termination of the professional relationship was primarily for the purpose of having sexual contact.<sup>230</sup>

Wisconsin and Colorado enacted the most liberal statutes. Wisconsin's statute provides that

[a]ny person who is or who holds himself or herself out to be a therapist and who intentionally has sexual contact with a patient or client during any ongoing therapist-patient or therapist-client relationship, regardless of whether it occurs during any treatment, consultation, interview or examination, is guilty of a Class D felony.<sup>231</sup>

The statute states explicitly that consent is not an issue in any prosecution under that subsection.<sup>232</sup> The Wisconsin statute encompasses all sexual exploitation that occurs while a therapist-patient relationship exists,<sup>233</sup> regardless of the time of exploitation.<sup>234</sup> The statute therefore comports with the theory that the power asymmetry and fiduciary responsibilities continue outside of therapy while the relationship exists.<sup>235</sup>

Colorado adopts the theory behind the Wisconsin statute, including the same protection as Wisconsin and specifically proscrib-

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225. See MCCORMICK ON EVIDENCE, *supra* note 177. The victim may have a formidable task in proving that she depended on the accused. See *supra* notes 174-77 and accompanying text.

226. 1990 Fla. Sess. Law Serv. 491.0112 § 1(1) (tentative assignment) (West).

227. *Id.* § 1(4)(c).

228. *Id.* § 1(4)(a).

229. *Id.* § 1(3).

230. *Id.* § 1(1).

231. WIS. STAT. ANN. § 940.22(2) (West Supp. 1990).

232. *Id.*

233. See *id.*

234. See *id.*

235. See Gabbard & Pope, *Sexual Intimacies After Termination: Clinical, Ethical, & Legal Aspects*, in SEXUAL EXPLOITATION IN PROFESSIONAL RELATIONSHIPS 115 (G. Gabbard ed. 1989). When a relationship terminates is a factual issue that may be left to the factfinder to decide.

ing sexual assault by "therapeutic deception."<sup>236</sup> The Colorado statute states that a psychotherapist who has "sexual penetration" with his client commits aggravated assault, a class four felony, if "[t]he actor is a psychotherapist and the victim is a client of the psychotherapist."<sup>237</sup> The complainant's consent is not a defense.<sup>238</sup> Colorado's law resembles the statutes of North Dakota and Wisconsin in that it extends protection only to current patients of psychotherapists—not to former patients.<sup>239</sup>

California's statute differs in kind from the felony statutes. Specifically, California adopts a different approach to penalizing offenders and treats former patients uniquely.<sup>240</sup> This statute establishes sexual contact in a therapeutic relationship as a public offense prosecutable by the district attorney even though the provision is in the civil code.<sup>241</sup> Sexual exploitation by a first offender, however, is a misdemeanor.<sup>242</sup> The state treats the second and any subsequent violations as "wobblers"—that is, the state may prosecute the offenses as either misdemeanors or felonies, but the maximum penalty for a second offense is one year in prison and a \$5,000 fine.<sup>243</sup>

Its small penalties have hampered this statute's usefulness. A victim may not want to subject herself to the rigors of the criminal process if the court will impose only a misdemeanor penalty on the guilty psychotherapist. This statute does offer protection to the former patient if the State proves beyond a reasonable doubt that the therapist terminated the relationship primarily for the purpose of engaging in sexual acts.<sup>244</sup> If, however, the psychotherapist refers the patient to an independent and objective subsequent therapist before engaging in sexual activity, the accused will not incur criminal liability, even if termination was for sexual reasons.<sup>245</sup> Giving a psychotherapist freedom to exploit a client after referring that client largely circumvents the statute's purpose.

Of the aforementioned states, only Minnesota, California, and Florida offer protection to the former patient. Minnesota offers

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236. See COLO. REV. STAT. § 18-3-405.5 (Supp. 1990).

237. *Id.* § 18-3-405.5(1)(a)(I).

238. *Id.* § 18-3-405.5(3).

239. See *id.* § 18-3-405.5(4)(a); N.D. CENT. CODE § 12.1-20-06.1 (Supp. 1989); WIS. STAT. ANN. § 940.22(2) (West Supp. 1990).

240. See CAL. BUS. & PROF. CODE § 729 (West 1990).

241. See *id.* § 729(b).

242. *Id.* § 729(b)(1).

243. *Id.* § 729(b)(2).

244. *Id.* § 729(a).

245. *Id.*

the greatest protection, because no time restrictions exist and the therapist cannot escape criminal liability by making a quick referral, as he can in California.<sup>246</sup> Neither California<sup>247</sup> nor Florida<sup>248</sup> imposes criminal penalties if the therapist does not terminate the professional relationship primarily to engage in sexual contact. North Dakota, Wisconsin, Colorado, and Maine do not prohibit therapists from terminating therapy for the purpose of engaging in sexual relations.<sup>249</sup>

(e) *Summary*

Nearly all of the states that have passed criminal psychotherapist exploitation statutes have made psychotherapist sexual exploitation a felony. Likewise, five of the seven states recognized that harm occurs short of penetration and defined the prohibited behavior in such a way as to include contact besides intercourse. Six states offer protection against exploitative unlicensed psychotherapists, thus filling a void that other legal remedies cannot reach. Perhaps most significantly, the states, with the exception of Maine, have completely circumvented traditional rape doctrine by excluding consent as a defense.

#### IV. CIVIL ACTIONS AS A MEANS OF REDRESS FOR VICTIMS OF SEXUAL EXPLOITATION

##### A. *Burgeoning Civil Actions*

Plaintiffs bring most suits claiming sexual impropriety under the civil law.<sup>250</sup> Because it is more flexible than its criminal counterpart, the civil law encompasses a wider range of abusive

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246. Compare *id.* § 729 with MINN. STAT. ANN. § 609.344(i), (j) (West 1987 & Supp. 1990). In California, the mere referral of a patient by a third party to another therapist vitiates any criminal act; the statute does not expressly require that the patient actually see another therapist. CAL. BUS. & PROF. CODE § 729(a).

247. CAL. BUS. & PROF. CODE § 729(a).

248. 1990 Fla. Sess. Law Serv. 491.0112 § 1(1) (tentative assignment) (West).

249. All four states make sexual contact with a patient or client a crime as long as the professional relationship exists. See COLO. REV. STAT. § 18-3-401(4) (1986); ME. REV. STAT. ANN. tit. 17-A, § 2255 (Supp. 1989); N.D. CENT. CODE § 12.1-20-02(4) (1985); WIS. STAT. ANN. § 940.225(5)(b) (West Supp. 1990). There is, however, no criminal responsibility if the professional relationship has ended. Therefore, criminal law does not prohibit sexual contact with a former patient.

250. According to a Michigan study, patients reportedly filed civil suits totaling \$4.7 million prior to 1981. MICHIGAN, SEXUAL EXPLOITATION BY THERAPISTS, *supra* note 116, at 30. In 1981, however, a jury awarded a verdict of \$4.6 million in *Walker v. Parzen*, discussed in 24 ATLA L. REP. 295 (1981).



behavior.<sup>251</sup> In the criminal system, the government must statutorily define each crime with great specificity in order to pass constitutional muster, and the State must prove each element of the offense beyond a reasonable doubt.<sup>252</sup> By contrast, civil actions can be defined statutorily or through the common law, and the plaintiff's burden of proof is usually the lower preponderance of the evidence standard.<sup>253</sup> Most actions for therapist exploitation are brought under the common law, although several states have created a new cause of action for exploitation by therapists.<sup>254</sup>

### *B. Common Law Actions*

No specific body of common law aimed at defining or curtailing sexual abuse by psychotherapists presently exists; however, several clearly defined areas of tort law may provide a remedy to victims of sexual exploitation.<sup>255</sup> These common law actions are often available not only to the direct victim of the sexual act, but also to indirect victims, including spouses and family members.<sup>256</sup> Of these actions, common law battery is the only action available solely to the direct victim of exploitation. The other actions—malpractice and infliction of emotional distress—may be available to third parties damaged by the exploitative behavior.<sup>257</sup> This Section discusses each of these causes of action.

#### *1. Battery*

The most readily applicable common law action against sexual contact is battery, which is intentional, offensive, and nonconsensual touching.<sup>258</sup> The touching must be of such a nature that a

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251. Statutes must and do specifically define criminal law and meet strict tests for constitutionality. *See* *People v. West*, 724 P.2d 623, 626 (Colo. 1986). Civil law, however, may be based on either statutes or the common law.

252. For a discussion, see *State v. Jenkins*, 326 N.W.2d 67, 71-72 (N.D. 1982).

253. W. PROSSER & W. KEETON, *THE LAW OF TORTS* § 41, at 269 (5th ed. 1984).

254. *See infra* notes 262, 386-87 and accompanying text.

255. *See infra* text accompanying notes 258-384.

256. *See infra* notes 264-73, 354-66, 374-83 and accompanying text.

257. Although this Article does not deal with contract actions at length, plaintiffs may also maintain them. *See, e.g.,* *Anclote Manor Found. v. Wilkinson*, 263 So. 2d 256 (Fla. Dist. Ct. App. 1972) (court awarded damages under a breach of contract theory to a husband in the amount he paid for his wife's therapy; his wife committed suicide after the defendant therapist's improper treatment of her, which included sexual overtures and a promise to marry her).

Third parties also may bring other actions for sexual exploitation, including loss of consortium. A thorough discussion of these other options is beyond the scope of this Article.

258. *See* W. PROSSER & W. KEETON, *supra* note 253, § 9, at 39.

reasonable member of society would find the contact offensive.<sup>259</sup> Plaintiffs rarely pursue this cause of action for therapist-patient sexual contact because many malpractice insurers do not provide insurance coverage for intentional acts, therefore depriving the plaintiff of assured compensation or a deep pocket.<sup>260</sup> Nonetheless, plaintiffs have argued this theory successfully.<sup>261</sup> An action for battery is a simple, straightforward cause of action which is useful when payment of judgment is not at issue.

## 2. *Malpractice*

Plaintiffs bring most cases of psychotherapist sexual exploitation as malpractice actions.<sup>262</sup> Malpractice is the negligent treatment of a patient.<sup>263</sup> A patient can bring a malpractice claim if she is a direct victim of the touching, and, in some instances, a patient can bring an action for a therapist's touching of someone else, including a spouse.<sup>264</sup> To state a cause of action for malpractice, the plaintiff must prove four elements by a preponderance of the evidence: (1) the defendant owed the patient a duty of care; (2) the therapist breached this duty; (3) the patient was injured; and (4) the psychotherapist's failure proximately caused the patient's injury.<sup>265</sup>

### (a) *Duty of Care*

Whenever a professional relationship is established, the law places a duty upon the professional to act with reasonable skill and care toward the other party.<sup>266</sup> Proof of the existence of a

259. *Id.* at 42.

260. See Simon, *Sexual Misconduct of Therapists: A Cause for Civil and Criminal Action*, 21 TRIAL 46, 50 (1985).

261. See, e.g., *Buchanan v. Lieberman*, 526 So. 2d 969 (Fla. Ct. App.) (the plaintiff pursued a battery action against her physician in order to take advantage of the longer statute of limitations for this action), *cert. denied*, 536 So. 2d 244 (Fla. 1988); *Rotenberry v. Wilhoit*, No. 78-1233-B (Fla. Cir. Ct. 1980) (court awarded a former prostitute \$474,000 for injuries sustained when the therapist administered carbon dioxide to the plaintiff and sexually assaulted her during a therapy session).

262. See D. LOUISELL & H. WILLIAMS, *supra* note 132, at 17.A.23 ("The psychiatrist who induces a patient to engage in sexual relations during the course of or under the guise of psychiatric treatment is guilty of malpractice . . ."); J. SMITH, *supra* note 144, § 9.02 ("The cause of action patients most commonly pursue is suit alleging medical malpractice for professional negligence.").

263. See J. SMITH, *supra* note 144, § 1.04.

264. See D. HARNEY, *supra* note 132, § 10.6, at 222; see also *Mazza v. Huffaker*, 61 N.C. App. 170, 176-78, 300 S.E.2d 833, 837-38 (court awarded patient damages in malpractice action against therapist who had sex with patient's wife), *rev. denied*, 309 N.C. 192, 305 S.E.2d 734 (1983).

265. J. SMITH, *supra* note 144, §§ 1.04, 4.03; Moisan, *supra* note 76, at 448.

266. See J. LEE & B. LINDAHL, *MODERN TORT LAW: LIABILITY AND LITIGATION* § 25.08

psychotherapist-patient relationship is sufficient to demonstrate that the therapist owed a duty of care to the client.<sup>267</sup> This duty arises when the therapist accepts a patient for treatment<sup>268</sup> and may continue for some period of time after the termination of the psychotherapist-patient relationship.<sup>269</sup>

On the other hand, the duty owed is not so clear in the case of an indirect victim of sexual exploitation. Several courts have suggested that a psychotherapist violates his duty of care by engaging in sexual contact with the spouse, lover, or child of a patient.<sup>270</sup> In these cases, the duty of care again exists by virtue of the therapeutic relationship. In *Mazza v. Huffaker*,<sup>271</sup> for example, the North Carolina Court of Appeals allowed a husband to bring a malpractice action for the sexual exploitation of his wife because the husband was a client of the therapist.<sup>272</sup> The court relied upon expert testimony stating that sexual relations between a therapist and a patient's spouse "are not therapeutic

(1990) (physician has a duty to exercise degree of care that an average member of profession would exercise); W. PROSSER & W. KEETON, *supra* note 253, § 32, at 187 (courts should hold a doctor treating a patient to the standard of "knowledge, skill and care ordinarily possessed and employed by members of the profession in good standing").

267. J. SMITH, *supra* note 144, § 1.04 ("[T]he patient must provide evidence that a doctor-patient relationship had been created. On the basis of the relationship a physician is impliedly obligated to treat the patient in a nonnegligent manner."). For a discussion of how the psychiatrist-patient relationship is formed, see *id.* §§ 2.01-05.

268. Moisan, *supra* note 76, at 448.

269. See *Noto v. St. Vincent's Hosp. & Medical Center*, 142 Misc. 2d 292, 295-96, 537 N.Y.S.2d 446, 448 (N.Y. Sup. Ct. 1988), *aff'd*, 160 A.D.2d 656, 559 N.Y.S.2d 510 (N.Y. App. Div. 1990). The court stated that Noto had a cause of action against Dr. Vittorio for having a sexual relationship with her *after* termination of therapy. *Id.* at 297, 537 N.Y.S.2d at 448. The court took notice of the fact that both California and Minnesota had civil statutes creating a cause of action for a former patient to sue her psychotherapist if the psychotherapist had a sexual relationship with the former patient within two years of the termination of therapy. *Id.* at 296, 537 N.Y.S.2d at 448. The court noted, "While no similar statute has been enacted in New York to date, under the facts here, and taking into consideration [the plaintiff's treating expert's] affidavit, the complaint can fairly be viewed as analogous to a cause of action for medical malpractice based on the seduction of a patient." *Id.*

270. See *Marlene F. v. Affiliated Psychiatric Medical Clinic, Inc.*, 48 Cal. 3d 583, 590-91, 770 P.2d 278, 282, 257 Cal. Rptr. 98, 102-03 (1989) (court upheld two mothers' claims of negligent infliction of emotional distress against psychiatrist who undertook treatment of both mothers and sons and who sexually molested boys during individual therapy sessions); *cf.* *Richard H. v. Larry D.*, 198 Cal. App. 3d 591, 596, 243 Cal. Rptr. 807, 810 (1988) (husband allowed to bring action based on psychiatrist's sexual relations with wife); *Rowe v. Bennett*, 514 A.2d 802, 804 (Me. 1986) (court vacated summary judgment and remanded case for trial on issue of whether social worker breached duty of care by becoming emotionally involved with patient's lesbian lover).

271. 61 N.C. App. 170, 300 S.E.2d 833, *rev. denied*, 309 N.C. 192, 305 S.E.2d 734 (1983).

272. *Id.* at 176-78, 300 S.E.2d at 837-39.

[and] would do harm to the mental well-being of the patient."<sup>273</sup>

(b) *Standard of Care*

In most negligence cases, the standard of care is that of a reasonably prudent person in the same or similar circumstances as the defendant.<sup>274</sup> Industry custom usually provides some evidence of the requisite duty of care. Failure to conform to that standard is some evidence of negligence, although the failure does not raise a conclusive presumption of negligence.<sup>275</sup> In medical malpractice cases, the industry standard is conclusive; the standard of care is that exercised by an average member of the profession.<sup>276</sup> Nevertheless, a question still exists as to whether courts will hold all psychotherapists to the standard of care of an average qualified therapist or whether the reasonable person standard will apply.

Most courts confronted with the issue have chosen the medical malpractice model.<sup>277</sup> In *Omer v. Edgren*,<sup>278</sup> the Washington Court of Appeals outlined the standard of care to which a psychiatrist is held:

As a medical specialist, a psychiatrist owes his patients the same duty of care owed by other medical specialists, i.e., a psychiatrist must exercise that degree of care that a reasonably prudent psychiatrist would exercise under the same or similar circumstances. Thus, the same general considerations which apply to other physicians and specialists are applicable as well to psychiatrists.<sup>279</sup>

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273. *Id.* at 176-77, 300 S.E.2d at 838.

274. W. PROSSER & W. KEETON, *supra* note 253, § 32, at 174..

275. *Id.* at 194-95.

276. See *Brune v. Belinkoff*, 354 Mass. 102, 109, 235 N.E.2d 793, 798 (1968); 3 C. KRAMER, MEDICAL MALPRACTICE § 28.05 (1981); W. PROSSER & W. KEETON, *supra* note 253, § 32, at 186-87.

277. See, e.g., *Simmons v. United States*, 805 F.2d 1363, 1365-66 (9th Cir. 1986); see J. SMITH, *supra* note 144, § 1.05; Note, *Malpractice in Psychotherapy: Is There a Relevant Standard of Care?*, 35 CASE W. RES. L. REV. 251, 260-63 (1984-85); cf. D. HARNEY, *supra* note 132, § 10.1 ("In determining the standard of care applicable to a psychiatrist, the locality rule is usually disregarded, and a national standard applied.") (footnote omitted).

278. 38 Wash. App. 376, 685 P.2d 635 (1984).

279. *Id.* at 378, 685 P.2d at 636 (quoting 2 J. DOOLEY, MODERN TORT LAW § 34.21.50, at 482 (B. Lindahl rev. ed. 1983)). But cf. *Erickson v. Christenson*, 99 Or. App. 104, 781 P.2d 383 (1989). In *Erickson*, the defendant argued that a finding of clerical malpractice would require the court to establish a standard of care for pastoral counseling, which would violate the Constitution by requiring the court to examine religious beliefs. *Id.* at 108,

To meet this standard, most plaintiffs allege the mishandling of the transference/countertransference phenomenon.<sup>280</sup> *Zipkin v. Freeman*,<sup>281</sup> one of the earliest exploitation cases, is an excellent example. Mrs. Zipkin accused Dr. Freeman, a psychiatrist, of negligently mishandling the transference she felt toward him.<sup>282</sup> Mrs. Zipkin was referred to Dr. Freeman to treat her severe diarrhea and headaches.<sup>283</sup> After two months of treatment, she was no longer suffering from these problems and asked her psychiatrist whether she needed to continue therapy.<sup>284</sup> Dr. Freeman persuaded her to continue.<sup>285</sup>

Mrs. Zipkin continued with counseling and eventually fell in love with Dr. Freeman.<sup>286</sup> The defendant began inviting her to accompany him on social occasions and overnight trips and to swim in the nude.<sup>287</sup> He convinced Mrs. Zipkin to attempt to divorce her husband, move into an apartment above him, invest in a farm he bought, and even break into her husband's house and steal his new suits.<sup>288</sup> Dr. Freeman controlled Mrs. Zipkin's life.<sup>289</sup>

The Supreme Court of Missouri held that Dr. Freeman "mis-handle[d] the transference"<sup>290</sup> that Mrs. Zipkin exhibited toward him "over a long period of time."<sup>291</sup>

As [Mrs. Zipkin's expert] explained, to take the relationship outside the office into social relationships, "would allow the

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781 P.2d at 386. The court stated:

[A] claim for breach of a confidential relationship is different from a claim for clerical malpractice. Plaintiff's complaint alleged the existence and breach of a confidential relationship; it did not allege the elements of malpractice. Moreover, plaintiff's claim for outrageous conduct is not premised on the mere fact that Christenson is a pastor, but on the fact that, because he was plaintiff's pastor and counselor, a special relationship of trust and confidence developed.

*Id.*

280. See *Simmons*, 805 F.2d at 1365-66 (listing cases finding mishandling of transference to be malpractice). For a discussion of the transference/countertransference phenomenon, see *supra* notes 37-50 and accompanying text.

281. 436 S.W.2d 753 (Mo. 1968).

282. *Id.* at 756.

283. *Id.* at 755.

284. *Id.* at 756-57.

285. *Id.* at 757.

286. *Id.*

287. *Id.*

288. *Id.* at 758-59.

289. *Id.* at 755 (complaint alleged that she was injured as a "result of the control" Dr. Freeman exercised over her).

290. *Id.* at 761.

291. *Id.*

patient to develop all sorts of unusual ideas just around the feelings that she has about the doctor," and that a psychiatrist should no more take an overnight trip with a patient than shoot her. . . .<sup>292</sup>

The breach of this psychiatrist's duty was complete at the first boundary violation.<sup>293</sup> The court did not consider sexual contact a prerequisite to recovery, although it was certainly present in this case:<sup>294</sup> "It is pretty clear from the medical evidence that the damage would have been done to Mrs. Zipkin even if the trips outside the state were carefully chaperoned, the swimming done with suits on, and if there had been ballroom dancing instead of sexual relations."<sup>295</sup>

Because the major health care organizations have universally condemned intimate sexual contact with a patient,<sup>296</sup> proving a breach of the duty of care is generally not difficult once the plaintiff proves that the abuse occurred.<sup>297</sup> This proof is not so easy, however, against unlicensed psychotherapists and those in many of the more marginal types of therapies.<sup>298</sup> Establishing a professional standard for these groups may be impossible. For this area of litigation, therefore, the better rule is that which courts follow in negligence cases other than malpractice. If no industry standard exists in nonmalpractice cases, then the standard remains that of a reasonably prudent person in like circumstances.<sup>299</sup> A court might utilize this standard in psychotherapist exploitation cases in which no professional standard exists.<sup>300</sup> These same issues arise when a direct victim brings a claim for

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292. *Id.*

293. *Id.* See *supra* note 49 for a discussion of boundary violations.

294. *Zipkin*, 436 S.W.2d at 761.

295. *Id.*

296. See *supra* notes 1-5 and accompanying text.

297. This statement is true because courts often look to the standards set by national licensing associations as evidence of the duty of care. See, e.g., *Andrews v. United States*, 732 F.2d 366, 368 n.2 (4th Cir. 1984) (Hippocratic oath indicative of medical profession's concern about potential for abuse); see also *supra* text accompanying notes 7-9.

298. See, e.g., *Martino v. Family Serv. Agency*, 112 Ill. App. 3d 593, 597, 445 N.E.2d 6, 9 (1982) (court dismissed malpractice action against social worker, stating that "[a]lthough the conduct alleged here was clearly improper, determination of the propriety of conduct of social workers and the relationship it might have to injury suffered by clients generally would be most difficult to ascertain").

299. See W. PROSSER & W. KEETON, *supra* note 253, § 32, at 174.

300. *But cf.* Annotation, *Nonverbal Therapy Injury*, 20 AM. JUR. PROOF OF FACTS 2D 439-40 (1979) (discussing necessity of ascertaining particular school of therapy in order to set relevant standard of care).

negligent supervision or when an indirect victim, such as a spouse, brings an action for malpractice.

(c) *Damages*

Before gaining compensation, the victim must prove that the psychotherapist's exploitation caused her damage. Sexual exploitation lawsuits have resulted in extremely large awards, principally because patients "often allege and prove that the sexual relationship with the therapist resulted in the absence of necessary treatment, which in turn led to the worsening of the patient's condition."<sup>301</sup>

The law entitles both primary and secondary victims of sexual exploitation to monetary compensation for all damages suffered as a result of the exploitation.<sup>302</sup> Accordingly, plaintiffs are usually entitled to a return of all monies paid for therapy with the abusive therapist, as well as past and future treatment expenses that the exploitation necessitated.<sup>303</sup> The law also may entitle plaintiffs to recover for lost earning capacity, mental anguish, and pain and suffering, and to receive punitive damages.<sup>304</sup> Additionally, a third party plaintiff, such as a spouse or child, may claim damages for lost companionship, affection, and society.<sup>305</sup>

A plaintiff need not prove that the sexual exploitation was the sole cause of her damages.<sup>306</sup> If a client suffered from mental illness that the psychotherapist's conduct exacerbated, courts

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301. S. TAUB, *Psychiatric Malpractice in the 1980s: A Look at Some Areas of Concern*, in LAW, MEDICINE & HEALTH CARE 97, 101 (1983).

302. See *infra* notes 303-05 and accompanying text.

303. See, e.g., *Phelps v. MacIntyre*, 397 Mass. 459, 461, 491 N.E.2d 1067, 1068-69 (1986) (sums expended for additional treatment may be considered in damage award for a personal injury case); *Turcotte v. DeWitt*, 333 Mass. 389, 392, 131 N.E.2d 195, 197 (1955) ("[Damages include] both the original debt or damage and whatever interest ought to be added to make a just verdict."); *Rodgers v. Boynton*, 315 Mass. 279, 280, 52 N.E.2d 576, 577 (1943) ("The measure of damages is fair compensation for injuries sustained.").

304. See *Lewis v. Springfield*, 261 Mass. 183, 187-88, 158 N.E. 656, 657 (1927); *Cantara v. Mass. Bay Transp. Auth.*, 3 Mass. App. Ct. 81, 87-90, 323 N.E.2d 759, 764-65 (1975); RESTATEMENT (SECOND) OF TORTS §§ 433, 454 (1965).

305. The highest court of Massachusetts recently decided an important case. In *Pinheiro v. Medical Malpractice Joint Underwriting Association*, 406 Mass. 288, 547 N.E.2d 49 (1989), the defendant's medical malpractice liability insurance policy contained a clause limiting the total liability for claims brought because of injury or death of any one person. *Id.* at 289, 547 N.E.2d at 50. The court construed this clause to allow a spouse or child to bring a claim for consortium separate and distinct from the claim of the injured person. *Id.* at 300, 547 N.E.2d at 55. Such claim will not be included in the limitation of liability against the injured party. *Id.* at 294-95, 547 N.E.2d at 53; see also *Spero & Jorgenson, Consortium*, 84-12 MASS. CONTINUING LEGAL EDUC. 71 (1983).

306. The eggshell skull rule makes defendants liable for damages suffered in excess of those that were reasonably foreseeable. See *infra* note 308 and accompanying text.

will hold the therapist accountable for the aggravation of that condition and the attendant consequences.<sup>307</sup> If the defendant's conduct combines with the previous illness or condition to create a new or different pathology, courts will hold him liable for the entire damage.<sup>308</sup> This situation often occurs when a plaintiff suffers from symptoms of posttraumatic stress disorder.<sup>309</sup> Studies indicate that certain types of mental disorders coupled with a trauma will more likely result in symptoms of posttraumatic stress disorder.<sup>310</sup> A plaintiff's predisposition toward this type of pathology, however, does not mitigate the defendant's responsibility for the results of his actions.<sup>311</sup>

Malpractice is the broadest of the common law actions and encompasses more situations than any of the other remedies.<sup>312</sup> The action is viable not only against the abuser himself, but also perhaps against his employer or supervisor.<sup>313</sup> The next Section focuses on the potential actions that plaintiffs may bring against employers, hospitals, or supervisors.

### 3. *Employer Liability*

Often, a plaintiff may maintain an independent action against a therapist's employer or supervisor. Courts may hold an employer or supervisor liable under two theories: (1) respondeat superior and (2) negligent supervision or employment. This Section examines these theories in the context of the psychotherapeutic profession.

#### (a) *Respondeat Superior*

Under a theory of respondeat superior, or vicarious liability,<sup>314</sup> if an employee commits a civil wrong while acting within the

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307. *See id.*

308. This is known as the eggshell skull plaintiff's rule. *See* J. LEE & B. LINDAHL, *supra* note 266, § 6.06; M. MINZER, J. NATES, C. KIMBALL, D. AXELROD, & R. GOLDSTEIN, DAMAGES IN TORT ACTIONS § 15.01 (1989); W. PROSSER & W. KEETON, *supra* note 253, § 43, at 292; RESTATEMENT (SECOND) OF TORTS § 461.

309. *See supra* notes 85-94 and accompanying text.

310. *See* Helzer, Robins, & McEvoy, *supra* note 91, at 1633 ("There is a growing body of evidence that personality and behavioral characteristics that antedate exposure to a traumatic event influence a person's response to that event.").

311. W. PROSSER & W. KEETON, *supra* note 253, § 43, at 291-92.

312. For a discussion of the other possible common law actions, *see supra* text accompanying notes 258-61 (battery) and *infra* text accompanying notes 347-85 (intentional and negligent infliction of emotional distress).

313. *See infra* notes 314-32 and accompanying text.

314. *See* Simmons v. United States, 805 F.2d 1363, 1370 (9th Cir. 1986) ("[T]he centrality



scope of his employment, a court may hold the employer liable even though the employer did nothing wrong.<sup>315</sup> In order to succeed, a plaintiff must prove that the defendant was an employee of another and that the defendant was acting within the scope of his employment when the exploitative behavior occurred.<sup>316</sup>

### (1) *Employer/Employee Relationship*

Whether an employer/employee relationship exists turns on how much control the hospital, supervising therapist, or clinic maintains over the defendant's actions. If an individual or entity has a right to control the conduct of an exploitative therapist, that individual or entity is an employer.<sup>317</sup> If, however, the therapist is merely subject to the supervisor's control or direction as to the result that the therapist should obtain, the therapist is not an employee of the supervisor but an independent contractor, and vicarious liability generally will not result.<sup>318</sup>

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of transference to therapy renders it impossible to separate an abuse of transference from the treatment itself. The district court correctly found that the abuse of transference occurred within the scope of [the counselor's] employment."); *Douglas v. Holyoke Mach. Co.*, 233 Mass. 573, 576, 124 N.E. 478, 479 (1919) ("If the act of the servant is performed in the course of doing his master's work, in carrying out the master's directions, or in accomplishing his master's business, then the latter will be answerable whether the wrong be merely negligent, or wanton and reckless."); *Erickson v. Christenson*, 99 Or. App. 104, 108-09, 781 P.2d 383, 386 (1989) ("An employee's act is within the scope of the employment if it occurs substantially within the time and space limits authorized by the employment, the employee is at least partially motivated by a purpose to serve the employer and the act is of a kind which the employee was hired to perform."); Annotation, *Liability of Hospital or Clinic for Sexual Relationships with Patients by Staff Physicians, Psychologists, and Other Healers*, 45 A.L.R.4TH 289, 292-95 (1986).

315. See *infra* notes 317-18 and accompanying text.

316. See *infra* notes 319-32 and accompanying text.

317. This test is the traditional means of establishing the employer/employee relationship necessary to invoke respondeat superior. The employer need never exercise the right of control, so long as it clearly exists. *J. LEE & B. LINDAHL*, *supra* note 266, § 7.04. Some jurisdictions augment the right-to-control test by other considerations. *Id.*; see *Riviello v. Waldron*, 47 N.Y.2d 297, 302-03, 391 N.E.2d 1278, 1280-81, 418 N.Y.S.2d 300, 302-03 (1979) (merging employer/employee relationship issues with traditional scope-of-employment analysis); *F. HARPER, F. JAMES, JR., & O. GRAY, THE LAW OF TORTS* § 26.11 (2d ed. 1986) (listing various practical considerations the courts take into account in deciding whether an employer/employee relationship exists); *W. PROSSER & W. KEETON*, *supra* note 253, § 70, at 501 (listing factors traditionally considered in determining the existence of a master/servant relationship); *RESTATEMENT (SECOND) OF AGENCY* § 220 (1958).

318. See *F. HARPER, F. JAMES, JR., & O. GRAY*, *supra* note 317, § 26.11 ("employers have been generally immune from vicarious liability for the acts of their independent contractors since the early nineteenth century"); *W. PROSSER & W. KEETON*, *supra* note 253, § 71, at 509; *RESTATEMENT (SECOND) OF AGENCY* § 2; see also *Doe v. Samaritan*

## (2) *Scope of Employment*

In general, "scope of employment" refers to those acts that constitute the method of carrying out the objectives of employment, even if those methods are improper.<sup>319</sup> Two cases addressing an employer's vicarious liability allow for the possibility that exploitative acts might fall within the scope of employment.<sup>320</sup> In *Marston v. Minneapolis Clinic of Psychiatry and Neurology, Ltd.*,<sup>321</sup> the Minnesota Supreme Court noted trial testimony that "sexual relations between a psychologist and a patient [were] a well-known hazard and . . . foreseeable and a risk of employment."<sup>322</sup> Further, the facts in *Marston* demonstrated that the sexual contact would not have occurred but for the psychologist's employment with the clinic.<sup>323</sup> The jury was to balance these facts,

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Counseling Center, 791 P.2d 344, 347-49 (Alaska 1990). In *Doe*, the court discussed the "motivation to serve" test found in the RESTATEMENT (SECOND) OF AGENCY § 228(1)(c) in the context of a suit against the counseling center for the sexual acts of one of its therapists. *Doe*, 791 P.2d at 347-48. The court explained that when sexual contact "arises out of and is reasonably incidental to the employee's legitimate work activities, the 'motivation to serve' test will have been satisfied." *Id.* at 348. Because an employer does not authorize an employee to commit a tort, the court construed RESTATEMENT (SECOND) OF AGENCY § 228(2) to mean "only that the act which leads to the tortious behavior cannot be different in kind from acts the employee is authorized to perform in furtherance of the employer's enterprise." *Id.* at 348 n.7; see also *Richard H. v. Larry D.*, 198 Cal. App. 3d 591, 596, 243 Cal. Rptr. 807, 810 (1988) (allegations that psychiatrist was agent of hospital stated cause of action against hospital); *Erickson v. Christenson*, 99 Or. App. 104, 109, 781 P.2d 383, 386-87 (1989) (allegations, if proven, show plaintiff was harmed by acts performed within defendant's scope of employment).

319. See *Simmons v. United States*, 805 F.2d 1363, 1369 (9th Cir. 1986) (master cannot excuse himself when authorized act was improperly performed). Under respondeat superior, an employer is liable for an employee's tort if the employee acted within the scope of employment. RESTATEMENT (SECOND) OF AGENCY § 219. Disagreement exists over what constitutes "scope of employment." Section 228 of the RESTATEMENT (SECOND) OF AGENCY provides:

1. Conduct of a servant is within the scope of employment if, but only if:
  - a. it is of the kind he is employed to perform;
  - b. it occurs substantially within the authorized time and space limits;
  - c. it is actuated, at least in part, by a purpose to serve the master; and
  - d. if force is intentionally used by the servant against another, the use of force is not expectable by the master.
2. Conduct of a servant is not within the scope of employment if it is different in kind from that authorized, far beyond the authorized time or space limits, or too little actuated by a purpose to serve the master.

*Id.* § 228.

320. *Simmons*, 805 F.2d 1363; *Marston v. Minneapolis Clinic of Psychiatry and Neurology, Ltd.*, 329 N.W.2d 306 (Minn. 1982).

321. 329 N.W.2d 306.

322. *Id.* at 311 (remanding foreseeability of psychiatrist's action as a question of fact).

323. *Id.* For a complete discussion of vicarious liability in the employment relationship,

along with the universal prohibition against therapists' sexual contact with patients, to determine whether the sexual contact was within the scope of employment.<sup>324</sup> In *Simmons v. United States*,<sup>325</sup> the United States Court of Appeals for the Ninth Circuit found that an Indian health services counselor was acting within the scope of his employment under the Federal Tort Claims Act when he engaged the plaintiff in sexual intercourse.<sup>326</sup>

Other courts that have considered vicarious liability in sexual abuse situations have held that this behavior is such a deviation from acceptable practice that it cannot be the basis of respondeat superior liability. For example, in *Andrews v. United States*,<sup>327</sup> the United States Court of Appeals for the Fourth Circuit found that a physician's assistant caused a patient emotional distress by seducing her.<sup>328</sup> The court ruled, however, that because the physician's assistant was not furthering his employer's business by seducing the client, it could not hold the employer liable under respondeat superior.<sup>329</sup> Likewise, in *Hoover v. University of Chicago Hospitals*,<sup>330</sup> an Illinois court held that the actions of a physician who allegedly sexually assaulted a patient he was seeing in his office within the hospital did not subject the hospital to vicarious liability because one could not regard the assault as having occurred in the course of the physician's employment.<sup>331</sup> Even those cases that have not allowed courts to base respondeat superior liability on sexual exploitation, however, have allowed patients to recover for supervisory negligence or negligent hiring of the therapist.<sup>332</sup>

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see Sykes, *The Boundaries of Vicarious Liability: An Economic Analysis of the Scope of Employment Rule and Related Legal Doctrines*, 101 HARV. L. REV. 563 (1988). "An enterprise 'fully causes' the wrong of an employee if the dissolution of the enterprise and subsequent unemployment of the employee would reduce the probability of the wrong to zero." *Id.* at 572. Sykes notes that "[t]he crucial variable in this analysis is the extent to which the employment relation increases the probability of each wrong." *Id.*

324. *Marston*, 329 N.W.2d at 311.

325. 805 F.2d 1363 (9th Cir. 1986).

326. *Id.* at 1369.

327. 732 F.2d 366 (4th Cir. 1984).

328. *Id.* at 370.

329. *Id.* The court held the employer liable under a negligent supervision theory. *Id.*

330. 51 Ill. App. 3d 263, 366 N.E.2d 925 (1977).

331. *Id.* at 266-67, 366 N.E.2d at 929.

332. See, e.g., *Andrews*, 732 F.2d at 366 (court did not impose liability based on respondeat superior under South Carolina law for sexual misconduct of physician's assistant, but allowed claim for supervisory negligence); *Birkner v. Salt Lake County*, 771 P.2d 1053, 1059 (Utah 1989) (defendant's conduct outside scope of employment as a matter of law, but employer may be liable for negligence in hiring and supervision even when respondeat superior is inapplicable); Annotation, *supra* note 314, at 292-97.

*(b) Employer Negligence*

Several courts have required that an employer of an abusive therapist be negligent itself in order for liability to attach.<sup>333</sup> More cases against an employer have prevailed on the grounds of negligent supervision than on a respondeat superior theory.<sup>334</sup> For a plaintiff to succeed with a claim of negligent supervision, she must prove supervisory malpractice in the same manner that she proves the negligent care of the abusive therapist.<sup>335</sup>

Generally, the injury suffered by virtue of the negligent supervision or hiring of the exploitative therapist is indistinguishable from the injury that the substandard psychotherapy caused.<sup>336</sup> This fact does not alleviate the employer's responsibility and may result in joint and several liability for the injury at issue.<sup>337</sup> The tests for determining whether a court should impose joint and several liability are concurrent negligence and inseparable damages.<sup>338</sup> When the negligence of the therapist and his employer contribute to a single result, a court may charge each with that entire result, even though the duties that each owes

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333. An employer may be liable under the theory of negligent hiring, retention, or supervision of an employee when the doctrine of respondeat superior is not applicable. See, e.g., *Birkner*, 771 P.2d at 1053. This theory is based upon the employer's primary responsibility, not vicarious liability. An employer may escape liability if it shows that it used due care. See *Todd v. Wernick*, 334 Mass. 624, 626, 138 N.E.2d 124, 125 (1956) ("[t]he owner . . . of a building who has used due care in selecting and agreeing with an independent contractor to do lawful work, is not responsible to third persons for the negligence of such contractor" (citation omitted)); *Rasimas v. Swan*, 320 Mass. 60, 62, 67 N.E.2d 662, 663 (1946); see also *Destefano v. Grabrian*, 763 P.2d 275, 286-87 (Colo. 1988) (relying on RESTATEMENT (SECOND) OF AGENCY § 213 (1958), court stated that even though defendant's acts did not create basis for holding diocese vicariously liable, diocese may be directly liable for negligently supervising defendant); *Erickson v. Christenson*, 99 Or. App. 104, 108-10, 781 P.2d 383, 386-87 (1989) (court reversed summary judgment against church on grounds that allegations, if proved, would allow reasonable jury to infer that church created risk of harm to plaintiff by failure to supervise, investigate, remove, or warn parishioners of pastoral counselor's abusive behavior); *Does v. CompCare, Inc.*, 52 Wash. App. 688, 694, 763 P.2d 1237, 1241 (1988) (court may hold employer liable for acts beyond scope of employment if employer had prior knowledge of employee's dangerous tendencies).

334. See Annotation, *supra* note 314, at 291-92.

335. For a discussion of malpractice, see *supra* text accompanying notes 262-313.

336. See *Andrews*, 732 F.2d at 368, 370 (had supervisor timely intervened, damage resulting would not have occurred). The supervisor's role is preventive in nature, designed to prevent damage from occurring. The supervisor's failure to act in this capacity does not change the nature of the damage—the injury to the patient is the same; however, the supervisor's failure to act allows damage to occur. For a discussion of the injuries caused by sexual exploitation, see *supra* text accompanying notes 85-94.

337. See W. PROSSER & W. KEETON, *supra* note 253, § 70, at 501-03.

338. See RESTATEMENT (SECOND) OF TORTS § 433A (1965).

are separate and their culpability may differ.<sup>339</sup> Thus, in cases in which the exploitative psychotherapist is without insurance, is judgment-proof, or acted intentionally, a court will find a supervisor or employer who is less culpable liable for the full amount of the damages.<sup>340</sup>

(c) *Summary*

Respondeat superior may be a viable action for victims of psychotherapist sexual abuse.<sup>341</sup> At least two cases have upheld verdicts against employers of abusive health care workers.<sup>342</sup> Because, however, nearly every reputable psychotherapeutic organization disavows sexual contact, a plaintiff will face difficulty in proving that the contact fell within the scope of the therapist's employment.

Employer liability will more likely attach in cases in which an employer is negligent in his or her hiring or supervising of the exploitative therapist.<sup>343</sup> Through joint and several liability, a court may hold an employer liable for the full damage caused by an exploitative therapist as surely as it would under respondeat superior.<sup>344</sup> Further, if a plaintiff brings an independent negligence claim against an employer, insurance coverage will likely be available, even if the abusive therapist's individual policy does not cover his actions.<sup>345</sup> This additional claim allows a plaintiff to prove both intentional acts, such as battery and intentional infliction of emotional distress, and negligent acts without fear of an uncollectible judgment.<sup>346</sup>

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339. See W. PROSSER & W. KEETON, *supra* note 253, § 70, at 501-03.

340. General principles of joint tortfeasor liability apply. For a discussion of these principles, see *id.*

341. See *supra* notes 314-32 and accompanying text.

342. *Simmons v. United States*, 805 F.2d 1363, 1371 (9th Cir. 1986); *Marston v. Minneapolis Clinic of Psychiatry and Neurosurgery, Ltd.*, 329 N.W.2d 306, 311 (Minn. 1982).

343. See Annotation, *supra* note 314, at 291-92.

344. See *supra* notes 337-40 accompanying text.

345. Coverage will probably be available because the failure to supervise sounds in malpractice. See *St. Paul Fire & Marine Ins. Co. v. Asbury*, 149 Ariz. 565, 567, 720 P.2d 540, 541 (1986) (tortious conduct took place in the course of and as an inseparable part of professional services); *Cotton v. Kambly*, 101 Mich. App. 537, 540-41, 300 N.W.2d 627, 628-29 (essence of claim is doctor's departure from standards of medical practice); *Zipkin v. Freeman*, 436 S.W.2d 753, 756 (Mo. 1968) (mishandling of transference phenomenon pertains directly to psychiatrist's professional services); *L.L. v. Medical Protective Co.*, 122 Wis. 2d 455, 459-60, 362 N.W.2d 174, 178-79 (Wis. App. 1984) (language of malpractice policy covers malpractice both of commission and omission).

346. See *Medical Protective Co.*, 122 Wis. 2d at 464, 362 N.W.2d at 179.

#### 4. *Infliction of Emotional Distress*

A cause of action for the infliction of emotional distress is a relatively recent development in the common law, and the scope of protection it affords varies significantly among jurisdictions. With varying degrees of success, plaintiffs in sexual exploitation cases often plead infliction of emotional distress. Plaintiffs may plead two causes of action: (1) negligent infliction of emotional distress and (2) intentional infliction of emotional distress. Plaintiffs have used both extensively against abusive therapists.<sup>347</sup>

##### (a) *Negligent Infliction of Emotional Distress*

Plaintiffs in physician-patient sex cases often plead negligent infliction of emotional distress.<sup>348</sup> A cause of action for the negligent infliction of emotional distress requires the same elements of proof as a negligence tort action: the plaintiff must prove that the actor owed a duty to the plaintiff, that the actor breached the duty, and that the breach proximately caused the plaintiff's injury.<sup>349</sup> The emotional distress usually must manifest itself in physical injury.<sup>350</sup> This cause of action is available to both direct and secondary victims of sexual exploitation.<sup>351</sup>

347. See, e.g., *Marlene F. v. Affiliated Psychiatric Clinic, Inc.*, 48 Cal. 3d 583, 591, 770 P.2d 278, 281, 257 Cal. Rptr. 98, 102 (1989) (sexual abuse of patient's child by her psychotherapist stated cause of action for negligent infliction of emotional distress); *Richard H. v. Larry D.*, 198 Cal. App. 3d 591, 596, 243 Cal. Rptr. 807, 810 (1988) (therapist's engaging in sexual relations with wife while engaged in marital counseling with husband states claim for emotional distress); *Rowe v. Bennett*, 514 A.2d 802, 806 (Me. 1986) (because of nature of psychotherapist-patient relationship, cause of action existed for negligent infliction of emotional distress against therapist who engaged in sexual relations with plaintiff); *Erickson v. Christenson*, 99 Or. App. 104, 108, 781 P.2d 383, 386 (1989) (plaintiffs' complaint stated cause of action against pastor for intentional infliction of emotional distress).

348. See, e.g., *Marlene F.*, 48 Cal. 3d at 583, 770 P.2d at 278, 257 Cal. Rptr. at 98.

349. W. PROSSER & W. KEETON, *supra* note 253, § 30, at 164-65.

350. RESTATEMENT (SECOND) OF TORTS §§ 436, 436A (1965). In "bystander" cases, plaintiffs who see another injured and are closely related to the injured person may recover damages even though they themselves were not physically injured. See, e.g., *Dillon v. Legg*, 68 Cal. 2d 728, 740-41, 441 P.2d 912, 920-21, 69 Cal. Rptr. 72, 81 (1968) (applying a foreseeability test). In addition, a recent California decision held that a plaintiff who was neither physically injured nor closely related to the injured person was able to prevail on a theory of negligent infliction of emotional distress. See *Bollinger v. Palm Springs Aerial Tramway*, No. E006050 (Cal. Ct. App. filed May 17, 1990). One court extended that reasoning to medical malpractice injuries. See *Johnson v. Ruark Obstetrics & Gynecology Ass'n*, No. 177PA88-Wake (N.C. filed Aug. 29, 1990).

351. Bystander cases exemplify when a secondary victim of sexual abuse might recover for infliction of emotional distress. For a discussion of the applicability of this tort to both primary and secondary victims, see *Marlene F.*, 48 Cal. 3d at 592, 770 P.2d at 283, 257 Cal. Rptr. at 103 (1989) (Arguelles, J., concurring).

Originally, negligent infliction of emotional distress was a bystander cause of action that allowed close relatives who had witnessed negligent injury to a loved one to recover for the emotional distress that the sight caused.<sup>352</sup> In jurisdictions that have omitted the physical injury requirement,<sup>353</sup> the usefulness of this cause of action to the direct victim in psychotherapist sexual exploitation cases is questionable. This action offers no real advantage over malpractice actions.

This action has great potential, however, as a remedial vehicle for secondary victims of sexual exploitation. The negligent infliction of emotional distress action has been successful in cases in which the defendant undertook an affirmative duty to both the plaintiff and the primary patient. For example, in *Marlene F. v. Affiliated Psychiatric Medical Clinic, Inc.*,<sup>354</sup> a psychologist treated two mothers and their minor sons.<sup>355</sup> Under the guise of treatment, the psychotherapist molested both boys at the clinic and one of the boys outside the clinic.<sup>356</sup> The California Supreme Court allowed the mothers to bring an action for negligent infliction of emotional distress because the defendant therapist owed them an affirmative duty of competent treatment.<sup>357</sup> He was aware of the familial relationship when he accepted the boys and their mothers as patients, and his counseling was intended to improve the family relationships.<sup>358</sup>

In these circumstances, the therapist, as a professional psychologist, clearly knew or should have known in each case that his sexual molestation of the child would directly injure and cause severe emotional distress to his other patient, the mother, as well as to the parent-child relationship that was also under his care. His abuse of the therapeutic relationship and molestation of the boys breached his duty of care to the mothers as well as to the children.<sup>359</sup>

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352. *Dillon*, 68 Cal. 2d at 740-41, 441 P.2d at 920-21, 69 Cal. Rptr. at 81.

353. *Marlene F.*, 48 Cal. 3d at 593, 770 P.2d at 285, 257 Cal. Rptr. at 104 (Arguelles, J., concurring) (disposing of the physical injury requirement for negligent infliction of emotional distress when the underlying conduct was extreme and outrageous) (citing *State Rubbish Collectors Ass'n v. Siliznoff*, 38 Cal. 2d 330, 240 P.2d 282 (1952)).

354. 48 Cal. 3d 583, 770 P.2d 278, 257 Cal. Rptr. 98.

355. *Id.* at 585, 770 P.2d at 279, 257 Cal. Rptr. at 99.

356. *Id.* at 585-86, 770 P.2d at 279, 257 Cal. Rptr. at 99.

357. *Id.* at 590-91, 770 P.2d at 283, 257 Cal. Rptr. at 102.

358. *Id.* at 590, 770 P.2d at 282, 257 Cal. Rptr. at 102.

359. *Id.* at 591, 770 P.2d at 282, 257 Cal. Rptr. at 102.

Even if the defendant owed no duty to the party with whom he had sexual relations, a therapist may be liable for negligent infliction of emotional distress to one to whom he does owe a duty. For example, in *Richard H. v. Larry D.*,<sup>360</sup> the plaintiff's allegation of a therapist's sexual relationship with the plaintiff's wife was sufficient to state a cause of action for negligent infliction of emotional distress.<sup>361</sup> The California Court of Appeals stated, "It is readily foreseeable that a patient seeing a psychiatrist for purposes of stabilizing and improving his or her marriage would feel betrayed and suffer emotional distress upon learning that the psychiatrist has, during the course of the patient's treatment, been engaging in sexual relations with the patient's spouse."<sup>362</sup>

*Rowe v. Bennett*<sup>363</sup> also recognized negligent infliction of emotional distress in an analogous situation.<sup>364</sup> In *Rowe*, the Supreme Judicial Court of Maine held that a patient stated a claim for negligent infliction of emotional distress based on a social worker's involvement with the patient's live-in lesbian companion.<sup>365</sup>

Thus, negligent infliction of emotional distress generally offers a broader scope of protection for indirect victims of abuse than does malpractice.<sup>366</sup> The same may be true with respect to intentional infliction of emotional distress.

#### (b) *Intentional Infliction of Emotional Distress*

A cause of action for the intentional infliction of emotional distress was first recognized in the California case of *State Rubbish Collectors Association v. Siliznoff*.<sup>367</sup> The following elements are necessary to establish a prima facie case: (1) the defendant engaged in extreme and outrageous conduct with the intention of causing, or reckless disregard for the probability of causing, emotional distress; (2) the plaintiff suffered extreme

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360. 198 Cal. App. 3d 591, 243 Cal. Rptr. 807 (1988).

361. *Id.* at 595, 243 Cal. Rptr. at 809.

362. *Id.* at 596, 243 Cal. Rptr. at 810.

363. 514 A.2d 802 (Me. 1986).

364. *Id.* at 807.

365. *Id.* at 806.

366. Negligent infliction of emotional distress differs from and may be broader than malpractice, as secondary victims need not have experienced the sexual abuse themselves. See *supra* notes 354-65. The cause of action may also be broader in that it may not require victims to prove that the act fell beneath the standard of care for the psychotherapist profession, but rather just that the act inflicted emotional distress.

367. 38 Cal. 2d 330, 240 P.2d 282 (1952).



emotional distress; and (3) the defendant's actions proximately caused the emotional distress.<sup>368</sup> As in negligent infliction of emotional distress, many states have abolished the requirement that a plaintiff suffer physical injury resulting from the defendant's conduct.<sup>369</sup> Courts, however, may require physical presence at the place of outrageous conduct.<sup>370</sup> This presence requirement may limit intentional infliction claims to direct victims.

*Destefano v. Grabrian*<sup>371</sup> provides an example of a direct victim's utilization of intentional infliction of emotional distress. In *Destefano*, the plaintiffs brought an action against a priest for engaging in sexual relations with the wife during marriage counseling.<sup>372</sup> The Supreme Court of Colorado held that the wife's allegations stated a claim for severe emotional distress.<sup>373</sup>

If courts modify the presence requirement, a wider range of plaintiffs will recover for emotional distress. Some authorities suggest that the requirement may be obviated, at least in some situations.<sup>374</sup> Prosser and Keeton noted that "[t]he Caveat is intended . . . to leave open the possibility of situations in which presence at the time may not be required."<sup>375</sup> Such situations may include actions against a defendant by those standing in close proximity to the victim or by those whom the defendant's conduct would foreseeably distress. At least two courts have considered eliminating the presence requirement in sexual abuse cases.<sup>376</sup>

368. See RESTATEMENT (SECOND) OF TORTS § 46(1) (1965).

369. See, e.g., *Hubbard v. United Press Int'l*, 330 N.W.2d 428, 438 (Minn. 1983).

370. See *Marlene F. v. Affiliated Psychiatric Medical Clinic, Inc.*, 48 Cal. 3d 583, 598, 770 P.2d 278, 287-88, 257 Cal. Rptr. 98, 107-08 (1989) (Arguelles, J., concurring); *Dillon v. Legg*, 68 Cal. 2d 728, 740-41, 441 P.2d 912, 920-21, 69 Cal. Rptr. 72, 81 (1968); *Nancy P. v. D'Amato*, 401 Mass. 516, 521, 517 N.E.2d 824, 827 (1988).

371. 763 P.2d 275 (Colo. 1988).

372. *Id.* at 278.

373. *Id.* at 286; see *Erickson v. Christenson*, 99 Or. App. 104, 781 P.2d 383 (1989). In *Erickson*, the court found that the complaint stated a cause of action for intentional infliction of emotional distress. *Id.* at 108, 781 P.2d at 386. The court stated:

[B]ecause plaintiff has alleged a confidential relationship, proof of her other allegations would permit the jury to infer that Christenson's actions exceeded the limits of social toleration, that they were done with the knowledge that they would cause her grave distress and that they in fact caused her severe emotional distress. That is sufficient to state a claim for intentional infliction of emotional distress.

*Id.*

374. See, e.g., RESTATEMENT (SECOND) OF TORTS § 46 comment 1 (1965).

375. *Id.*

376. See *infra* notes 377-81 and accompanying text.

The Supreme Judicial Court of Massachusetts briefly considered relaxing the presence requirement in *Nancy P. v. D'Amato*,<sup>377</sup> in which the court noted that "[a] custodial parent of a young child sexually abused by a trusted adult neighbor might present a particularly appealing case for not imposing a presence requirement."<sup>378</sup> In *Delia S. v. Torres*,<sup>379</sup> the California Court of Appeals dropped the presence requirement and allowed a husband to recover for intentional infliction of emotional distress after his friend raped his wife.<sup>380</sup> "[T]he wrong for which recovery was sought was personal to [the husband] . . . . [I]t is his relationship to the object of the act and the effect of the transgression on him personally which gives rise to the cause of action."<sup>381</sup>

Although neither of these cases dealt with sexual exploitation by a therapist, the therapist's position of trust and therapy's closed, confidential setting are sound reasons for an exception to the presence requirement. In his concurring opinion in *Marlene F. v. Affiliated Psychiatric Medical Clinic, Inc.*,<sup>382</sup> Justice Arguelles argued for a finding of intentional infliction of emotional distress: "In brief, I believe that what we have before us is a case of outrageous conduct, atrocious and offensive acts committed within a relationship of trust, that might permit the imposition of liability for the intentional infliction of emotional distress, in addition to the other theories available."<sup>383</sup> Applying the claim of intentional infliction of emotional distress to exploitative psychotherapists thus opens up whole new vistas for secondary victims of sexual exploitation. Although the law has not yet settled firmly on the elements the plaintiff must prove or on the parameters of the action's scope, intentional infliction of emotional distress appears well suited to the needs of secondary victims.

### (c) Summary

Both negligent and intentional infliction of emotional distress claims are evolving areas of the law. Unfortunately, no general rules of application exist at this time. The proof requirements and outcomes vary from jurisdiction to jurisdiction, though a

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377. 401 Mass. 516, 517 N.E.2d 824 (1988).

378. *Id.* at 522, 517 N.E.2d at 828.

379. 134 Cal. App. 3d 471, 184 Cal. Rptr. 787 (1982).

380. *Id.* at 484, 184 Cal. Rptr. at 795.

381. *Id.*

382. 48 Cal. 3d 583, 770 P.2d 278, 257 Cal. Rptr. 98 (1989).

383. *Id.* at 592, 770 P.2d at 283-84, 257 Cal. Rptr. at 104 (Arguelles, J., concurring).

trend may be developing away from the traditional presence and physical injury requirements which would make the action lucrative for plaintiffs.<sup>384</sup> A few states, however, have attempted to set aside common law uncertainties entirely in favor of statutes that more clearly define the prohibited behavior and the plaintiff's remedies.<sup>385</sup>

### C. Statutory Civil Actions

The states are beginning to enact civil causes of action that benefit victims in response to the problem of psychotherapeutic exploitation. Minnesota and Wisconsin took the lead in 1986.<sup>386</sup> The Minnesota statute was essentially duplicated by California in 1987 and Illinois in 1989.<sup>387</sup>

#### 1. Purpose

Although one may now bring an action for therapist exploitation under the common law in all states, the results in similar cases vary dramatically. Civil statutes make sexual exploitation of a patient negligence per se and create an irrebuttable presumption as to the therapist's duty of care.<sup>388</sup> Minnesota and Illinois have enacted substantively identical actions, which state:

A cause of action against a psychotherapist for sexual exploitation exists for a patient or former patient for injury caused by sexual contact with the psychotherapist, if the sexual contact occurred:

(1) during the period the patient was receiving psychotherapy from the psychotherapist; or

(2) after the period the patient received psychotherapy from the psychotherapist if (a) the former patient was emotionally dependent on the psychotherapist; or (b) the sexual contact occurred by means of therapeutic deception.

The patient or former patient may recover damages from a

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384. For a detailed discussion, see *id.* at 588-91, 770 P.2d at 285-87, 257 Cal. Rptr. at 101-03. See also *supra* notes 374-83 and accompanying text.

385. See CAL. CIV. CODE § 43.93(b) (West Supp. 1990); ILL. ANN. STAT. ch. 70, para. 802 (Smith-Hurd 1989); MINN. STAT. ANN. § 148A.02 (West 1989); WIS. STAT. ANN. § 895.70(2) (West Supp. 1989).

386. See MINN. STAT. ANN. § 148A.02; WIS. STAT. ANN. § 895.70(2).

387. See CAL. CIV. CODE § 43.93(b); ILL. ANN. STAT. ch. 70, para. 802.

388. See *infra* notes 389-96 and accompanying text.

psychotherapist who is found liable for sexual exploitation. It is not a defense to the action that sexual contact with a patient occurred outside a therapy or treatment session or that it occurred off the premises regularly used by the psychotherapist for therapy or treatment sessions.<sup>389</sup>

California's statute differs in the scope of its coverage and in its approach to former patients by eliminating the requirement of emotional dependency or therapeutic deception.<sup>390</sup> The Wisconsin statute differs greatly from the three statutes discussed above. It provides:

Any person who suffers, directly or indirectly, a physical, mental or emotional injury caused by, resulting from or arising out of sexual contact with a therapist *who is rendering or has rendered* to that person psychotherapy, counseling or other assessment or treatment of or involving any mental or emotional illness, symptom or condition has a civil cause of action against the psychotherapist for all damages resulting from, arising out of or caused by that sexual contact.<sup>391</sup>

Wisconsin, like California, does not require a showing of emotional dependency.<sup>392</sup> Wisconsin specifically allows for emotional injuries.<sup>393</sup> In addition, its statute provides for recovery of all damages resulting from or arising out of sexual contact.<sup>394</sup> If the defendant's actions aggravated a preexisting condition, a court may assess all damages against the abusing psychotherapist.

Although they take different approaches, all four states have established the wrongfulness of sexual contact in psychotherapeutic relationships.<sup>395</sup> This statutory prohibition lessens the plaintiff's burden. For liability to attach, she need prove only that sexual contact occurred and caused her damage. This type of statute is an improvement over the common law because it creates clarity and uniformity by prohibiting sexual relations in a therapeutic setting. Under common law, a plaintiff must still prove with expert testimony the proper standard of care and that the defendant's action fell below it.<sup>396</sup>

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389. MINN. STAT. ANN. § 148A.02; see ILL. ANN. STAT. ch. 70, para. 802.

390. See *infra* text accompanying notes 400, 415-18.

391. WIS. STAT. ANN. § 895.70(2) (West Supp. 1989) (emphasis added).

392. See *id.*

393. See *id.*

394. See *id.*

395. See *supra* notes 388-94 and accompanying text.

396. See *supra* notes 274-300 and accompanying text.

## 2. *Scope of Coverage*

The definitions of these statutes set their parameters. The definitions of "psychotherapist" and "psychotherapy" delineate the restricted class of defendants, and the definition of "sexual contact" describes the prohibited behavior.<sup>397</sup> The definition of "patient" is important because it describes the class of persons that the statute protects.<sup>398</sup>

### (a) *Class of Defendants*

The statutes of Wisconsin, Minnesota, and Illinois define "psychotherapist" broadly to cover nearly all counselors, both licensed and unlicensed.<sup>399</sup> California is much more restrictive. Its statute specifies only certain groups for coverage and does not include unlicensed counselors and other therapists.<sup>400</sup>

Broad definitions of "psychotherapist" vastly enlarge the class of potential defendants. Otherwise, a plaintiff would encounter great difficulty in establishing a duty of care for clergy malpractice or "New Age" counseling.<sup>401</sup> The Minnesota, Wisconsin, and Illinois statutes hold unlicensed therapists, otherwise unaccountable to licensing or other disciplinary procedure, responsible in the same way as a licensed, board-certified therapist.<sup>402</sup> Statutorily broadening the class of defendants to include unlicensed psychotherapists effectively eliminates many common law loopholes.

### (b) *"Psychotherapy" Defined*

The definition of "psychotherapy" in Minnesota and California states, "'Psychotherapy' means the professional treatment, assessment, or counseling of a mental or emotional illness, symptom, or condition."<sup>403</sup> Illinois' definition is more restrictive. The Illinois

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397. See *infra* notes 399-413 and accompanying text.

398. See, e.g., *infra* notes 414-26 and accompanying text.

399. ILL. ANN. STAT. ch. 70, para. 801(1)(d) (Smith-Hurd 1989); MINN. STAT. ANN. § 148A.01(5) (West 1989); WIS. STAT. ANN. § 895.70(1)(e) (West Supp. 1989).

400. CAL. CIV. CODE § 43.93(a)(2) (West Supp. 1991).

401. See *supra* notes 298-300 and accompanying text.

402. See *supra* note 399. These statutes set a minimum standard of behavior for all therapists, whether licensed or unlicensed. For a discussion of the purposes behind criminalizing behaviors, see W. CLARK & W. MARSHALL, *supra* note 113, at 4. For a discussion of the advantages and limitations of licensing procedures, see *infra* notes 470-548 and accompanying text.

403. CAL. CIV. CODE § 43.93(a)(1); MINN. STAT. ANN. § 148A.01(6).

statute specifically excludes counseling of a religious or spiritual nature and social work.<sup>404</sup> It also specifically excludes a family member or friend's casual advice.<sup>405</sup> The Wisconsin statute defines "psychotherapy" by describing treatment methods and goals and is therefore somewhat narrower than the others, but no significant difference in application should exist.<sup>406</sup> No one has challenged any of these definitions, and all appear sufficiently broad to include nearly all, if not all, types of counselors. Illinois' exclusion of clergy, however, has limits and confuses the scope of this definition, especially when a clergyman is fulfilling dual roles for profit.

(c) *Prohibited Behavior*

Unfortunately, all of the statutes have borrowed or adopted the criminal law's definitions of "sexual contact." California and Wisconsin adopt verbatim the definitions of "sexual contact" from their penal codes.<sup>407</sup> Basically, these statutes adhere to the "bikini rule"—a psychotherapist cannot touch or allow the patient to touch any part of the body that is normally covered by a bikini bathing suit.<sup>408</sup> Some states, however, extend the scope of prohibited touching. For example, Minnesota's definition also includes the buttocks and thighs.<sup>409</sup> The Minnesota statute provides:

"Sexual contact" means any of the following, whether or not occurring with the *consent* of a patient or former patient:

(1) sexual intercourse, cunnilingus, fellatio, anal intercourse or any intrusion, however slight, into the genital or anal openings of the patient's or former patient's body by any part of the psychotherapist's body or by any object used by the psychotherapist for this purpose, or any intrusion, however slight, into the genital or anal openings of the psychotherapist's

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404. ILL. ANN. STAT. ch. 70, para. 801(1)(e) (Smith-Hurd 1989).

405. *Id.*

406. See WIS. STAT. ANN. § 455.01(6) (West 1988).

407. See CAL. PENAL CODE § 243.4(d) (West 1988); WIS. STAT. ANN. § 940.225(5)(b) (West Supp. 1989). Focusing on genital contact ignores the true nature of the boundary violation. See *supra* note 49; *infra* text accompanying notes 412-13. Attempting to describe all possible situations in which liability could attach, however, would be even more difficult. One could make a determination of what constitutes "sexual contact" on a case-by-case basis using the reasonable man standard. One problem with this approach is that it would again introduce the discretion of an uneducated court system and would perhaps lead to the same problems that exist in the common law.

408. Author Linda Jorgenson originally created the term "bikini rule."

409. See MINN. STAT. ANN. § 148A.01(7) (West 1989).

body by any part of the patient's or former patient's body or by any object used by the patient or former patient for this purpose, if agreed to by the psychotherapist;

(2) kissing of, or the intentional touching by the psychotherapist of the patient's or former patient's genital area, groin, inner thigh, buttocks, or breast or of the clothing covering any of these body parts;

(3) kissing of, or the intentional touching by the patient or former patient of the psychotherapist's genital area, groin, inner thigh, buttocks, or breast or of the clothing covering any of these body parts if the psychotherapist agrees to the kissing or intentional touching.

"Sexual contact" includes *requests* by the psychotherapist for conduct described in clauses (1) to (3).

"Sexual contact" does not include conduct described in clause (1) or (2) that is a part of standard medical treatment of a patient.<sup>410</sup>

Illinois duplicates the Minnesota statute.<sup>411</sup> Although these definitions severely restrict the zones of behavior, many sexually exploitative behaviors remain outside the scope of the prohibitions. For example, these statutes do not prohibit pornographic videos or, as occurred in California, cases in which a psychotherapist branded his patients.<sup>412</sup> It is difficult to draft a statute sufficiently broad to cover all forms of sexual exploitation. It seems unnecessary, however, to graft a criminal code definition of "sexual contact" onto a civil statute. The civil definition need not be as specific as the criminal to meet constitutional requirements.<sup>413</sup> By restricting the range of prohibited behavior only to that which is also criminal, the statute cannot cover even extremely sadistic acts in which touching of the genitals or other specified body parts does not occur.

#### (d) *Class of Plaintiffs*

The four states that have passed civil statutes protect not only patients but also some former patients.<sup>414</sup> California's provision

410. *Id.* (emphasis added). Perhaps legislators should add kissing on the mouth to the list of prohibited behavior.

411. See ILL. ANN. STAT. ch. 70, para. 801(1)(f) (Smith-Hurd 1989). Note that both statutes cover requests for such contact.

412. See *Psychotherapist's Sexual Involvement with Patients: Hearings on SB1004 Before Comm. on Bonded Indebtedness and Methods of Financing*, Aug. 24, 1989 (floor statement of Daniel Boatwright, California State Senator) (on file with the authors).

413. States must draft criminal statutes so as to defeat challenges based on vagueness. Such challenges are not available to civil defendants. See *supra* notes 191-211 and accompanying text for a discussion of the void for vagueness doctrine.

414. See *infra* notes 415-26 and accompanying text.

covers former patients who received psychotherapy within two years of sexual contact with their therapists.<sup>415</sup> Both Illinois and Minnesota restrict a former patient's standing to sue.<sup>416</sup> Their statutes require that a former patient prove that she was emotionally dependent upon the psychotherapist at the time of the contact or that sexual contact resulted from therapeutic deception, such as when the therapist leads the plaintiff to believe that the sexual contact is necessary to her therapy.<sup>417</sup> California eliminates the need to prove either: any sexual contact with a patient within two years of termination is negligence per se.<sup>418</sup>

Wisconsin's statute is unique in that it covers any person who suffers an injury as a result of sexual contact with a therapist who *has rendered* psychotherapy to that person.<sup>419</sup> Under the Wisconsin statute, apparently the plaintiff no longer must prove that she is a member of the protected class; rather, the defendant must prove that the plaintiff is not.<sup>420</sup> One may argue that the statute covers any former patient who has suffered harm.

The purpose of including a period of time after termination, even though the period may be arbitrary, is to recognize the power asymmetry between therapist and patient that extends beyond the termination of the relationship. Studies bear out the wisdom of including at least a six-month prohibition, as the vast majority of sexual exploitation cases occur during therapy or within six months of termination.<sup>421</sup>

Some psychoanalysts take the Wisconsin view one step further, holding that once a person becomes a patient, the therapist must always regard her as a patient.<sup>422</sup> This extreme view discounts the fact that a patient and therapist could develop a personal relationship with each other at some point that the prior therapeutic relationship would not influence. Statutorily setting an arbitrary period of prohibition following termination appears to decrease the likelihood of a psychotherapist abusing a former

415. See CAL. CIV. CODE § 43.93(b)(2) (West Supp. 1990); see also *Noto v. St. Vincent's Hosp. & Medical Center*, 142 Misc. 2d 292, 296, 537 N.Y.S.2d 446, 448 (Sup. Ct. 1988), *aff'd*, 160 A.D.2d 656, 559 N.Y.S.2d 510 (N.Y. App. Div. 1990).

416. See ILL. ANN. STAT. ch. 70, para. 802(2) (Smith-Hurd 1989); MINN. STAT. ANN. § 148A.02(2).

417. ILL. ANN. STAT. ch. 70, para. 802(2)(a)(2); MINN. STAT. ANN. § 148A.02(2).

418. CAL. CIV. CODE § 43.93(b)(2).

419. See WIS. STAT. ANN. § 895.70(2) (West Supp. 1989).

420. See *id.*

421. See, e.g., Gartrell, Herman, Olarte, Feldstein, & Localio, *Prevalence of Psychiatrist-Patient Sexual Contact*, in *SEXUAL EXPLOITATION IN PROFESSIONAL RELATIONSHIPS* 11 (G. Gabbard ed. 1989); see also Gartrell & Herman, *supra* note 65, at 1126.

422. See M. Stone, *supra* note 32, at 675-76; see also *supra* note 419 and accompanying text.



patient who has unresolved transference feelings. Some psychiatrists have recommended that the therapist refer the patient to a subsequent therapist to work through such transference and if both parties are still interested after therapy, they might then pursue a romantic relationship.<sup>423</sup>

Each of these approaches curtails or eliminates sexual exploitation of former patients. The imposition of a time period in which sexual contact is prohibited probably will not cover all instances of exploitative behavior;<sup>424</sup> however, statistics indicate that this approach, which is easier to apply statutorily than the others, would protect most victims.<sup>425</sup> The risk-management approach, which Wisconsin apparently followed to some extent, will protect against all abuse of former patients, but it is probably unconstitutional.<sup>426</sup> The idea of referring a patient to another counselor is idealistic at best, and the prohibition is easier to circumvent than the imposition of a set time period.

### 3. *Special Concerns*

#### (a) *Statute of Limitations*

The states that passed civil actions against psychotherapists also considered statute of limitations problems.<sup>427</sup> Therapists' exploitation severely traumatizes many of their victims. The traumatic nature of the damage often prevents victims from being able to confront their former therapists for many years. Transference, extreme guilt, humiliation, and depression stop victims from pursuing their legal rights. Furthermore, some

423. See Coleman, *supra* note 102, at 19; see also *supra* note 246.

424. One should note that the transference/countertransference phenomenon may still be active following termination and may render a former patient vulnerable to an exploitative therapist. See generally Gabbard & Pope, *Sexual Intimacies After Termination: Clinical, Ethical and Legal Aspects*, in *SEXUAL EXPLOITATION IN PROFESSIONAL RELATIONSHIPS* 116-28 (G. Gabbard ed. 1989) (transference continues after treatment is terminated and is "never fully resolved"); Gartrell & Herman, *supra* note 65 (discussing psychiatrists' views on posttermination sexual contact).

425. See Gartrell & Herman, *supra* note 65, at 1128. When sexual contact occurred only after termination, it began within one month in 18% of the cases and within six months in 63% of the cases. *Id.* Therefore, this approach would protect all patients and a majority of former patients. See *id.*

426. Critics frequently raise the argument that an absolute prohibition violates the patient's and psychotherapist's freedom of association. A discussion of the legal merits of this issue is beyond the scope of this Article.

427. See *infra* text accompanying notes 428-38.

therapists have threatened, intimidated, or manipulated their patients.<sup>428</sup> Often, the psychotherapist so damages his sexually exploited patients that by the time they realize the harm and are able to pursue a cause of action, the civil statute of limitations has run.<sup>429</sup>

The California and Minnesota task forces both suggested that legislatures expand their statutes of limitations for patient sexual exploitation.<sup>430</sup> Recently, Minnesota amended its statute of limitations to provide that a plaintiff may bring a negligence action within six years from the time the plaintiff knows or has reason to know that sexual abuse caused the injury.<sup>431</sup> The statute is suspended during the disability.<sup>432</sup> Wisconsin requires the plaintiff to bring an action within three years.<sup>433</sup> If the patient is unable to bring an action against an offending therapist because of the damaging effects of the sexual abuse or because of any threats or statements by the therapist, the statute extends the limitations period to fifteen years.<sup>434</sup>

Lengthening the statute of limitations does not, in itself, raise difficult equity issues. Any extension of the statute of limitations, however, must be fair to both the patient and the accused psychotherapist. Stale cases raise the problem of access to records years after the fact, which unfairly inhibits the right to gather evidence.<sup>435</sup> The therapist's entitlement to a closure of old

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428. See CALIFORNIA, REPORT OF TASK FORCE, *supra* note 156, at 2; MINNESOTA, REPORT OF TASK FORCE, *supra* note 156, at 10-11.

429. See *Simmons v. United States*, 805 F.2d 1363, 1366-67 (9th Cir. 1986) (court relied on findings that plaintiff did not know of injury within statutory period); *Greenberg v. McCabe*, 453 F. Supp. 765, 772 (E.D. Pa. 1978) (because injury and cause were subtler than normal malpractice, inappropriate to determine as a matter of law what plaintiff should have known), *aff'd*, 594 F.2d 854 (3d Cir.), *cert. denied*, 444 U.S. 840 (1979); *Lenhard v. Butler*, 745 S.W.2d 101, 106 (Tex. Ct. App. 1988) (statute of limitations barred claim despite transference phenomenon).

430. See CALIFORNIA, REPORT OF TASK FORCE, *supra* note 156, at 12 (suggesting five years); MINNESOTA, REPORT OF TASK FORCE, *supra* note 156, at 32-33 (suggesting statute of limitations tolls when client is unable to complain for a period of time due to effects of sexual contact or due to "threats, instructions or statements").

431. See 1989 Minn. Laws 190 § 2.

432. *Id.*

433. WIS. STAT. ANN. § 893.585(1) (West Supp. 1989).

434. The Wisconsin statute provides:

If a person entitled to bring the action . . . is unable to bring the action due to the effects of the sexual contact or due to any threats, instructions or statements from the therapist, the period of inability is not part of the time limited for the commencement of the action, except that this subsection shall not extend the time limitation by more than 15 years.

*Id.* § 893.585(2).

435. See CALIFORNIA, REPORT OF TASK FORCE, *supra* note 156, at 12-13.

occurrences at some point, however, should not allow him to hide unfairly behind a procedural limitation.<sup>436</sup>

The uncertainty created by the "capacity to bring suit" troubles many.<sup>437</sup> These statutes raise a problem in that they require a mental health professional to determine whether a victim was competent to file suit and to assess the victim's capacity to file suit over a substantial period of time. As Appelbaum aptly noted, "If the plaintiff's capacities varied over time . . . some estimate of the period during which the plaintiff might have been competent—and therefore during which the clock would be ticking on the statute of limitations—will be required."<sup>438</sup> Courts could more easily apply a clear statute of limitations. Unless the limitation were fifteen or twenty years, however, the statute would hinder many victims from coming forward.

### (b) *Employer Liability*

Unfortunately, employment of therapists by agencies and institutions does not insure patients against sexual exploitation. Fourteen percent of psychotherapist-patient sexual exploitation occurs in agencies or institutions.<sup>439</sup> A careful screening may prevent this exploitation if the offending psychotherapist has abused patients at other institutions as well. Under common law principles of respondeat superior and negligent supervision,<sup>440</sup> employers are responsible for their employees' acts. Generally, for liability to attach, the employer must either know or have reason to know that the psychotherapist would sexually exploit patients.<sup>441</sup>

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436. The Wisconsin statute of limitations gives the therapist some time protection. See WIS. STAT. ANN. § 893.585(2). Prejudice to the therapist is unlikely because the evidence is still within his control. Critics of a fixed time limitation may argue that some victims will still be unaware of their injuries within that period. Fifteen years, however, will give most victims sufficient time to come forward. Balanced against an accused therapist's rights, it appears that an extension beyond this period may be undesirable.

The application of the so-called "discovery rule" to this area of the law would avoid the problems created by a fixed limitation period. Authors Jorgenson and Randles advocated this position in Brief for Appellant at 14-39, *Riley v. Presnell*, No. DAR-5238 (Mass.) (argued Oct. 3, 1990). The Massachusetts Supreme Judicial Court accepted this argument in ruling that the discovery rule should apply to psychotherapist malpractice cases. See *Riley v. Presnell*, No. SJC-5343, slip op. at 16 (Mass. Jan. 28, 1991). Nevertheless, an in-depth discussion of this area exceeds the scope of this Article.

437. See, e.g., Appelbaum, *Commentary*, 2 EXPERT OPINION Forensic Newsletter Div., Forensic Mental Health 8 (Fall 1988).

438. *Id.* at 9.

439. K. POPE & J. BOUHOUTSOS, *supra* note 72, at 152.

440. See *supra* text accompanying notes 319-40.

441. *Id.*

No uniform standard governs an employer before liability attaches; rather, the employer must scrutinize the employee's acts and omissions on a case-by-case basis.<sup>442</sup> The lack of a uniform standard leads to unjustified differences in results and allows an employer who knows of prohibited conduct to do nothing.<sup>443</sup> For example, California task force members learned of several cases in which employers had actual knowledge of employee sexual involvement with patients but chose to take no action.<sup>444</sup> As a result of the task force's findings, California now requires a psychotherapist or a psychotherapist's employer who becomes aware that a previous psychotherapist sexually exploited a patient to furnish that patient with a state-prepared brochure explaining the patient's rights.<sup>445</sup> Failure to discuss this brochure constitutes unprofessional conduct to which administrative penalties apply.<sup>446</sup> Interestingly, this requirement does not extend to former patients even though the civil statute covers them for a period of two years after termination of treatment.<sup>447</sup>

Minnesota and Illinois have passed more comprehensive legislation.<sup>448</sup> In these states, an employer may be civilly liable if the employer knows or has reason to know that a psychotherapist sexually exploited a patient or former patient and the employer fails to take appropriate and timely action.<sup>449</sup> This duty extends well beyond the passing out of pamphlets.<sup>450</sup>

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442. Compare *Andrews v. United States*, 732 F.2d 366, 370 (4th Cir. 1984) (employer not liable for employee's sexual misconduct as "[n]othing in the records suggests that [the employee] considered his sexual adventures to be a *bona fide* part of the therapy he was employed to provide") with *Doe v. Samaritan Counseling Center*, 791 P.2d 344, 348 (Alaska 1990) (employer liable for employee's sexual misconduct as "it could reasonably be concluded that the resulting sexual conduct was 'incidental' to the therapy").

443. See *Andrews*, 732 F.2d at 368.

444. CALIFORNIA, REPORT OF TASK FORCE, *supra* note 156, at 13.

445. See CAL. BUS. & PROF. CODE §§ 337, 728(a) (West 1990); see also *infra* note 534 (discussing California's brochure).

446. See CAL. BUS. & PROF. CODE § 728(b).

447. Compare CAL. CIV. CODE § 43.93(b)(2) (West Supp. 1990) (former patient has a cause of action against violating psychotherapist for two years) with CAL. BUS. & PROF. CODE § 728(a) (employer required to provide a present patient with a brochure if patient had alleged sexual contact with a previous psychotherapist).

448. See ILL. ANN. STAT. ch. 70, para. 803(3) (Smith-Hurd 1989); MINN. STAT. ANN. § 148A.03 (West 1989).

449. See ILL. ANN. STAT. ch. 70, para. 803(3); MINN. STAT. ANN. § 148A.03(a)(1).

450. Compare MINN. STAT. ANN. § 148A.03 (employer must take "reasonable action" if there is reason to know sexual contact with patients occurred previously) and ILL. ANN. STAT. ch. 70, para. 803(3) (employer must take "reasonable action") with CAL. BUS. & PROF. CODE § 728(a) (employer must provide brochure).

Minnesota has established specific procedures for safeguarding against abusive therapists.<sup>451</sup> Employers of psychotherapists must write to a job applicant's employers for the previous five years to ascertain whether the applicant has a history of sexual exploitation.<sup>452</sup> When a prospective employer sends a written request and an authorization release to a former employer, the former employer must respond in writing or else this employer will be liable for the future damages that such failure causes a patient.<sup>453</sup> Minnesota reports that its employer liability rules have been very successful.<sup>454</sup> Placing an affirmative duty on the employer lessens the plaintiff's difficulties in bringing a negligent supervision action because the statute clearly defines the standard of care.<sup>455</sup> The major limitation of this kind of statute is that an employer in a different state would not have to comply unless the law of that state imposed a similar duty.

(c) *Victim Shield*

A necessary addition to any legislative enactment concerning psychotherapist-patient exploitation is a victim shield statute. Because a therapist can never justify engaging in sexual activity with his client, the victim's sexual history or consent should be irrelevant in any judicial proceeding. Given the fiduciary nature of the psychotherapist-patient relationship, the psychotherapist bears the responsibility of abstaining from sexual exploitation, regardless of provocation.<sup>456</sup>

The defendant often calculates admission of the plaintiff's sexual history to humiliate and embarrass the victim and to dis-

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451. See MINN. STAT. ANN. § 148A.03(b); see also MINN. TASK FORCE, IT'S NEVER O.K.: PROFESSIONAL HANDBOOK, *supra* note 1, at app. B-1.

452. See MINN. TASK FORCE, IT'S NEVER O.K.: PROFESSIONAL HANDBOOK, *supra* note 1, at app. B-1.

453. See *id.*

454. See *id.* at 147-52.

455. See MINN. STAT. ANN. § 148A.03.

456. See K. POPE & J. BOUHOUTSOS, *supra* note 72, at 124:

It is important to recognize that *the therapist is solely responsible for ensuring that sexual contact with the patient never, under any circumstances, occurs.* If the patient was seductive, desired sex, or in any way attempted to involve the therapist in activities that were not therapeutic, it was still the *sole responsibility* of the therapist to deal with that behavior and explore it professionally and therapeutically rather than to exploit it. To do otherwise was to act in an unethical and clinically destructive manner. *There is never an ethical or clinical justification for a therapist to participate in sex with a patient.*

courage her from taking action or to cause courts to try her along with the therapist. Nevertheless, when assessing the extent of damages, the court may appropriately elicit the victim's sexual history. If the victim alleges damage to sexual function, the court in fairness must allow the defendant to inquire about the victim's sexual history. Furthermore, the need to evaluate the possibility that personality disorders predating the sexual abuse caused certain symptoms may also justify inquiry into the plaintiff's sexual history.<sup>457</sup> In addition, a defense against a false accusation may entail the demonstration of sexual delusions about a number of persons.<sup>458</sup>

All of the states that have passed psychotherapist sexual exploitation statutes included a victim shield provision that deems prior sexual history irrelevant for purposes of both discovery and admission at trial.<sup>459</sup> All of the statutes passed to date, however, do allow the defendant to introduce this type of evidence if the court accepts an offer of proof setting forth the evidence the defendant will use and the purpose of the evidence.<sup>460</sup>

#### (d) *Summary*

One of the most significant differences in the common law and the new civil statutory schemes is the coverage they afford to

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457. *But cf.* Letter from Susan Beck, Member to the Statutes Subcommittee of the Massachusetts House Committee on Sexual Misconduct by Physicians, to Mass. State Rep. Salvador DiMasi, House Chairman Joint Committee on the Judiciary (Aug. 6, 1990). Responding to this issue, Beck stated that a Massachusetts court found that the victim shield component of the Massachusetts rape statute did *not* bar evidence of the victim's prior allegations of sexual misconduct because such allegations did not constitute "'sexual conduct.'" *Id.* (quoting *Commonwealth v. Bohannon*, 376 Mass. 90, 95, 378 N.E.2d 987, 991 (1978)). However, "a complaining witness's prior arrests as a prostitute were [held by the SJC to be] relevant in [another] rape prosecution." *Id.* (citing *Commonwealth v. Joyce*, 382 Mass. 222, 231, 415 N.E.2d 181, 187 (1981)). Beck noted that "the existing case law seeks to prevent . . . the practice of humiliating a complainant in an effort to discourage him or her from continuing with the case." *Id.*

458. *But cf.* MINNESOTA, REPORT OF TASK FORCE, *supra* note 156, at 30 ("Testimony from psychotherapy professionals and research in the field has indicated that accusations of sexual exploitation by clients are usually not fabricated or a misinterpretation on the client's part.").

459. *See* ILL. ANN. STAT. ch. 70, paras. 804-05 (Smith-Hurd 1989) (regarding scope of discovery); MINN. STAT. ANN. § 148A.05 (regarding admission of evidence); WIS. STAT. ANN. § 901.04(3)(C) (West Supp. 1990) (regarding admission of evidence).

460. "In an action for sexual exploitation, evidence of the plaintiff's sexual history is not subject to discovery except when the plaintiff claims damage to sexual functioning . . . ." MINN. STAT. ANN. § 148A.04; *see also* ILL. ANN. STAT. ch. 70, paras. 804-05; WIS. STAT. ANN. § 901.04(3)(C).

former patients.<sup>461</sup> All four states with a civil cause of action protect former patients.<sup>462</sup> The expanded coverage ranges from one year in Illinois to an indefinite period of time in Wisconsin<sup>463</sup>—certainly an increase over the time generally allowed by common law.<sup>464</sup> Civil statutes prohibiting psychotherapist-patient sexual exploitation also expressly define the standard of care required of psychotherapists.<sup>465</sup> This prohibition is a great advantage over the common law.

In addition, all four civil statutes addressing psychotherapist-patient sexual exploitation include victim shield provisions.<sup>466</sup> These provisions are important to protect the victim from harassment while she pursues her rights. Furthermore, these civil statutes explicitly prohibit sexual contact regardless of the victim's consent to the sexual act.<sup>467</sup> Some of the statutes also provide a unique opportunity to hold employers accountable for their negligent hiring practices.<sup>468</sup>

461. See *supra* notes 414-26 and accompanying text.

462. *Id.*

463. *Id.*

464. In an action by a former patient for sexual contact occurring after the termination of therapy, a plaintiff will be required to prove the defendant owed a "duty" to her. See *supra* notes 266-69 and accompanying text. If no professional relationship exists, does a legal duty to refrain from sexual contact exist? This question must be litigated case by case. In *Noto v. Saint Vincent's Hospital & Medical Center*, 142 Misc. 2d 292, 296, 537 N.Y.S.2d 446, 448 (Sup. Ct. 1988), *aff'd*, 160 A.D.2d 656, 559 N.Y.S.2d 510 (N.Y. App. Div. 1990), the court, in deciding whether sexual relations with a patient after termination of a professional psychiatric relationship is actionable, concluded:

While no similar statute [to Minnesota or California] has been enacted in New York to date, under the facts here and taking into consideration Dr. Sears [sic] affidavit, the complaint can fairly be viewed as analogous to a cause of action for medical malpractice based on the seduction of the patient.

*Id.*

Controversy surrounds whether former patients should be extended special protection. See generally *Coleman, supra* note 102 (describing impetus behind total prohibition and why such a rule is unduly restrictive).

465. See CAL. CIV. CODE § 43.93 (West Supp. 1990); ILL. ANN. STAT. ch. 70, para. 801-02 (Smith-Hurd 1989); MINN. STAT. ANN. §§ 148A.01-02 (West 1989); WIS. STAT. ANN. § 895.70 (West Supp. 1990).

466. See CAL. CIV. CODE § 43.93(d) (victim shield); ILL. ANN. STAT. ch. 70, para. 805 (regarding admission of evidence); MINN. STAT. ANN. § 148A.04 (regarding scope of discovery); *id.* § 148A.05 (regarding admission of evidence); WIS. STAT. ANN. § 901.04(3) (victim shield).

467. See *supra* text accompanying notes 388, 395-96. Illinois and Minnesota prohibit all sexual contact that occurs in the office. For any acts occurring outside the office setting or following termination of the therapeutic relationship, however, a plaintiff must show emotional dependence or allege that the sexual contact occurred by means of therapeutic deception. ILL. ANN. STAT. ch. 70, para. 802, § 2(a)(1), (2); MINN. STAT. ANN. § 148A.02(2).

468. See *supra* notes 439-55 and accompanying text.

The lingering damage of sexual intimacy during a therapeutic relationship bears upon the length of time in which a plaintiff must bring suit. A psychotherapist's sexual exploitation of a patient requires an extended limitations period because the victim is often so loathe to face her abuser that years may pass before she comes forward.<sup>469</sup> In addition, abusive therapists may use a subtle form of mind-control or brainwashing to prevent a victim from fully realizing what has happened. As a result of these circumstances, the victim may fail to timely realize the damages she has sustained, and the statute of limitations may run. States should therefore expand the statute of limitations on psychotherapist-patient sexual exploitation actions.

## V. ADMINISTRATIVE STATUTES

### A. Introduction

Administrative licensing procedures are the final method states employ to regulate psychotherapist sexual exploitation. All states license psychiatrists and psychologists, and forty-eight states license or register social workers.<sup>470</sup> A minority of states license family and marriage counselors, drug and chemical dependency workers, and educational psychologists.<sup>471</sup>

In many states, however, a person without any specific qualifications may hold himself out as a psychotherapist. Unlicensed and unregistered therapists represent a sizeable loophole in the regulation of the psychotherapeutic profession.<sup>472</sup> Nevertheless,

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469. See *supra* notes 427-38 and accompanying text.

470. See QUALITY ASSURANCE DEP'T, NAT'L ASS'N OF SOCIAL WORKERS, STATE COMPARISON OF LAWS REGULATING SOCIAL WORK (1991).

471. See, e.g., COLO. REV. STAT. §§ 12-43-503, -603 (Supp. 1990) (licensure for marriage and family therapists and professional counselors).

472. See CALIFORNIA, REPORT OF TASK FORCE, *supra* note 156, at 29; MINNESOTA, REPORT OF TASK FORCE, *supra* note 156, at 40-41. Three states—Minnesota, Colorado, and Florida—recently enacted administrative statutes that address unlicensed therapists. See COLO. REV. STAT. §§ 12-43-101, -711; FLA. STAT. ANN. § 490.012 (West Supp. 1990); MINN. STAT. ANN. §§ 148-B40-B47 (1989 & Supp. 1990). Colorado provides:

The general assembly hereby finds and declares that, in order to safeguard the public health, safety, and welfare of the people of this state and in order to protect the people of this state against the unauthorized, unqualified, and improper application of psychotherapy, psychology, clinical social work, marriage and family therapy, professional counseling, and school psychology, it is necessary that the proper regulatory authorities be established and adequately provided for. The general assembly further finds that, in order to best provide such protections and safeguards and to expedite complaints and



state board regulations provide the most comprehensive regulatory scheme and are an important component to any survey of the law in this area.

Half of the states have recently enacted regulations or legislation that specifically list psychotherapists' sexual contact as unprofessional conduct for which disciplinary action is appropriate.<sup>473</sup> At least a dozen states have regulations that denounce immoral or lewd conduct as unprofessional.<sup>474</sup>

## *B. Scope of Power and Features of Board Regulation*

### *1. Scope*

The legislatures of each state delegate to boards of registration the power to regulate psychotherapeutic professions. In the enabling statutes, the legislatures frequently define the purpose and nature of the licensing boards.<sup>475</sup>

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disciplinary proceedings relating to the practice and delivery of psychotherapy, psychology, clinical social work, marriage and family therapy, professional counseling services, and school psychology, there shall be established a grievance board with the authority to take disciplinary actions or bring injunctive actions or both concerning unlicensed psychotherapists, licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, licensed professional counselors, and certified school psychologists.

COLO. REV. STAT. § 12-43-101. Colorado has attempted to regulate the unlicensed through the state grievance board. *See id.* § 12-43-704(1)(3). The grievance board shall find that any psychotherapist who engaged in sexual contact with a client during the time of a professional relationship or within six months after a professional relationship terminated engaged in unprofessional conduct. *See id.* § 12-43-704(1)(q). The grievance board may revoke the therapist's license and may obtain an injunction against an unlicensed therapist to prevent that therapist from practicing. *Id.* § 12-43-704.5(3). Further, the statute allows a civil cause of action sounding in strict liability for prohibited sexual contact: "Damages for injury or death occurring as a result of the services may be recovered in an appropriate action without any showing of negligence." *Id.* § 12-43-707(5)(b). A client may recover any money paid if the psychotherapist engages in sexual contact with her. *Id.* § 12-43-707(5)(a). Unlicensed therapists who commit any act prohibited by the statute may be perpetually enjoined from practicing psychotherapy. *See id.* § 12-43-708(2); *see also* FLA. STAT. ANN. § 491.012 (therapist licensing statute); MINN. STAT. ANN. §§ 148.B40-B47 (establishes board that regulates unlicensed therapists).

473. *See, e.g.,* ARIZ. REV. STAT. ANN. § 32-2081(5)(f) (1986) ("The certificate of any person certified by the board may be suspended or revoked by the board or the person may be placed on probation . . . [if he h]as engaged in unprofessional conduct which shall include . . . [s]exual intimacies with clients.").

474. *See, e.g.,* ALASKA STAT. § 08.64.326(a)(9) (1962) ("engaged in unprofessional conduct or in lewd or immoral conduct in connection with the delivery of professional services to patients"); ARK. STAT. ANN. § 17-93-409(7) (1987) (grounds for denial, suspension, or revocation of medical license include "[g]rossly negligent or ignorant malpractice").

475. For example, Texas' enabling statute states, "[T]he practice of medicine is a

States generally give the professional review boards the power and responsibility of establishing each profession's code of ethics and of enforcing them through administrative rules. Because the boards conduct legislative and judicial functions, state courts may review all final decisions of each board pursuant to each state's Administrative Procedure Act.<sup>476</sup>

The scope of power that legislatures grant to the boards varies from state to state. In many states, the legislature completely forfeits control over licensing by granting to boards the power to decide what conduct to proscribe.<sup>477</sup> In other states, boards supplement, refine, and define the grounds for finding unprofessional conduct through rulemaking procedures and case adjudication.<sup>478</sup> In all states, the boards' powers are generally broad so as to avoid the evidentiary and procedural difficulties that could arise in criminal and civil proceedings.<sup>479</sup>

## 2. Features

Administrative boards have a variety of features that are advantageous to a complaining party. A broad range of sanctions, from reprimands and fines to injunctive relief and prison terms,

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privilege and not a natural right of individuals and as a matter of policy it is considered necessary to protect the public interest through the specific formulation of this Act to regulate . . . ." TEX. REV. CIV. STAT. ANN. art. 4495b, § 1.02(1) (Vernon Supp. 1990); *see also* COLO. REV. STAT. § 12-43-101 (1985) (stating the legislative declaration for "a proper regulatory authority").

476. *See, e.g.*, TEX. REV. CIV. STAT. ANN. arts. 4512c, § 8, 6252-13a, §§ 3(1), 19.

477. For example, Oklahoma's legislature declared a broad code of ethics for psychologists, stating:

The Board shall publish a code of ethics. The code shall take into account the professional character of psychological service and shall be designed to protect the interest of the client and the public. In developing and revising this code, the Board shall hold hearings where interested persons may be heard on the subject and the Board may take into account the Ethical Standards of Psychologists promulgated by the American Psychological Association.

OKLA. STAT. ANN. tit. 59, § 1361 (West 1989).

478. *See, e.g.*, DEL. CODE ANN. tit. 24, § 1731(b)(17) (1988) (allows board to discipline one whom the board determines engaged in "unprofessional conduct," which is defined as "[t]he violation of this chapter, or the violation of an order or regulation of the Board directly related to medical procedures, the performance of which would harm or injure the public or any individual"); D.C. CODE ANN. § 2-3305.14(a)(24) (1988) (allows board to impose sanctions upon persons regulated by the board who "[v]iolate[ ] any provision of this chapter or rules and regulations issued pursuant to this chapter"); KY. REV. STAT. ANN. § 311.565(1) (Michie/Bobbs-Merrill 1990) (allows board to exercise all administrative functions of the state).

479. *See infra* text accompanying notes 480-520.

are available to boards.<sup>480</sup> The burden of proof and the rules of evidence are generally more relaxed than those of civil or criminal courts, and most states provide for either no statutes of limitations or have longer statutes of limitations for board actions.<sup>481</sup> Some boards provide victim shield protection similar to that afforded rape victims in most jurisdictions.<sup>482</sup>

Administrative boards also tend to be more sensitive to the issues raised by intraprofessional reporting. Boards in some states protect from liability those reporting suspected unethical or unprofessional acts, and boards in other states protect individual board members.<sup>483</sup>

Finally, boards have addressed the issue of whether the law should require a subsequent treating therapist to report a former therapist's sexual abuse of a patient. States' responses to this issue have ranged from mandating reporting over the victim's objections to refusing to require any reporting.<sup>484</sup>

Not only do different states vary in their treatment of this area of the law, but different boards within each state differ as well. The following Section discusses this inconsistency in application.

(a) *Wide Range of Available Sanctions*

The range of sanctions available to boards allows wide discretion in fashioning appropriate relief. Typically, a board may issue a private reprimand, public reprimand, probation, suspension, limitation, denial of license, or revocation of license.<sup>485</sup> A board also may set conditions for continued practice, including monitoring the psychotherapist's conduct through supervision.<sup>486</sup> Most states allow boards to fine offenders, and a few states allow orders for restitution.<sup>487</sup>

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480. See *infra* text accompanying notes 485-93.

481. See *infra* text accompanying notes 494-508, 510-16.

482. See *infra* text accompanying notes 517-20.

483. See *infra* text accompanying notes 521-22.

484. See *infra* text accompanying notes 523-42.

485. Courts have upheld the power of boards to revoke the licenses of those they regulate. See, e.g., *Cooper v. Board of Medical Examiners*, 49 Cal. App. 3d 931, 950, 123 Cal. Rptr. 563, 575 (1975) (revocation of psychiatrist's license); *Bernstein v. Board of Medical Examiners*, 204 Cal. App. 2d 378, 386, 22 Cal. Rptr. 419, 424 (Dist. Ct. App. 1962) (revocation of psychiatrist's license); *Morra v. State Bd. of Examiners of Psychologists*, 212 Kan. 103, 112, 510 P.2d 614, 622 (1973) (revocation of psychologist's license upheld on appeal).

486. See, e.g., ILL. ANN. STAT. ch. 111, paras. 4400-37 (Smith-Hurd Supp. 1990).

487. See, e.g., COLO. REV. STAT. § 12-43-707(5)(a) (Supp. 1990) (patient "entitled to recover the amount of any fee paid for the services").

Some states provide criminal sanctions for violations of an administrative board's disciplinary rules. In Louisiana, a violation of any disciplinary rule may be a misdemeanor.<sup>488</sup> Texas follows a similar procedure; the State may enjoin or criminally prosecute a therapist for a misdemeanor.<sup>489</sup> Hawaii has an especially stringent sanction: the board regulation for psychologists allows both a fine and a jail term for up to one year.<sup>490</sup>

Several states have taken an innovative approach involving injunctive relief. In these states, after a board finds a violation of the disciplinary rules, it requests that a court enjoin the psychotherapist from committing any act that further violates the disciplinary rules.<sup>491</sup> Should the offending psychologist commit another enjoined act, he will be "summarily" tried and punished for contempt of court.<sup>492</sup> Courts may accord injunctive relief in addition to all other remedies, including criminal prosecution.<sup>493</sup>

*(b) Lower Burden of Proof*

Before the board issues any sanction, state laws require a hearing in which the complainant or the board by its own action must prove the occurrence.<sup>494</sup> Although the standard of proof

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488. See LA. REV. STAT. ANN. § 37:2360(A)(4) (West 1988) ("It shall be a misdemeanor . . . [f]or any person to otherwise violate the provisions of this Chapter").

489. See TEX. REV. CIV. STAT. ANN. art. 4512c, § 24 (Vernon 1976) (Texas board has right to institute action in own name to enjoin violation; injunction in addition to other actions; represented by attorney general or district attorneys).

490. See HAW. REV. STAT. § 465-15(b) (Supp. 1989) ("Any person who violates this chapter shall be fined not more than \$1,000 for each violation of this chapter or imprisoned not more than one year, or both.").

491. See, e.g., COLO. REV. STAT. § 12-43-708(2)-(4) (providing additionally that the "board shall not be required to allege or prove either that an adequate remedy at law does not exist or that substantial or irreparable damage would result"); LA. REV. STAT. ANN. § 37:2361(B) ("The board may apply for an injunction in any court of competent jurisdiction to enjoin any person from committing any act which is in violation of this Chapter"); TEX. REV. CIV. STAT. ANN. art. 4512c, § 24 ("The Texas State Board of Examiners of Psychologists shall have the right to institute an action in its own name to enjoin the violation of any provisions of this Act").

492. See, e.g., LA. REV. STAT. ANN. § 37:2361(D) ("In case of violation of any injunction issued under the provisions of this Section, the court may summarily try and punish the offender for contempt of court.").

493. See *id.* § 37:2361(E) ("Such injunctive proceedings shall be in addition to, and not in lieu of, all penalties and other remedies.").

494. See, e.g., ARIZ. REV. STAT. ANN. § 32-2082(A) (1986) ("A certificate shall not be suspended or revoked and a psychologist shall not be placed on probation until after a hearing."); ARK. STAT. ANN. § 17-93-410(b) (Supp. 1989) (providing for a hearing to be scheduled within 30 days of the mailing of a copy of the complaint to the defendant); CONN. GEN. STAT. ANN. § 20-45 (West 1989) ("Proceedings relative to the revocation, suspension or annulment of a license or toward disciplinary action may be begun by the filing of written charges, verified by affidavit, by the commissioner of health services.").

required for finding a violation of a disciplinary rule varies, typically the board must find by a preponderance of the evidence that the therapist engaged in the prohibited practice, even if the therapist is subject to criminal sanctions.<sup>495</sup>

All of the board members need not find a violation. For example, in Louisiana, four out of five board members must find that a violation exists:

The board shall have the power and duty to suspend, place on probation, require remediation for a specified time, revoke any license to practice psychology, or take any other action specified in the rules and regulations whenever the board, *by affirmative vote of at least four of its five members*, shall find by a preponderance of the evidence that a psychologist has engaged in any of the following acts or offenses:

- ...  
 (2) Practicing psychology in such a manner as to endanger the welfare of clients or patients, including but not limited to:  
 (a) Harassment, intimidation, or abuse, sexual or otherwise, of a client or patient.  
 (b) Engaging in sexual intercourse or other sexual contact with a client or patient.<sup>496</sup>

In Massachusetts, the standard is also a preponderance of the evidence.<sup>497</sup> The law does not require the respondent to testify in any hearing; however, the board may draw an adverse inference from his failure to take the stand.<sup>498</sup>

Likewise, in Oklahoma, the board may sanction a respondent in his absence.<sup>499</sup> The State Board of Examiners of Psychologists can require a psychologist to appear before the Board.<sup>500</sup> If the psychologist does not appear, the Board may hold the hearing in his absence.<sup>501</sup> If a majority of the Board decides that the psy-

495. See, e.g., *Medical Malpractice Joint Underwriting Ass'n v. Commissioner of Ins.*, 395 Mass. 43, 46, 478 N.E.2d 936, 941 (1985). But see *In re Zar*, 434 N.W.2d 598, 602 (S.D. 1989) (standard of proof for license revocation proceedings is "clear and convincing evidence").

496. LA. REV. STAT. ANN. § 37:2359(B)(2) (emphasis added).

497. See *Medical Malpractice Joint Underwriting Ass'n*, 395 Mass. at 46, 478 N.E.2d at 941 (preponderance of evidence generally applicable to administrative proceedings).

498. See *In re Sze K. Kaan*, No. 86-12-BO, slip op. at 9 (Mass. Bd. of Registration in Med. May 6, 1987) (citing *Arthurs v. Stern*, 560 F.2d 477 (1st Cir. 1977), cert. denied, 434 U.S. 1034 (1978)).

499. OKLA. STAT. ANN. tit. 59 § 1370(E) (West 1989) ("If the psychologist fails or refuses to appear, the Board may proceed to hearing and determine the charges in his absence.").

500. *Id.* § 1370(B).

501. *Id.* § 1370(E).

chologist committed the alleged act of unprofessional conduct, the Board may impose any authorized penalty, including license revocation.<sup>502</sup>

(c) *Less Stringent Rules of Evidence*

Strict rules of evidence often do not apply to board hearings.<sup>503</sup> In fact, some states permit the reviewing body to rely on its own expertise and specialized knowledge of the area rather than the *tabula rasa*, or blank slate, jurors are expected to bring to a proceeding.<sup>504</sup> The board's power to evaluate the evidence in a hearing before it is coextensive with a judicial body's discretion. In an adjudicatory proceeding, when hearing officers evaluate conflicting evidence, their credibility assessment is "largely unreviewable by the courts."<sup>505</sup> In *Block v. Ambach*,<sup>506</sup> the court reasoned:

Although petitioner Block argues to us that the complainant's testimony against him was unreliable, her credibility was a matter for the Hearing Panel to resolve and judicial review of the agency's determination is limited to the question of whether there is substantial evidence in the record to support that determination.<sup>507</sup>

In Iowa, the legislature gave the board extensive powers to evaluate evidence.<sup>508</sup> This broad delegation of power makes the board's findings virtually unreviewable.

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502. *Id.*

503. See, e.g., *Damino v. Board of Regents*, 124 A.D.2d 271, 272, 508 N.Y.S.2d 618, 620 (1986) (strict rules of evidence are not binding).

504. See, e.g., *In re Fong*, No. 02-87-465 DIA NO. 88DPHMB-5, slip op. at 1 (Iowa Bd. Med. Examiners Sept. 13, 1988) (panel to review complaints filed with the Iowa State Board of Medical Examiners composed of three doctors alone). Other states, however, fill their boards with a mix of practicing professionals and laypersons. See, e.g., COLO. REV. STAT. § 12-43-302(2) (Supp. 1990) (five psychologists and two laypersons); HAW. REV. STAT. § 453-5(a) (1985) (seven physicians and two lay members of the public); IDAHO CODE § 54-1806A(1) (Supp. 1990) (four physicians and one member of good character not licensed to practice medicine or surgery).

505. *Berenhaus v. Ward*, 70 N.Y.2d 436, 443, 517 N.E.2d 193, 196, 522 N.Y.S.2d 478, 481 (1987) (in police disciplinary hearing, assessment of credibility left to hearing officer); see also *Block v. Ambach*, 73 N.Y.2d 323, 335, 537 N.E.2d 181, 186-87, 540 N.Y.S.2d 6, 11-12 (1989) (credibility is a matter for hearing panel to resolve; judicial review limited to whether substantial evidence supports that determination).

506. 73 N.Y.2d 323, 537 N.E.2d 181, 540 N.Y.S.2d 6.

507. *Id.* at 335, 537 N.E.2d at 186, 540 N.Y.S.2d at 11-12.

508. See *Fong*, No. 02-87-465 DIA NO. 88DPHMB-5, slip op. at 7, in which the board

(d) *Longer Statute of Limitations*

Perhaps the most advantageous aspect of board hearings for complainants is that the vast majority of states do not impose a time limit on bringing actions against licensed therapists. In *In re Fong*,<sup>509</sup> the Iowa board found that a twelve-year lapse did not bar an action.<sup>510</sup> In that case, the doctor had responded earlier to the same charges at the Polk County Medical Society.<sup>511</sup> The board held that the prior record could refresh the doctor's recollection as to the events at issue.<sup>512</sup> The appellate court upheld the board's ruling, finding that the delay did not violate due process and that the doctrine of laches did not bar the action:

The Respondent-Appellant argued on appeal that the Board's action in pursuing the complaint of patient number one after the passage of twelve years denied the Respondent due process. There was no due process violation. The Board pursued this complaint as soon as it found out about it, and there was no prejudice to the Respondent by the delay. . . .

The Respondent-Appellant argued that laches bars the prosecution of the complaint of patient number one. Laches does not bar this prosecution. First, the equitable doctrine of laches is generally not available against the government. Second, laches is only available where there has been some unreasonable delay. In this case, patient number one filed a written complaint with the Polk County Medical Society almost immediately. The Iowa Board did not find out about this complaint until the fall of 1987, and then did not delay in filing a complaint against the Respondent. Additionally, the Respondent has not been prejudiced by the lapse of time.<sup>513</sup>

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stated,

The legislature specifically contemplated that the fact-finders in hearings regarding medical licenses would be members of the medical profession with medical expertise. [Iowa Code §] 17A.14(5) (1987) states that an "agency's experience, technical competence, and specialized knowledge may be utilized in the evaluation of the evidence." The panel members certainly acted appropriately and in the manner contemplated by the Iowa statutes and rules when they used their medical expertise to evaluate the evidence including expert testimony.

*Id.*

509. No. 02-87-465 DIA NO. 88DPHMB-5.

510. *See id.* slip op. at 7.

511. *Id.* slip op. at 4.

512. *Id.*

513. *Id.* slip op. at 8 (citation omitted).

One should note that courts make due process determinations on a case-by-case basis and that undue delay may bar a complaint on due process grounds.<sup>514</sup> In *Appeal of Plantier*,<sup>515</sup> the court found that a nine-year lapse from the time of the incident to the disciplinary hearing was too long.<sup>516</sup>

(e) *Victim Shield*

In the past, hearing procedures often discouraged victims from issuing complaints against offending therapists because the hearing often became a trial of the victim's sexual history. As this Article noted previously, the patient's sexuality, seductiveness, attractiveness, and sexual history are irrelevant to the proceeding.<sup>517</sup> The therapist always has the duty not to engage in sexual contact with his patients, regardless of their background or behavior.<sup>518</sup>

The Minnesota legislature passed a statute limiting the discovery and admission of evidence of a patient's past sexual conduct in a board or administrative proceeding for the revocation or suspension of a license when the alleged violation is based on therapist-patient sexual contact.<sup>519</sup> The legislature modeled this statute after rape shield laws that protect the victim from going on trial herself. The statute drastically restricts the admissibility of the victim's past sexual conduct<sup>520</sup> and, given the psychotherapist's probable awareness of many of the painful details of the

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514. See *Appeal of Plantier*, 126 N.H. 500, 509, 494 A.2d 270, 275-76 (1985), cited in Annotation, *Applicability of Statute of Limitations or Doctrine of Laches to Proceeding to Revoke or Suspend License to Practice Medicine*, 51 A.L.R.4TH 1129 (1987).

515. 126 N.H. 500, 494 A.2d 270 (1985).

516. *Id.* at 507-09, 494 A.2d at 274.

517. See *supra* notes 456-60 and accompanying text.

518. See *supra* notes 2-9 and accompanying text.

519. See MINN. STAT. ANN. § 148A.04 (West 1989). The statute provides:

In an action for sexual exploitation, evidence of the plaintiff's sexual history is not subject to discovery except when the plaintiff claims damage to sexual functioning; or

(1) the defendant requests a hearing prior to conducting discovery and makes an offer of proof of the relevancy of the history; and (2) the court finds that the history is relevant and that the probative value of the history outweighs its prejudicial effect.

The court shall allow the discovery only of specific information or examples of the plaintiff's conduct that are determined by the court to be relevant. The court's order shall detail the information or conduct that is subject to discovery.

*Id.*

520. See *id.*



victim's past, is necessary to prevent harassment. At the same time, the statute reflects the need to balance the protection of victims against the necessity of assessing possible false accusations.

(f) *"Good Faith" Shield From Liability*

Many states specifically shield therapists who give information, or testify about another therapist to a board, from libel, slander, and defamation actions.<sup>521</sup> Some states, such as Idaho, protect the board members as well.<sup>522</sup>

(g) *Mandatory Reporting*

One of the more difficult issues confronting administrative boards is whether to require a subsequent therapist to report a former therapist's sexual abuse of a patient. The best available data indicates that only four to eight percent of those who are sexually exploited by their psychotherapist report such abuse.<sup>523</sup> Sexually exploited patients may have many reasons for not reporting their abuse. They may fear public exposure for family reasons, such as the fear of losing a spouse or children.<sup>524</sup> In addition, abused victims often have a great deal of difficulty trusting subsequent therapists.<sup>525</sup>

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521. See, e.g., TENN. CODE ANN. § 63-6-214(d) (1990) ("Any doctor of medicine, any medical society or any other person who in good faith shall report to the board any information that a doctor of medicine is or may be in violation of any of the provisions of subsection (b) shall not be subject to suit for civil damages as a result thereof."); WIS. STAT. ANN. § 940.22(5) (West Supp. 1990). In Wisconsin, subsequent treating psychotherapists who report abusers are not liable for damages caused by the report. *Id.* The Wisconsin statute states:

Any person or institution participating in good faith in the making of a report or record under this section is immune from any civil or criminal liability that results by reason of the action. For the purpose of any civil or criminal action or proceeding, any person reporting under this section is presumed to be acting in good faith.

*Id.*

522. See, e.g., IDAHO CODE § 54-1806A(13) (Supp. 1990).

There shall be no liability on the part of and no action for damages against:

(a) Any member of the board of professional discipline or the staff or officials thereof for any action undertaken or performed within the scope of the functions of said board or this chapter; or

(b) Any person providing information or testimony to the said board or its staff or officials.

523. See K. POPE & J. BOUHOUTSOS, *supra* note 72, at 192; Gartrell & Herman, *supra* note 75, at 289.

524. See G. SCHOENER & J. MILGROM, *supra* note 1, at 235-44.

525. See *supra* note 89 and accompanying text; see also Strasburger, Jorgenson, & Randles, *Mandatory Reporting*, 18 BULL. AM. ACAD. PSYCHIATRY & L. 379 (1990).

Colleagues of the offending psychotherapist frequently learn of the offense through either their patients or other psychotherapists, but very few report their knowledge.<sup>526</sup> Subsequent psychotherapists are often accused of maintaining a "conspiracy of silence."<sup>527</sup> A closer analysis reveals, however, that these charges are not wholly accurate. Important competing interests often collide when a subsequent therapist considers whether to report sexual abuse.

The most compelling argument against reporting is that it breaches client confidentiality. The confidentiality that exists between the patient and the subsequent treating psychotherapist prevents reporting against the patient's wishes. If mandatory reporting requirements required the therapist to break this confidentiality, many patients who have already been betrayed will suffer a second wrong or fail to go to a subsequent therapist.<sup>528</sup> One must, however, balance the need to protect the victim from further injury against the need to protect other patients from exploitation.<sup>529</sup>

Even though the resolution of mandatory reporting issues is difficult, some states have addressed the issue.<sup>530</sup> Of those states with laws on psychotherapist-patient sexual exploitation, only Minnesota has mandated that a subsequent therapist report the offending psychotherapist's name in spite of the victim's objections.<sup>531</sup> California<sup>532</sup> and Wisconsin<sup>533</sup> have mandatory reporting

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526. See CALIFORNIA, REPORT OF TASK FORCE, *supra* note 156, at 17; Gartrell & Herman, *supra* note 75, at 289-90.

527. See Stone, *Sexual Misconduct by Psychiatrists: The Ethical and Clinical Dilemma of Confidentiality*, 140 AM. J. PSYCHIATRY 195, 195 (1983).

528. *Id.* at 196.

529. See George, *Psychotherapist-Patient Sex: A Proposal for a Mandatory Reporting Law*, 16 PAC. L.J. 431 (1985). George takes an extreme view, arguing that the fundamental right in privacy must give way to the compelling state interest of stopping abusive psychotherapists. *Id.* He proposes a mandatory reporting statute requiring the reporting of both the offending psychotherapist and the patient unless the reporting would be "unusually" injurious to the patient. *Id.* at 446-59.

530. The task force reports of both California and Minnesota recommended a version of mandatory reporting. CALIFORNIA, REPORT OF TASK FORCE, *supra* note 156, at 17; MINNESOTA, REPORT OF TASK FORCE, *supra* note 156, at 33-35. The Minnesota task force found mandatory reporting to be a difficult issue to resolve. MINNESOTA, REPORT OF TASK FORCE, *supra* note 156, at 33-34. "Balancing the very important needs of victims against the needs of unsuspecting future patients is extremely difficult. See *id.* at 33.

531. Minnesota failed to pass a comprehensive statute dealing with mandatory reporting. Various boards, however, have mandatory reporting requirements. Minnesota requires that the psychologist report by name the offending psychotherapist, even if the patient objects. If the patient does not give the name of the offending psychotherapist, however, the subsequent therapist is not required to guess. See G. SCHOENER & J. MILGROM, *supra*

laws that leave the control of the reports up to the abused patient. California encourages reporting by educating the victim:

Any psychotherapist or employer of a psychotherapist who becomes aware through a patient that the patient had alleged sexual intercourse or alleged sexual contact with a previous psychotherapist during the course of a prior treatment, shall provide to the patient a brochure promulgated by the department which delineates the rights of, and remedies for, patients who have been involved sexually with their psychotherapist. Further, the psychotherapist or employer shall discuss with the patient the brochure prepared by the department.<sup>534</sup>

The statute regards as unprofessional conduct the failure to provide the brochure and to discuss it with the patient.<sup>535</sup> Interestingly, this statute does not require a therapist to report the sexual exploitation of a former patient even though California has a civil cause of action for former patients that is available for two years after the termination of therapy.<sup>536</sup>

Wisconsin leaves the decision of whether to file a report against the abusing therapist to the patient, but then goes a step fur-

note 1, at 562-65. Actually, Minnesota's mandatory reporting requirements are a patchwork of requirements pertaining to the various professional boards which predate and postdate the Minnesota task force's recommendations. *See id.* at 697-700 (Appendix K, consisting of summary of reporting requirements in Minnesota).

532. *See* CAL. BUS. & PROF. CODE § 728 (West 1990).

533. *See* WIS. STAT. ANN. § 940.22(3)(d) (West Supp. 1990) (makes the failure to report a misdemeanor).

534. CAL. BUS. & PROF. CODE § 728(a). As for the brochure,

(a) The department shall prepare and disseminate an informational brochure for victims of psychotherapist-patient sexual contact and advocates for those victims. This brochure shall be developed by the department in consultation with members of the Sexual Assault Program of the Office of Criminal Justice Planning and the office of the Attorney General.

(b) The brochure shall include, but is not limited to, the following:

(1) A legal and an informal definition of psychotherapist-patient sexual contact.

(2) A brief description of common personal reactions and histories of victims and victim's families.

(3) A patient's bill of rights.

(4) Options for reporting psychotherapist-patient sexual relations and instructions for each reporting option.

(5) A full description of administrative, civil, and professional associations complaint procedures.

(6) A description of services available for support of victims.

*Id.* § 337.

535. *Id.* § 728(b).

536. *See* CAL. CIV. CODE § 43.93(b)(2) (West Supp. 1990).

ther.<sup>537</sup> If the patient wants the subsequent psychotherapist to file a report and signs a consent to such filing, the subsequent psychotherapist must file within thirty days a report with the agency that licenses the offending psychotherapist or with the district attorney.<sup>538</sup> The report may not contain information about the victim's identity without the victim's written consent.<sup>539</sup> If the department or district attorney receives two or more reports regarding the offending therapist, the department or district attorney may inform the reporting psychotherapists of that fact; then the reporting psychotherapists may inform applicable patients.<sup>540</sup> If a person fails to make a required report, he or she has committed a Class A misdemeanor.<sup>541</sup>

Although the Wisconsin statute leaves initial control with the victim, the statute makes it a subsequent psychotherapist's responsibility to report prior therapist contact if the victim grants written permission.<sup>542</sup> This provision will break any "conspiracy of silence" while protecting patients from embarrassing disclosure. Although California offers a superior education program, its statute does not create an affirmative duty on the part of the victim to request a report.

### 3. *Inconsistency in Application*

One major disadvantage of board regulation is that authority over psychotherapists is often fractured and inconsistent. Such different classes of psychotherapists as social workers, psychologists, family and marriage counselors, and psychiatrists have differing regulations.<sup>543</sup> Each board maintains control over the group it licenses. Although some well-funded boards can aggressively pursue cases, other boards have backlogs of several years.<sup>544</sup> Because differing boards in a given state handle complaints differently, approaches and outcomes vary from state to state.

Florida provides a classic case in which the fracturing of authority results in great inconsistencies. Florida licenses both

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537. See WIS. STAT. ANN. § 940.22(3)(a).

538. *Id.* § 940.22(3)(b).

539. *Id.* §§ 940.22(3)(c), (4)(a).

540. Interestingly, a reporting therapist may tell his patient but is not required to do so. *Id.* § 940.22(4)(b)(1)-(4).

541. *Id.* § 940.22(3)(d).

542. *Id.* § 940.22(3)(a).

543. See *supra* note 531 (discussing Minnesota mandatory reporting requirements vis-a-vis different professional boards).

544. See CALIFORNIA, REPORT OF TASK FORCE, *supra* note 156, at 22.

physicians and psychologists.<sup>545</sup> If a *psychiatrist* engages in sexual misconduct with a patient *the day after* termination of treatment, he does not violate any medical disciplinary rules.<sup>546</sup> If a Florida *psychologist* engages in sexual misconduct with a patient *twenty years after* the psychologist-patient relationship terminated, the psychologist violates the disciplinary rules of the psychology board, and the recommended penalty is a \$1,000 fine and license revocation.<sup>547</sup>

### C. Summary

Although administrative statutes are no panacea, they form one of the quickest, most effective means of dealing with psychotherapist misconduct. Fines, loss of license, severe financial penalties, and criminal sanctions can have a marked deterrent effect. Cases show that unlicensed psychotherapists sexually exploit their patients;<sup>548</sup> however, regulating these unlicensed psychotherapists remains a difficult problem. Licensing can bring drug, alcohol, marital, and family counselors, as well as other groups, under regulation. Simply prohibiting the use of the titles

545. See FLA. ADMIN. CODE ANN. r. 21R-19.002(13), r. 21U-18.003(1)(k) (1990).

546. *Id.* r. 21R-19.002(13) ("If the sexual relationship develops outside the physician's professional practice, no penalty; otherwise fine up to \$5,000 and probation to six months suspension.").

547. *Id.* r. 21U-18.003(1)(k) (disciplinary guidelines prohibit "[c]ommitting any act upon a patient or client which would constitute sexual battery or which would constitute sexual misconduct as defined in Section 490.0111 F[lorida] S[tatutes]. The usual recommended penalty shall be an administrative fine of \$1,000 and revocation"). The Board of Psychological Examiners in Florida provides:

In accordance with the intent of Chapter 490, Florida Statutes, to preserve the health, safety and welfare of the public, sexual misconduct as defined herein is prohibited. The Board finds that the effects of the psychologist-client relationship are powerful and subtle and that clients are influenced consciously and subconsciously by the unequal distribution of power inherent in such relationships. Furthermore, the Board finds that the effects of the psychologist-client relationship endure after psychological services cease to be rendered. Therefore, the client shall be presumed incapable of giving valid, informed, free consent to sexual activity involving the psychologist and the assertion of consent by the client shall not constitute a defense against charges of sexual misconduct . . . .

For purposes of determining the existence of sexual misconduct

. . . .

. . . the psychologist-client relationship is deemed to continue *in perpetuity*.

*Id.* r. 21U-15.004(1) & (5)(a) (emphasis added).

548. See Kuchan, *Survey of Incidence of Psychotherapists' Sexual Contact with Clients in Wisconsin*, in G. SCHOENER & J. MILGROM, *supra* note 1, at 51-64 (reports the results of a Wisconsin study on sexual misconduct by therapists, including unlicensed therapists).

"psychotherapist" and "psychotherapy" by unlicensed practitioners may provide a useful measure of public protection.

Deciding whether to require a therapist to report abuse by a patient's former therapist is perhaps the most difficult issue that these cases raise. Unless the patient consents to the therapist's decision to report, the danger of her further injury is very real. Yet, without mandatory reporting, malpracticing therapists may harm future patients.

## VI. CONCLUSION

This Article surveyed and analyzed the problem of psychotherapist-patient sexual exploitation and the remedies available to direct and secondary victims of abuse. Therapists' sexual abuse of clients is a major problem both in terms of numbers and impact on the lives of those exploited. Conservative estimates indicate that approximately ten percent of psychiatrists and psychologists exploit their patients.<sup>549</sup> There is, however, limited available data on the incidence of sexual abuse among unlicensed psychotherapists.<sup>550</sup> The number of victims of these unlicensed practitioners is likely high. Victims of psychotherapist exploitation suffer great personal injury, often requiring hospitalization. Serious psychological disorders result from the abuse; many suffer the same symptoms as rape and incest victims. The families and loved ones of sexually exploited patients also suffer loss of companionship, humiliation, and monetary damages.

In recognition of the terrible toll created by unscrupulous therapists, many jurisdictions have altered their handling of these cases. Civil negligence claims still constitute the lion's share of claims that victims bring. Currently, victims of sexual abuse have up to four avenues of redress: criminal complaints, common law civil actions, statutory civil actions, and professional board complaints.<sup>551</sup>

Seven states have passed criminal statutes aimed specifically at psychotherapists, and six of these statutes include unlicensed therapists within their scope.<sup>552</sup> These statutes preclude consent as a defense and shift the focus to therapists' fiduciary duty to avoid taking advantage of their position for sexual gratification—

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549. See *supra* notes 53-68 and accompanying text.

550. See *supra* note 548.

551. See *supra* notes 126-383, 386-462, 470-522 and accompanying text.

552. See *supra* notes 156-64, 187-90 and accompanying text.

perhaps the most important improvement over the common law rape or sexual assault statutes now in effect.<sup>553</sup>

The criminal model does have disadvantages. First, the burden of proof is extremely difficult for an abused client to meet. Second, states designed the criminal proceedings not to compensate the victim, but only to punish the accused. Third, the scope of prohibited behavior under the current statutes is very narrow. Indeed, sexualized behavior that does not reach the point of intercourse or sexual contact is not prohibited. Finally, criminalization of this conduct allows most insurers to deny malpractice coverage, which sometimes precludes the victim from recovering monetary damages for her injuries.

Under civil common law actions, courts and juries are most likely to find sexualized, as well as sexual, contact abusive. The common law covers the widest variety of situations and plaintiffs. Not only can direct victims of sexual exploitation recover for injuries sustained due to the relationship, but secondary victims, such as spouses, also may recover. Additionally, the common law may provide for employer liability. Proving that sexual relations fall below the standard of care required for a therapist, however, may be difficult, especially with respect to marginal or "alternative" forms of therapy.

Other weaknesses also exist. First, courts often consider consent a defense to the action, despite the universal prohibition by the major therapeutic organizations. Second, no common law victim shield prevents the defendant from parading the plaintiff's past sexual history before the courtroom, thus further victimizing her. Finally, the actions of an abusive therapist often render a patient incapable of coming forward to press a claim until after the statute of limitations has run.

To rectify some of these concerns, four states have passed civil statutes making sexual exploitation of patients malpractice *per se*.<sup>554</sup> These civil statutes are advantageous over the common law because they establish the wrongfulness of the behavior, thus obviating the plaintiff's burden to establish a standard of care. Some of these states also have lengthened the statute of limitations and included a victim shield law.<sup>555</sup> All of the statutes include former patients within their scope.<sup>556</sup>

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553. See *supra* notes 212-49 and accompanying text.

554. See *supra* notes 388-96 and accompanying text.

555. See *supra* notes 427-38, 456-60 and accompanying text.

556. See *supra* notes 414-26 and accompanying text.

Nevertheless, the civil statutes also have drawbacks. First, these statutes have unnecessarily restricted the scope of coverage by adopting their criminal codes' definitions of "sexual contact." Second, the question whether the statutory civil remedies are exclusive of or cumulative with common law remedies remains unanswered. If the statutes are exclusive, then they divest indirect victims of sexual exploitation of remedies for legitimate grievances.

Administrative statutes are the most flexible, and sometimes the most effective, remedy. An administrative board has wide latitude to control the actions of its members. Its power of license suspension and revocation can be a formidable weapon against registered or licensed therapists. The rules of evidence generally do not apply as stringently to administrative board proceedings, and most boards have no statute of limitations.

Although board regulation can be the most effective means of stopping sexually exploitative therapists, it can also be the worst. Boards can regulate and scrutinize only their members, thus excluding unlicensed therapists from review.<sup>557</sup> In addition, a board's effectiveness depends on its jurisdiction and composition. Many boards are professional and ambitious and will attempt to rid their professions of substandard practitioners; but others, akin to the proverbial fox guarding the chicken coop, are incapable of overcoming the conflict of interest inherent in this form of self-regulation and are thus unlikely to prosecute their colleagues. Furthermore, many states have more than one board governing psychotherapists, which results in fractured authority and inconsistencies.

For all of the new enactments and differing solutions to this problem, no one approach clearly suffices to protect society and victims from exploitative therapists or to compensate all victims for their injuries. To be truly effective, each jurisdiction should combine criminal, civil, and administrative remedies. In addition, states should more closely synchronize board regulations among the states and especially within each state. They should give special attention to the plight of former patients and possibly to expanding the statute of limitations.

All jurisdictions face the issue of therapist-patient sexual abuse in one form or another. This area of the law is expanding as public sensitivity to the problem increases. Unfortunately, the

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557. Some states have attempted to close this loophole, most notably Minnesota, Colorado, and Florida. See *supra* note 472.



law's growth merely reflects a growth in the number of patients injured by sexual abuse. The development of a comprehensive legal scheme, coupled with professional and consumer education, is crucial to amelioration of the problem.<sup>558</sup>

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558. In Massachusetts, State Rep. Barbara Gardner, chairperson of a special committee on the sexual misconduct of physicians, therapists, and other related health care professionals, divided the work on the special committee into education, civil/criminal statutes, victims, professional associations, and board subcommittees. Each subcommittee is co-chaired by a member of the House of Representatives. This organizational structure should produce coherent, well-organized legislation. *Meeting of Special Subcommittee of the House, Physician/Therapist Misconduct*, Commonwealth of Mass., House of Rep. (May 25, 1989). Task forces in Minnesota and California have reiterated the same goals. See CALIFORNIA, REPORT OF TASK FORCE, *supra* note 156, at 8-37; MINNESOTA, REPORT OF TASK FORCE, *supra* note 156, at 15-42.