

SEXUAL MISCONDUCT BY PSYCHOTHERAPISTS: LEGAL OPTIONS AVAILABLE TO VICTIMS AND A PROPOSAL FOR CHANGE IN CRIMINAL LEGISLATION

A woman suffering from low self-esteem, compulsive disorders, premenstrual syndrome and suicidal tendencies consults a therapist. The woman has difficulty discussing sexual issues, but the therapist pressures her, telling her that he wants to "work" with her on her sexuality and that sex is a gift from God. The therapist then suggests that the woman's problems may be attributable to her husband and discourages her from confiding in friends.

After several months of counseling, the therapist and patient begin to hug and kiss during the therapy sessions. The woman questions the therapist as to whether this physical contact is "normal counseling." The therapist simply replies that he loves her. When the woman requests a platonic relationship, the therapist presents her with a rose and assures her that their relationship will remain pure and chaste. Yet within months, the two have engaged in sexual intercourse at a local motel. In one of the thirty-two cards and letters the woman wrote to the therapist, she stated, "I, the undersigned, have given [the therapist] control of my life—my future out of my abiding love for him."¹

National surveys reveal that up to 12.1% of male psychotherapists may be sexually intimate with their patients.² Commentators speculate that sexual relations between therapists and patients may be more prevalent than studies reveal, due to a reluctance by therapists to admit to such behavior.³ The American Psychological As-

¹ The facts of this scenario were derived from the case of *State v. Dutton*, 450 N.W.2d 189, 191-92 (Minn. Ct. App. 1990).

² KENNETH S. POPE & JACQUELINE BOUHOUTSOS, *SEXUAL INTIMACY BETWEEN THERAPISTS AND PATIENTS* at v (1986).

³ See SOHAN LAL SHARMA, *THE THERAPEUTIC DIALOGUE* 235 (1986). Most therapists recognize such behavior as unethical and may fear legal action. See *id.* In addition, the number of complaints filed with ethics committees, licensing boards and the courts probably do not accurately represent the prevalence of therapist-patient sexual contact. Kenneth S. Pope, *Research and Laws Regarding Therapist-Patient Sexual Involvement: Implications for Therapists*, 40 AM. J. PSYCHOTHERAPY 564, 566 (1986). Complaints are rarely filed for a number of reasons. The patient's feelings of powerlessness, guilt or mistrust may prevent her from filing a complaint. Jacqueline Bouhoutsos, *Therapist-Client Sexual Involvement: A Challenge for Mental Health Professionals and Educators*, 55 AM. J. ORTHOPSYCHIATRY 177, 179 (1985). Patients may also fear publicity. *Id.* Moreover, some patients do not file complaints because they have not

sociation and the American Psychiatric Association have stated that any sexual contact between psychotherapists and their patients is unethical and harmful to patients.⁴ Patients who have engaged in sexual relationships with their therapists experience severe emotional trauma, sometimes resulting in hospitalization or attempted suicide.⁵

Both the psychotherapeutic and legal communities have engaged in research and discussion on the most effective way to combat this problem.⁶ Psychotherapeutic professionals have recommended better training for therapists and consumer education for patients.⁷ Courts and legislatures have created civil causes of action for plaintiffs.⁸ Many courts have held that psychotherapists who engage in sexual conduct with their patients are liable for malpractice based upon mishandling of the therapeutic phenomenon known as "transference."⁹ Juries have awarded sexually exploited patients millions of dollars in compensatory and punitive damages.¹⁰ In addition, most courts require the therapist's malpractice insurance company to defend the therapist in the civil suit or pay the patient's damage award, depending upon the terms of the malpractice policy.¹¹

More recently, several states have passed strict statutes criminalizing this behavior.¹² Prior to the enactment of these statutes,

completely resolved their feelings of transference and do not want to cause the therapist any pain. *Id.*

⁴ See Jean Corey Holroyd & Annette M. Brodsky, *Psychologists' Attitudes and Practices Regarding Erotic and Nonerotic Physical Contact with Patients*, 32 AM. PSYCHOLOGIST 843, 843 (1977).

⁵ Bouhoutsos, *supra* note 3, at 178; Jacqueline Bouhoutsos et al., *Sexual Intimacy Between Psychotherapists and Patients*, 14 PROF. PSYCHOL.: RES. & PRAC. 185, 190-91 (1983).

⁶ See, e.g., Bouhoutsos, *supra* note 3, at 177; Kenneth S. Pope, *Preventing Therapist-Patient Sexual Intimacy: Therapy for a Therapist at Risk*, 18 PROF. PSYCH.: RES. & PRAC. 624, 627 (1987).

⁷ See Pope, *supra* note 6, at 625; POPE & BOUHOUTSOS, *supra* note 2, at 151-55.

⁸ See, e.g., MINN. STAT. ANN. § 148A.02 (West 1989) (creating a civil cause of action for sexual exploitation by a psychotherapist); *Roy v. Hartogs*, 381 N.Y.S.2d 587, 588 (N.Y. App. Div. 1976) (allowing a malpractice action against a sexually exploitative psychiatrist).

⁹ See, e.g., *St. Paul Fire & Marine Ins. Co. v. Love*, 459 N.W.2d 698, 702 (Minn. 1990) (sexual activity resulting from the mishandling of the transference phenomenon is malpractice); *Zipkin v. Freeman*, 436 S.W.2d 753, 761 (Mo. 1968) (same); *L.L. v. Medical Protective Co.*, 362 N.W.2d 174, 178 (Wis. Ct. App. 1984) (same).

¹⁰ Pope, *supra* note 3, at 565.

¹¹ See, e.g., *Love*, 459 N.W.2d at 702; *Zipkin*, 436 S.W.2d at 761; *Medical Protective*, 362 N.W.2d at 463.

¹² See CAL. CRIM. CODE § 729 (West 1990); COLO. REV. STAT. § 18-3-405.5 (1986); 1990 FLA. LAWS ch. 70; ME. REV. STAT. ANN. tit. 17-A, § 253 (West Supp. 1990); MINN. STAT. ANN. §§ 609.344, 609.345 (West Supp. 1991); N.D. CENT. CODE § 12.1-20-06.1 (Supp. 1989); WIS. STAT. ANN. § 940.22 (West Supp. 1990).

therapists who engaged in sexual contact with their patients could only be prosecuted for rape or sexual assault.¹³ These statutes, however, criminalize a broad range of sexual contact.¹⁴ Furthermore, because the statutes eliminate consent as a defense for the therapist, states can prosecute these therapists more easily.¹⁵

This note examines the problem of sexual misconduct by psychotherapists and discusses both civil and criminal remedies available to victims. Section I defines the problem and explores how sexual relationships between therapists and patients arise and why they are harmful to the patients.¹⁶ Section II traces the development of the different administrative and civil causes of action available to victims of sexual misconduct.¹⁷ This section also discusses how insurance companies have responded to lawsuits from patients.¹⁸ Section II also examines the recently enacted criminal statutes that criminalize sexual contact between therapists and patients.¹⁹ This section discusses the range of behavior that the statutes cover and the controversy surrounding the elimination of consent as a defense.²⁰ Finally, Section III examines the sufficiency of various legal remedies to combat sexual misconduct and concludes that although the criminal legislation enacted by most states provides some benefits to victims of sexual misconduct, the criminal statutes are generally too broad and legislatures could better serve psychotherapeutic professionals, their victims and the general public by revising the statutes to fulfill additional goals.²¹

I. THERAPIST-PATIENT SEX: CAUSES AND EFFECTS

In recent years, both the general public and the psychotherapeutic professional community have become increasingly concerned with the growing problem of therapist-patient sexual exploitation.²²

¹³ See, e.g., *Bernstein v. Board of Medical Examiners*, 22 Cal. Rptr. 419, 420 (Cal. Ct. App. 1962) (prosecution for statutory rape); *Eberhart v. State*, 34 N.E. 637, 637 (Ind. 1893) (prosecution for rape); *State v. Ely*, 194 P. 988, 988 (Wash. 1921) (prosecution for rape).

¹⁴ See, e.g., CAL. BUS. & PROF. CODE § 729 (West 1990) (prohibited sexual contact includes touching of any intimate part); WIS. STAT. ANN. §§ 940.22 (5), 940.225 (5)(b) (West Supp. 1990) (prohibited sexual contact includes any intentional touching).

¹⁵ See, e.g., CAL. BUS. & PROF. CODE § 729 (West 1990); COLO. REV. STAT. § 18-3-405.5 (1986); WIS. STAT. ANN. § 940.22 (West Supp. 1990).

¹⁶ See *infra* notes 22-79 and accompanying text.

¹⁷ See *infra* notes 80-185 and accompanying text.

¹⁸ See *infra* notes 186-252 and accompanying text.

¹⁹ See *infra* notes 253-300 and accompanying text.

²⁰ See *infra* notes 262-74 and accompanying text.

²¹ See *infra* notes 301-27 and accompanying text.

²² See Pope, *supra* note 3, at 564; Bouhoutsos et al., *supra* note 5, at 185.

In one survey, 7.1% of male psychiatrists and 3.1% of female psychiatrists acknowledged having sexual contact with their patients.²³ A survey of psychologists found that 9.4% of male therapists and 2.5% of female therapists engaged in sexual intimacies with patients.²⁴ The overwhelming majority of these sexual relationships occur between male therapists and their female patients.²⁵ Almost all therapists agree that such sexual contact is unethical and usually harmful to the patient.²⁶

In examining this problem, one must consider the context in which the sexual activity arises. The frailty of both the therapist and the patient, combined with the dynamics of the therapeutic relationship itself, provide a foundation for the problem.²⁷ Individuals seek therapy for a wide variety of reasons, ranging from minor neurotic conflicts to major cognitive, affective or organic disorders.²⁸ Some patients have a history of psychiatric illness or substance

²³ Nanette Gartrell, *Psychiatrist-Patient Sexual Contact: Results of a National Survey, I: Prevalence*, 143 AM. J. PSYCHIATRY 1126, 1126 (1986). Different surveys may present varying statistics. See, e.g., POPE & BOUHOUTSOS, *supra* note 2, at v.

²⁴ Kenneth S. Pope et al., *Sexual Attraction to Clients*, 41 AM. PSYCHOLOGIST 147, 152 (1986). Again, different surveys may present varying statistics. See, e.g., Holroyd & Brodsky, *supra* note 4, at 843 (5.5% of male psychologists and 0.6% of female psychologists reported engaging in sexual intercourse with patients). According to this survey, an additional 2.6% of male therapists engaged in sexual intercourse with their patients within three months subsequent to the termination of therapy. *Id.*

²⁵ SHARMA, *supra* note 3, at 237-38; see also *St. Paul Fire & Marine Ins. Co. v. Love*, 459 N.W.2d 698, 700 n.1 (Minn. 1990). For this reason, this note will refer to the therapists as males and the patients as females. In rare instances, a sexual relationship may occur between a female therapist and a male patient. See, e.g., *Johnson v. Arkansas Bd. of Examiners in Psychology*, 808 S.W.2d 766, 767-68 (Ark. 1991) (female psychologist appealed board decision to suspend license because of sexual relationship with male patient); *Weaver v. Union Carbide Corp.*, 378 S.E.2d 105, 106 (W. Va. 1989) (wife sued female counselor for engaging in intimate relations with husband-patient). Sexual contact has also occurred between therapists and patients of the same sex. See, e.g., *State v. Leiding*, 812 P.2d 797, 801 (N.M. Ct. App. 1991) (Bivens, J., specially concurring).

²⁶ See Judith Lewis Herman et al., *Psychiatrist-Patient Sexual Contact: Results of a National Survey, II: Psychiatrists' Attitudes*, 144 AM. J. PSYCHIATRY 164, 165 (1987) (98% of psychiatrists believe sexual contact is always inappropriate and usually harmful to the patient); see also Debra S. Borys & Kenneth S. Pope, *Dual Relationships Between Therapist and Client: A National Study of Psychologists, Psychiatrists, and Social Workers*, 20 PROF. PSYCHOL.: RES. & PRAC. 283, 289 (1989) (98.3% of psychiatrists, psychologists and social workers believe sexual contact with patients is never ethical); Holroyd & Brodsky, *supra* note 4, at 845 (only 4% of psychologists thought erotic contact might ever be beneficial to the opposite sex patient).

²⁷ See Roberta J. Apfel & Bennett Simon, *Patient-Therapist Sexual Contact*, 43 PSYCHOTHERAPY & PSYCHOSOMATICS 57, 57 (1985). Commentators have suggested that these factors and others make elimination of the problem unlikely. *Id.* For a general discussion of vulnerabilities of patients and potential "risk groups," see POPE & BOUHOUTSOS, *supra* note 2, at 46-56.

²⁸ Pope, *supra* note 3, at 567.

abuse.²⁹ Others have experienced childhood incest or sexual abuse.³⁰

Patients who have histories of sexual abuse are particularly vulnerable to sexual exploitation by their therapists.³¹ Such sexual abuse often results in serious difficulties with interpersonal relationships, for which the patients seek help.³² A patient who has been a victim of childhood sexual abuse may experience the same fears in therapy that she experienced as a child—that she cannot survive without the parent's or therapist's love and protection.³³ Because of the dynamics of the original abusive relationship, the patient is particularly vulnerable to exploitation.³⁴ She will assume the blame for the sexual activity and will reenact the patterns of secrecy learned in childhood.³⁵ Thus, as the patient attempts to resolve her own emotional childhood trauma, she is particularly vulnerable to exploitation.

The therapeutic relationship itself also contributes to the patient's vulnerability.³⁶ The patient who enters therapy places much trust in the therapist and reveals her thoughts and fantasies in hopes of attaining relief from her discomfort.³⁷ Because of this trust, she may believe that the therapist will only act to help her, and therefore she may become confused by the therapist's sexual advances and let down her customary defenses.³⁸

²⁹ See, e.g., *St. Paul Fire & Marine Ins. Co. v. D.H.L.*, 459 N.W.2d 704, 705 (Minn. 1990) (patient had drug abuse problem); *Marston v. Minneapolis Clinic of Psychiatry*, 329 N.W.2d 306, 308 (Minn. 1982) (patient severely depressed and chemically dependent); *Olson v. Connerly*, 457 N.W.2d 479, 480 n.1 (Wis. 1990) (patient treated for alcohol and drug dependency for years); see also *Bouhoutsos*, *supra* note 3, at 178.

³⁰ See, e.g., *St. Paul Fire & Marine Ins. Co. v. Love*, 459 N.W.2d 698, 699 (Minn. 1990) (patient sexually abused as child); *D.H.L.*, 459 N.W.2d at 705 (patient sexually abused as child); *Olson*, 457 N.W.2d at 480 n.1 (patient sexually abused and raped as a child); see also *POPE & BOUHOUTSOS*, *supra* note 2, at 53–54.

³¹ See *POPE & BOUHOUTSOS*, *supra* note 2, at 53–54.

³² See *id.* at 54 (patients with a history of abuse frequently are diagnosed as having histrionic or borderline personality disorder). See generally Thomas J. Gutheil, *Borderline Personality Disorder, Boundary Violations, and Patient-Therapist Sex: Medicolegal Pitfalls*, 146 *AM. J. PSYCHIATRY* 567 (1989) (discussing borderline personality disorder and its relation to therapist-patient sex).

³³ *POPE & BOUHOUTSOS*, *supra* note 2, at 53.

³⁴ See *id.*

³⁵ See *id.*

³⁶ See *id.* at 46.

³⁷ *Id.*

³⁸ See, e.g., *id.* (therapist promises confidentiality, concern and help in return for patient's trust); see also *Marston v. Minneapolis Clinic of Psychiatry*, 329 N.W.2d 306, 308 (Minn. 1982) (patient testified that she became "quite upset and confused" because of the trust she placed in her psychologist).

Furthermore, there is an unequal distribution of power in the therapeutic relationship, which favors the therapist by increasing the patient's vulnerability.³⁹ The patient's desperate need to end her discomfort and her belief in her therapist's knowledge may "purvey this power differential and color the therapeutic interchange."⁴⁰ Some patients submit to the therapist's sexual advances because of their perception of the therapist's status and authority.⁴¹ Furthermore, some patients acquiesce to their therapist's sexual advances out of a fear that the therapist might abandon them by terminating therapy.⁴² The unequal distribution of power in the therapeutic relationship is yet another factor that creates a particular vulnerability in the patient and underlies the problem of sexual misconduct as a whole.

Most sexual relationships between therapists and patients arise from the "transference phenomenon."⁴³ Transference is the emotional reaction that the patient experiences toward the therapist during therapy.⁴⁴ The patient may develop an extreme emotional dependence on the therapist, projecting onto the therapist feelings of love or need that remain unresolved from prior relationships.⁴⁵ Some patients develop erotic feelings or fantasies toward the therapist.⁴⁶ In some instances, the patient may become seductive toward the therapist in an attempt to resolve these feelings.⁴⁷ Other patients report warm and trustful feelings, which some therapists may interpret as sexual in nature.⁴⁸ Sigmund Freud likened transference

³⁹ See POPE & BOUHOUTSOS, *supra* note 2, at 46.

⁴⁰ *Id.*

⁴¹ Bouhoutsos, *supra* note 3, at 178.

⁴² See *Doe v. Samaritan Counseling Center*, 791 P.2d 344, 345 (Alaska 1990); *Morris v. Board of Registration in Medicine*, 539 N.E.2d 50, 51 (Mass.), *cert. denied*, 493 U.S. 977 (1989); see also Bouhoutsos, *supra* note 3, at 178.

⁴³ Pope et al., *supra* note 24, at 148-50. In at least one case, however, a court has stated that sexual relationships between therapists and patients may not always grow out of the transference phenomenon. See *St. Paul Fire & Marine Ins. Co. v. Love*, 459 N.W.2d 698, 702 (Minn. 1990). Because the therapist often plays an active role in instigating the sexual contact, his personal needs and motivations may be a large contributor. See SHARMA, *supra* note 3, at 235.

⁴⁴ See SHARMA, *supra* note 3, at 179-218. Transference is considered a basic part of psychoanalysis and was discussed extensively by Freud. See *id.* at 180-82; see also *L.L. v. Medical Protective Co.*, 362 N.W.2d 174, 177 (Wis. Ct. App. 1984).

⁴⁵ See *Medical Protective Co.*, 362 N.W.2d at 177. These feelings may have been originally directed toward the client's parents or significant others. SHARMA, *supra* note 3, at 179.

⁴⁶ SHARMA, *supra* note 3, at 200.

⁴⁷ *Id.* at 238. In one case, the patient began asking personal questions of the therapist and became flirtatious, stating, "I felt that he liked me, so I felt that I had to be sexual." *Love*, 459 N.W.2d at 699.

⁴⁸ See SHARMA, *supra* note 3, at 201-02.

to "falling in love," which is induced by the therapeutic situation rather than by the personality or character of the individual therapist.⁴⁹

In healthy therapeutic relationships, the therapist uses transference to aid the patient in resolving her feelings arising from past unsettled relationships.⁵⁰ The therapist explains to the patient that a patient commonly develops feelings toward the therapist during psychotherapy and encourages the patient to discuss these feelings, helping her to relate them to interpersonal relationships in her own life.⁵¹ During the normal course of therapy, the therapist should maintain a neutral emotional position while still demonstrating interest and concern.⁵² In many therapeutic relationships, however, therapists will react to the patient's growing love and dependence by developing feelings for the patient.⁵³ This "counter-transference" is a reaction to the patient's transference, rather than true feelings for the patient as an individual.⁵⁴ Some of these feelings, such as empathy, warmth and compassion, are necessary to a successful therapeutic relationship.⁵⁵ Other feelings of the therapist, romantic or erotic in nature, can become damaging to the therapeutic relationship, if not handled properly.⁵⁶ The less counter-transference the therapist develops, the more effective the therapist will be in aiding the patient in resolving her feelings of transference because the therapist's own emotions will not intrude upon his assessment of the patient.⁵⁷

⁴⁹ POPE & BOUHOUTSOS, *supra* note 2, at 29; Pope et al., *supra* note 24, at 149 (citing FREUD, *Further Recommendations in the Technique of Psychoanalysis: Observations on Transference-Love*, in FREUD: THERAPY AND TECHNIQUE 167, 169 (P. Rieff ed. 1915).

⁵⁰ See SHARMA, *supra* note 3, at 208-11.

⁵¹ *Id.* at 214. For example, the therapist might say, "Being aware of your feelings will help you work out some of the important and conflicting emotions in your interpersonal relationships. Recognizing the feelings that you have toward me is a step in your ability to feel and to relate to other people." *Id.*

⁵² *Id.* at 211.

⁵³ *Id.* at 223.

⁵⁴ Pope et al., *supra* note 24, at 149.

⁵⁵ SHARMA, *supra* note 3, at 223.

⁵⁶ *Id.* at 233-34. Professionals have differing views regarding the counter-transference phenomenon. Pope et al., *supra* note 24, at 149. Some authorities view the therapist's attraction to the client as "a therapeutic error, something to hide and be ashamed of." *Id.* Others feel that when counter-transference is correctly managed it can be a "valuable therapeutic resource." *Id.* In either case, counter-transference is a widespread phenomenon based on the high percentage of therapists who have reported feeling attracted to their patients at some point during practice. See *id.* at 155.

⁵⁷ SHARMA, *supra* note 3, at 211.

Thus, if the therapist is professional in his handling of the transference phenomenon, he is less apt to act sexually upon his feelings of counter-transference.⁵⁸ Instead, he will recognize and resolve these feelings, either by himself or with another professional.⁵⁹ The therapist mishandles the transference phenomenon, however, when he acts upon his personal needs and motivations, and enters into a sexual relationship with the patient.⁶⁰

Almost all patients who have been victims of sexual misconduct by their psychotherapists sustain some type of damage.⁶¹ Patients have reported severe emotional harm such as humiliation, mental anguish, shock, shame, depression and general deterioration of emotional well-being.⁶² Many sexually exploited patients suffer from post-traumatic stress disorder.⁶³ Patients often suffer marital difficulties or break-ups.⁶⁴ Due to the emotional trauma, many patients require subsequent medical treatment, including both therapy and hospitalization.⁶⁵ In one case, a victim was forced to seek hos-

⁵⁸ See *L.L. v. Medical Protective Co.*, 362 N.W.2d 174, 178 (Wis. Ct. App. 1984).

⁵⁹ SHARMA, *supra* note 3, at 252-53. The most widely accepted method of resolving counter-transference is through the course of supervision with a superior or a peer group. *Id.* at 253. In addition, some professionals recommend discussing counter-transference with the patient as it occurs. *Id.* at 253-54.

⁶⁰ See *Medical Protective Co.*, 362 N.W.2d at 178.

⁶¹ Bouhoutsos, *supra* note 3, at 178; Bouhoutsos et al., *supra* note 5, at 191.

⁶² See *Zipkin v. Freeman*, 436 S.W.2d 753, 755 (Mo. 1968) (patient suffered remorse, humiliation, anguish, nervousness and insomnia); *Corgan v. Muehling*, 522 N.E.2d 153, 154 (Ill. App. Ct. 1988) (patient experienced fear, shame, humiliation and guilt), *aff'd*, 574 N.E.2d 602 (Ill. 1991); *Omer v. Edgren*, 685 P.2d 635, 636 (Wash. Ct. App. 1984). Some researchers have termed these emotional symptoms "Therapist-Patient Sex Syndrome." See POPE & BOUHOUTSOS, *supra* note 2, at 64. The symptoms include ambivalence, guilt, feelings of isolation, feelings of emptiness, cognitive dysfunction, identity and boundary disturbance, inability to trust, sexual confusion, moodiness, suppressed rage and increased suicidal risk. *Id.* These symptoms are the same or similar to those experienced by victims of incest and child abuse. *Id.*

⁶³ POPE & BOUHOUTSOS, *supra* note 2, at 65. Researchers have noted: "Many who are seriously traumatized have literally spent lifetimes undoing the damage [sexual involvement with their therapists] has caused." *Id.* The trauma causes them to be obsessed with the sexual involvement, and they are isolated and unable to seek support or help. *Id.* at 65-66. Furthermore, if they do talk about it, they may be blamed for the involvement by others and revictimized. *Id.* at 66; see also *Olson v. Connerly*, 457 N.W.2d 479, 480 (Wis. 1990) (conflicting testimony as to whether patient sustained Post-Traumatic Stress Disorder).

⁶⁴ See, e.g., *Anclote Manor Found. v. Wilkinson*, 263 So. 2d 256, 257 (Fla. 1972); *Zipkin*, 436 S.W.2d at 758; *Omer*, 685 P.2d at 636; see also Bouhoutsos et al., *supra* note 5, at 190 (26% of patients' sexual, marital or intimate relationships worsened); Apfel & Simon, *supra* note 27, at 60 (already troubled marriages become worse as a result of sexual involvement).

⁶⁵ See, e.g., *Corgan v. Muehling*, 522 N.E.2d 153, 154 (Ill. App. Ct. 1988) (patient required extensive psychotherapeutic care and counseling), *aff'd*, 574 N.E.2d 602 (Ill. 1991); *Roy v. Hartogs*, 381 N.Y.S.2d 587, 588 (N.Y. App. Div. 1976) (patient sought hospitalization

pitalization on two separate occasions following a thirteen-month sexual relationship with her psychiatrist.⁶⁶ A small percentage of sexually abused patients have even attempted suicide as a result of this abuse.⁶⁷ Some patients also experience physical trauma arising out of the emotional turmoil, such as severe abdominal pain or headaches.⁶⁸

Furthermore, the harm patients suffer may be exacerbated by a reluctance to seek any further therapy due to an inability to trust another therapist.⁶⁹ Some patients may not seek therapy at all or delay the process for many years.⁷⁰ If the patient does attempt to seek therapy, the patient may still reveal an ambivalence towards therapy represented by an inability to choose a new therapist or by frequent changes of therapists.⁷¹ Also, the patient may mistrust the new therapist's judgment and she may fear her story will not be believed.⁷² Finally, if able to commit to a new therapeutic relationship, the patient may be so guarded that she asks for a promise of "no sex" from the new therapist.⁷³ Underlying much of the difficulty in re-entering therapy is the patient's continuing emotional commitment or allegiance to the former therapist.⁷⁴

In sum, patients who enter therapy are vulnerable.⁷⁵ They place their trust and emotional well-being under the care of a profes-

twice); see also Bouhoutsos et al., *supra* note 5, at 190 (11% of patients were hospitalized as a result of sexual involvement with a therapist).

⁶⁶ *Hartogs*, 381 N.Y.S.2d at 588.

⁶⁷ See, e.g., *Simmons v. United States*, 805 F.2d 1363, 1364 (9th Cir. 1986) (patient attempted suicide); *Anclote Manor Found.*, 263 So. 2d at 257 (patient committed suicide after involvement with therapist and other traumatic events); *Pundy v. Department of Professional Regulation*, 570 N.E.2d 458, 461 (Ill. App. Ct. 1991) (patient testified that she attempted suicide); see also Bouhoutsos et al., *supra* note 5, at 190 (one percent of patients committed suicide because of sexual involvement with therapist).

⁶⁸ *Zipkin*, 436 S.W.2d at 755-56 (patient was unable to sleep and had headaches); *Olson v. Connerly*, 445 N.W.2d 706, 712 (Wis. Ct. App. 1989) (patient described extreme abdominal pain connected with recollection of therapist's actions, and "panic attacks" causing inability to breathe, gagging and sweating), *aff'd*, 457 N.W.2d 479, 484 (Wis. 1990).

⁶⁹ See *Zipkin*, 436 S.W.2d at 759. In one survey, almost half of the patients interviewed found it more difficult to recommence therapy with another therapist. See Bouhoutsos et al., *supra* note 5, at 190-91. The more intense the sexual involvement, the greater likelihood that patients have difficulty returning to therapy. *Id.* at 191; see also Apfel & Simon, *supra* note 27, at 58.

⁷⁰ Apfel & Simon, *supra* note 27, at 58; Bouhoutsos et al., *supra* note 5, at 191.

⁷¹ Apfel & Simon, *supra* note 27, at 58; Bouhoutsos et al., *supra* note 5, at 191.

⁷² Apfel & Simon, *supra* note 27, at 58; Bouhoutsos et al., *supra* note 5, at 191.

⁷³ Bouhoutsos et al., *supra* note 5, at 191.

⁷⁴ Apfel & Simon, *supra* note 27, at 58; Bouhoutsos et al., *supra* note 5, at 191.

⁷⁵ See *L.L. v. Medical Protective Co.*, 362 N.W.2d 174, 177 (Wis. Ct. App. 1984) (patient developed extreme emotional dependence on therapist). See generally POPE & BOUHOUTSOS, *supra* note 2, at 46-47.

sional.⁷⁶ The patient may begin to experience transference and develop an emotional dependence on the therapist.⁷⁷ The proper handling of the patient's transference can lead to a resolution of emotional conflicts and relief of the patient's distress.⁷⁸ If, however, the therapist mishandles the transference and enters into a sexual relationship with the patient, the patient's trust is violated, the care is jeopardized and the patient is likely to suffer severe emotional or physical trauma.⁷⁹

II. LEGAL RESPONSES TO SEXUAL MISCONDUCT BY PSYCHOTHERAPISTS

A. *Administrative Remedies*

Victims of sexual misconduct can seek redress through several different administrative mechanisms.⁸⁰ Depending on what victims seek as compensation, they may choose to act through either a professional association or licensing board.⁸¹ Commentators recognize these methods as having varying degrees of efficiency and effectiveness.⁸²

Professional associations are voluntary organizations of professional practitioners that exist at local, state or national levels.⁸³ Nationally, such professional organizations include the American Psychiatric Association, the American Psychological Association and the National Association of Social Workers.⁸⁴ In order to file an ethics complaint with a professional organization, the complainant typically must complete a form for an investigatory subcommittee, describing the particular ethical principles violated by the therapist.⁸⁵

⁷⁶ See *Medical Protective Co.*, 362 N.W.2d at 177; see also POPE & BOUHOUTSOS, *supra* note 2, at 46.

⁷⁷ See *Medical Protective Co.*, 362 N.W.2d at 177.

⁷⁸ See SHARMA, *supra* note 3, at 208.

⁷⁹ See *Medical Protective Co.*, 362 N.W.2d at 177-78; Bouhoutsos et al., *supra* note 5, at 191.

⁸⁰ See Leonard L. Riskin, *Sexual Relations Between Psychotherapists and their Patients: Toward Research or Restraint*, 67 CAL. L. REV. 1000, 1006-08 (1979); Stone, *The Legal Implications of Sexual Activity Between Psychiatrist and Patient*, 133 AM. J. PSYCHIATRY 1138, 1138 (1976).

⁸¹ See POPE & BOUHOUTSOS, *supra* note 2, at 155-59.

⁸² See *id.* at 157-59.

⁸³ See *id.* at 155-56.

⁸⁴ See *id.* at 30-31.

⁸⁵ *Id.* at 156. The major mental health professional organizations, including the American Psychiatric Association, the American Psychological Association, the National Association of Social Workers, the American Psychoanalytic Association and the American Association for Marriage and Family Therapy have revised their ethics codes to explicitly prohibit

After a subcommittee has reviewed evidence from both sides, it makes a recommendation to an entire ethics committee.⁸⁶ The ethics committee and ultimately the board of directors vote on the disposition of the case.⁸⁷ Possible penalties include expulsion from the organization, probation, surveillance or a required apology.⁸⁸

Commentators have stated that professional associations may not be the most effective method of resolving the problem of therapist sexual misconduct.⁸⁹ These associations, beyond threatening expulsion, have little authority to act regarding the problem of sexual exploitation by therapists.⁹⁰ Furthermore, these organizations have no control over practitioners who are not members and who are therefore not bound by the association's code of ethics.⁹¹ In addition, few victims choose to file complaints through professional associations, perhaps because of the complexity of the complaint filing system.⁹² Other patients may feel that an implicit bias exists in the process, because the ethics committees are composed of other psychotherapeutic professionals.⁹³

Patients may also choose to file a complaint through the local licensing board.⁹⁴ These boards, granted authority by state governments to oversee licensed professionals and thereby to protect consumers, may revoke the professional's license to practice.⁹⁵ Psychiatrists are generally under the jurisdiction of a medical board,

therapist-patient sexual contact. *Id.* at 30-31. For example, the code of the American Psychiatric Society states, "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. Sexual activity with a patient is unethical." *Id.* at 31.

⁸⁶ *Id.* at 156.

⁸⁷ *Id.*

⁸⁸ See, e.g., MASSACHUSETTS PSYCHOLOGICAL ASSOCIATION GUIDELINES FOR THE OPERATION OF THE STATE PSYCHOLOGICAL ASSOCIATION ETHICS COMMITTEE, Section VII (6); see also POPE & BOUHOUTSOS, *supra* note 2, at 156.

⁸⁹ See Pope & Bouhoutsos, *supra* note 2, at 157.

⁹⁰ See *id.* at 155; Stone, *supra* note 80, at 1140.

⁹¹ POPE & BOUHOUTSOS, *supra* note 2, at 155-56.

⁹² *Id.* at 157.

⁹³ *Id.*

⁹⁴ *Id.* at 158; Stone, *supra* note 80, at 1140-41; see, e.g., Solloway v. Department of Professional Regulation, 421 So. 2d 573, 573-74 (Fla. Dist. Ct. App. 1982) (psychiatrist appealed revocation of license by Department of Professional Regulation, Board of Medical Examiners for sexual exploitation), *rev. denied*, 430 So. 2d 452 (Fla. 1983); Morris v. Board of Registration in Medicine, 539 N.E.2d 50, 50 (Mass.) (psychiatrist appealed revocation of license by Board of Registration in Medicine for sexual misconduct), *cert. denied*, 493 U.S. 977 (1989).

⁹⁵ See POPE & BOUHOUTSOS, *supra* note 2, at 158.

whereas psychologists and other counselors are under the jurisdiction of either a medical or other professional licensing board.⁹⁶

In a typical complaint procedure, the complainant must first complete a form identifying all of the descriptive information, such as relevant dates and the name of the perpetrator.⁹⁷ The licensing board staff determines whether to forward the complaint to the board's investigatory unit or the attorney general's office.⁹⁸ The board then receives a preliminary investigative report and decides whether to close the case or file a formal complaint.⁹⁹ Eventually, if the case cannot be settled, an administrative law judge will hear the case.¹⁰⁰ After the administrative law judge renders his or her decision, the board must either accept or reject that decision.¹⁰¹ If the therapist is found guilty, the board may then take some disciplinary action, possibly the revocation or suspension of the practitioner's license.¹⁰² The decisions of licensing boards are final and often withstand challenges in court.¹⁰³

A patient who has been sexually exploited by her therapist can opt for administrative remedies.¹⁰⁴ Commentators, however, note that these alternatives have many disadvantages and inadequa-

⁹⁶ *Id.*

⁹⁷ *Id.* at 161.

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ *Id.* at 162.

¹⁰¹ *Id.*

¹⁰² *Id.* See, e.g., Board of Registration of Psychologists, 251 Mass. Regs. Code § 3.14 (1989) (Board may suspend or revoke license); Board of Registration in Medicine, 243 Mass. Regs. Code § 1.05 (1988) (Board may revoke, suspend, or cancel certificate of registration; reprimand, censure, or impose a fine; or require the performance of public service).

¹⁰³ See, e.g., Johnson v. Arkansas Bd. of Examiners in Psychology, 808 S.W.2d 766, 767 (Ark. 1991) (court upheld Board's decision to suspend psychologist's license); Dresser v. Board of Medical Quality Assurance, 181 Cal. Rptr. 797, 804 (Cal. Ct. App. 1982) (court held that Board did not abuse discretion in revoking psychologist's license); Solloway v. Department of Professional Regulation, 421 So. 2d 573, 575 (Fla. Dist. Ct. App. 1982) (court upheld Board decision to revoke license of psychiatrist), *petition for rev. denied*, 430 So. 2d 452 (Fla. 1983); Pundy v. Department of Professional Regulation, 570 N.E.2d 458, 467 (Ill. App. Ct. 1991) (court upheld Department's decision to suspend psychiatrist's license and did not abuse its discretion); Gares v. New Mexico Bd. of Psychologist Examiners, 798 P.2d 190, 191-92 (N.M. 1990) (court upheld Board's decision to revoke psychologist's license based on plentiful substantial evidence in record); Davis v. Psychology Examining Bd., 431 N.W.2d 730, 731 (Wis. Ct. App. 1988) (court held that substantial evidence supported Board's decision not to reissue psychologist's license). But see Morris v. Board of Registration in Medicine, 539 N.E.2d 50, 55-56 (Mass. 1989) (Board's decision was not supported by substantial evidence and court remanded for further proceedings), *cert. denied*, 493 U.S. 977 (1989).

¹⁰⁴ See Stone, *supra* note 80, at 1138.

cies.¹⁰⁵ For example, the procedure of license revocation, including the administrative hearing, is time-consuming and stressful for the patient.¹⁰⁶ Moreover, in many states, therapists who have had their licenses revoked may still be able to practice unlicensed under a different title.¹⁰⁷ Therefore, given the drawbacks of these administrative options, many patients seek to redress the sexual misconduct by bringing a civil lawsuit.¹⁰⁸

B. Civil Lawsuits

Victims of sexual misconduct by psychotherapists may seek redress by bringing a civil suit, typically under a theory of malpractice or negligent infliction of emotional distress.¹⁰⁹ Patients may seek compensatory damages for the emotional harm that they have suffered, as well as punitive damages for the therapist's unprofessional conduct.¹¹⁰ These damages may aid the patient in paying for future therapy or hospitalization.¹¹¹ Civil litigation in this area has increased dramatically in recent years.¹¹²

¹⁰⁵ See POPE & BOUHOUTSOS, *supra* note 2, at 157-59; see also Riskin, *supra* note 80, at 1006.

¹⁰⁶ See POPE & BOUHOUTSOS, *supra* note 2, at 162.

¹⁰⁷ *Id.* at 159. For example, an unlicensed therapist may continue to practice under the title "counselor," "therapist," or "analyst." *Id.* One therapist merely told her patients that she had to change her title because she had run into bureaucratic red tape. See *id.* at 160. In addition, a therapist whose license has been revoked may apply for reinstatement after a certain amount of time. See, e.g., Board of Registration of Psychologists, 251 Mass. Regs. Code § 3.14 (1989) (person whose license has been revoked may apply for reinstatement three years after the date of revocation); Board of Registration in Medicine, 243 Mass. Regs. Code § 1.05 (1988) (person previously registered by the Board may apply for reinstatement no sooner than five years after revocation, unless Board orders otherwise).

¹⁰⁸ See, e.g., Roy v. Hartogs, 381 N.Y.S.2d 587, 588 (N.Y. App. Div. 1976); Olson v. Connerly, 445 N.W.2d 706, 707 (Wis. Ct. App. 1989), *aff'd*, 457 N.W.2d 479, 484 (Wis. 1990).

¹⁰⁹ See, e.g., Hartogs, 381 N.Y.S.2d at 588 (malpractice); Olson, 445 N.W.2d at 712 (malpractice and negligent infliction of emotional distress). In a few states, legislatures have also created statutory causes of action for sexual misconduct by psychotherapists. See, e.g., MINN. STAT. ANN. § 148A.02 (West 1989); WIS. STAT. ANN. 895.70(2) (West, Supp. 1991); CAL. CIV. CODE 43.93(b) (West Supp. 1991); ILL. ANN. STAT. ch. 70, para. 802 (Smith-Hurd 1989). This note, however, traces the evolution of the common law. For a fuller discussion of statutory causes of action, see Linda Jorgenson et al., *The Furor Over Psychotherapist-Patient Sexual Contact: New Solutions to an Old Problem*, 32 WM. & MARY L. REV. 645, 702-08 (1991).

¹¹⁰ See, e.g., Hartogs, 381 N.Y.S.2d at 589 (court allowed compensatory damages, but found that the evidence did not justify punitive damages).

¹¹¹ See POPE & BOUHOUTSOS, *supra* note 2, at 133.

¹¹² See Daniel Goleman, *New Guidelines Issued on Patient-Therapist Sex*, N.Y. TIMES, Dec. 20, 1990, at B21.

The legal theories on which courts have granted relief to victimized patients have evolved over the years. Historically, courts allowed a cause of action for "seduction," which involved the persuasion of a woman of chaste character to depart from her "path of virtue."¹¹³ Although the parents or guardian of the seduced female usually brought this right of action, some jurisdictions allowed the female victim herself to bring the suit in her own name.¹¹⁴ More often, however, the spouse of the female victim would bring suit against the seducer based upon the tort theories of alienation of affections or criminal conversation.¹¹⁵ An action of alienation of affections involved a situation in which another person intentionally seduced the wife in order to encourage her to separate from her husband.¹¹⁶ Criminal conversation was an action requiring proof of marriage and adulterous intercourse.¹¹⁷

The actions of seduction, alienation of affections and criminal conversation were abolished in most jurisdictions either by statute or judicial decision.¹¹⁸ Grounding their actions on public policy, legislatures abolished these actions in order to prevent extortion or blackmail between spouses and to prevent innocent people from having to defend against fraudulent or meritless litigation.¹¹⁹ In

¹¹³ *Cotton v. Kambly*, 300 N.W.2d 627, 628 (Mich. Ct. App. 1980) (citing *Savage v. Embrey*, 184 N.W. 503, 505 (Mich. 1921)).

¹¹⁴ *Id.*

¹¹⁵ See *Nicholson v. Han*, 162 N.W.2d 313, 317 (Mich. Ct. App. 1968). In modern cases, the spouse of a victim is not able to sue the therapist unless he was also a patient of the therapist and therefore himself a victim of malpractice. *Weaver v. Union Carbide*, 378 S.E.2d 105, 107 (W. Va.), *aff'd*, 873 F.2d 78, 79 (4th Cir. 1989); see also *Richard H. v. Larry D.*, 243 Cal. Rptr. 807, 810 (Cal. Ct. App. 1988); *Horak v. Biris*, 474 N.E.2d 13, 17 (Ill. App. Ct. 1985); *Figueiredo-Torres v. Nickel*, 584 A.2d 69, 74 (Md. 1991). Courts have reasoned that the therapist owes a clear duty to both his patients, husband and wife, to engage in conduct that is calculated to improve their mental or emotional well-being. See *Richard H.*, 243 Cal. Rptr. at 809; *Horak*, 474 N.E.2d at 17. But see *Martino v. Family Serv. Agency*, 445 N.E.2d 6, 9 (Ill. App. Ct. 1982). In one case, the court allowed a patient to maintain an action for malpractice against his therapist, who had engaged in sexual relations with the patient's wife, who was not a patient. See *Mazza v. Huffaker*, 300 S.E.2d 833, 839 (N.C. Ct. App.), *petition denied*, 305 S.E.2d 734 (N.C. 1983), *reconsideration denied*, 313 S.E.2d 160 (N.C. 1984).

¹¹⁶ *Nicholson*, 162 N.W.2d at 317.

¹¹⁷ *Id.*

¹¹⁸ *Weaver*, 378 S.E.2d at 108. The statutes abolishing these actions are often referred to as "heart-balm statutes." See POPE & BOUHOUTSOS, *supra* note 2, at 130. Some of the abolishing statutes were enacted in the 1930s, whereas others were not enacted until much later. See, e.g., *Cotton v. Kambly*, 300 N.W.2d 627, 628 (Mich. Ct. App. 1980) (Michigan abolished seduction action for women under eighteen in 1935); *Weaver*, 378 S.E.2d at 108 n.6 (West Virginia abolished alienation of affections action in 1969).

¹¹⁹ See *Richard H.*, 243 Cal. Rptr. at 809; *Roy v. Hartogs*, 381 N.Y.S.2d 587, 588 (N.Y. App. Div. 1976); *Weaver*, 378 S.E.2d at 108.

addition, as views about marriage and women changed, society began to regard these causes of action as treating women like property.¹²⁰ Finally, the abolition of these causes of action has in part been motivated by the inability of the court system to determine objectively and fairly the loss in these situations.¹²¹

As these causes of action were abolished, courts began to interpret the sexual misconduct complaints as actions for malpractice, rather than actions for seduction, in order to give victims an avenue of relief.¹²² For example, in the 1976 case of *Roy v. Hartogs*, the New York Supreme Court, Appellate Term held that a patient who was induced to have sexual intercourse as part of therapy had a cause of action for malpractice.¹²³ The plaintiff in *Hartogs* alleged in the complaint that during the last thirteen months of her treatment with the defendant psychiatrist, he induced her to have sexual intercourse as part of her prescribed therapy, causing her to sustain emotional and mental injury.¹²⁴

The court in *Hartogs* stated that the legislation did not abolish all causes of action where sexual intercourse contributed to the ultimate harm.¹²⁵ The court reasoned that the harm to the patient was caused not only by the sexual contact with the therapist, but also by the therapist's deviation from professionally acceptable conduct.¹²⁶ Because the complaint alleged that the harm was caused by the deceptive treatment of the therapist, the court held that the plaintiff had stated a viable malpractice claim.¹²⁷ Thus, although some of the elements of the abolished causes of action may appear in the complaint, most courts will look to the substance of the complaint, rather than its form, to determine whether a cause of action is viable.¹²⁸

¹²⁰ See *Weaver*, 378 S.E.2d at 108 (alienation of affections resembles a "forced sale" of a spouse's affections).

¹²¹ *Id.*

¹²² For example, in *Cotton v. Kambly*, 300 N.W.2d 627, 628-29 (Mich. Ct. App. 1980), the court stated: "We see no reason for distinguishing between this type of malpractice and others, such as improper administration of a drug or a defective operation. In each situation, the essence of the claim is the doctor's departure from proper standards of medical practice." See also *Roy v. Hartogs*, 381 N.Y.S.2d 587, 588 (1976).

¹²³ 381 N.Y.S.2d at 588.

¹²⁴ *Id.*

¹²⁵ *Id.*

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ See, e.g., *Cotton v. Kambly*, 300 N.W.2d 627, 628-29 (Mich. Ct. App. 1980) (court looked at "the essence of the claim" and found cause of action for malpractice); *Weaver v. Union Carbide*, 378 S.E.2d 105, 109 (W. Va. 1989) (court looked to "the substance of the

Today, the majority of suits for sexual exploitation by a psychotherapist are based directly on medical malpractice claims.¹²⁹ In order to prevail in a malpractice suit, the plaintiff must show that a duty existed on the part of the therapist toward the patient, that the therapist departed from the proper standards of practice, and that some harm resulted to the plaintiff that was caused by the therapist's actions.¹³⁰ In examining the first element of malpractice, that of duty, courts have characterized the relationship between doctor and patient as a fiduciary relationship, analogous to a guardian-ward relationship.¹³¹ In such a relationship, the guardian cannot waive performance of this duty.¹³² As medical specialists, therapists owe their patients the same duty of care as do other medical professionals.¹³³ Such duty requires that the specialist engage only in activities that are calculated to improve the patient's mental or emotional well-being, and refrain from conduct that carries with it a foreseeable risk of emotional harm to the patient.¹³⁴ In addition, at least one court has held that an individual holding himself out to be a psychologist will be held to the same professional standard of care as if he were indeed a psychologist.¹³⁵ The law is well-settled that such a duty exists between psychotherapists and their patients.¹³⁶

The second element of the malpractice claim requires that the plaintiff demonstrate that the therapist's conduct departed from

plaintiff's complaint and not merely to its form" and found cause of action for malpractice). *But see* *Nicholson v. Han*, 162 N.W.2d 313, 317 (Mich. Ct. App. 1968) (court looked at "the gist of the action" and found it to be for abolished alienation of affections and criminal conversation causes of action, and affirmed trial court's granting of summary judgment).

¹²⁹ See, e.g., *Cotton*, 300 N.W.2d at 628-29; *Hartogs*, 381 N.Y.S.2d at 588 (1976). Medical malpractice is defined as "the failure of a member of the medical profession, employed to treat a case professionally, to fulfill the duty to exercise that degree of skill, care and diligence exercised by members of the same profession . . . in light of the present state of medical science." *Cotton*, 300 N.W.2d at 628 (citing *Kambas v. St. Joseph's Mercy Hosp.*, 205 N.W.2d 431, 434 (Mich. 1973)).

¹³⁰ See *Cotton*, 300 N.W.2d at 628-29; *Hartogs*, 381 N.Y.S.2d at 588; *Omer v. Edgren*, 685 P.2d 635, 637 (Wash. Ct. App. 1984).

¹³¹ *Omer*, 685 P.2d at 636.

¹³² *Id.* (citing *Roy v. Hartogs*, 366 N.Y.S.2d 297, 299 (N.Y. App. Div. 1975)). Courts have stated that the ward is incapable of consenting when the guardian acts as seducer. See, e.g., *Omer*, 685 P.2d at 636.

¹³³ *Omer*, 685 P.2d at 636; see also *Horak v. Biris*, 474 N.E.2d 13, 17 (Ill. App. Ct. 1985).

¹³⁴ *Horak*, 474 N.E.2d at 17.

¹³⁵ See, e.g., *Corgan v. Muehling*, 522 N.E.2d 153, 155 (Ill. App. Ct. 1988), *aff'd*, 574 N.E.2d 6022 (Ill. 1991).

¹³⁶ See *Omer*, 685 P.2d at 636; *Weaver v. Union Carbide*, 378 S.E.2d 105, 107 (W. Va. 1989).

standard, acceptable procedures.¹³⁷ Some courts have determined, based on the therapist's mishandling of the transference phenomenon, that sexual misconduct is malpractice.¹³⁸ At least one of these courts reasoned that in order to benefit from therapy the patient must trust the therapist.¹³⁹ Courts also recognize that as the therapeutic relationship develops, the patient may begin to experience transference, expressing a strong need for parental love and guidance.¹⁴⁰ A proper handling of the transference phenomenon may lead to a resolution of the patient's emotional conflicts.¹⁴¹ A therapist who seeks to gratify his own personal needs, however, has departed from professional standards of care and harms the patient by violating her trust.¹⁴² In addition to focusing upon transference as a breach in the standard of care, courts acknowledge that the medical authorities themselves are nearly unanimous in considering therapist-patient sexual contact to be malpractice.¹⁴³ Thus, courts look to the mishandling of the transference phenomenon, as well as to the general consensus of the psychotherapeutic community, to determine what constitutes a departure from the proper standard of care.

This departure from acceptable standards of practice may occur when the therapist deliberately manipulates the patient.¹⁴⁴ In such situations, the therapist may induce the patient into sexual relations under the guise of treatment, telling her the sexual contact is part of her prescribed therapy.¹⁴⁵ The sexual acts may occur during the therapy session, and in one case the therapist labeled these acts as "relaxation exercises."¹⁴⁶ In these cases, in which the

¹³⁷ See, e.g., *Cotton v. Kambly*, 300 N.W.2d 627, 628-29 (Mich. Ct. App. 1980).

¹³⁸ See, e.g., *St. Paul Marine & Fire Ins. Co. v. Love*, 459 N.W.2d 698, 702 (Minn. 1990); *Zipkin v. Freeman*, 436 S.W.2d 753, 761 (Mo. 1968); *L.L. v. Medical Protective Co.*, 362 N.W.2d 174, 178 (Wis. Ct. App. 1984).

¹³⁹ *Medical Protective*, 362 N.W.2d at 177.

¹⁴⁰ See *Simmons v. United States*, 805 F.2d 1363, 1365 (9th Cir. 1986); *Medical Protective*, 362 N.W.2d at 177.

¹⁴¹ *Medical Protective*, 362 N.W.2d at 177.

¹⁴² *Id.* at 178.

¹⁴³ *Id.* at 176; see also *Simmons*, 805 F.2d at 1365; *Love*, 459 N.W.2d at 700.

¹⁴⁴ *Cotton v. Kambly*, 300 N.W.2d 627, 627 (Mich. Ct. App. 1980); *Roy v. Hartogs*, 381 N.Y.S.2d 587, 588 (N.Y. App. Div. 1976).

¹⁴⁵ *Sharples v. State*, 793 P.2d 175, 176 and n.1 (Haw. 1990); *Cotton*, 300 N.W.2d at 627; *Gares v. New Mexico Bd. of Psychologist Examiners*, 798 P.2d 190, 191 (N.M. 1990); *Hartogs*, 381 N.Y.S.2d at 588.

¹⁴⁶ See, e.g., *Marston v. Minneapolis Clinic of Psychiatry*, 329 N.W.2d 306, 308 (Minn. 1982) (plaintiff sought therapy for chronic headaches and back pain; relaxation exercises evolved into body massages and sexual encounters); *Medical Protective*, 362 N.W.2d at 175 (sexual acts occurred during therapy sessions).

sexual contact occurred during therapy, courts have held that this behavior clearly departs from acceptable therapeutic practice.¹⁴⁷

In fact, even in cases in which the sexual contact occurred outside of therapy and over an extended period of time, courts have also held that sexual contact between the therapist and the patient constitutes malpractice.¹⁴⁸ For example, in the 1968 case of *Zipkin v. Freeman*, the Missouri Supreme Court held that a psychiatrist's personal and sexual involvement with his patient, which occurred outside the office, was malpractice.¹⁴⁹ In *Zipkin*, the patient engaged in a sexual relationship with the therapist, attended nude swimming parties with the therapist's friends, went on overnight trips with him, and eventually moved into a residence on his property.¹⁵⁰ The court reasoned that the therapist's actions departed from the proper standard of conduct because he had mishandled the transference phenomenon.¹⁵¹ The court further stated that the therapist would have damaged the patient even if the overnight trips were chaperoned, the swimming was done in bathing suits, and "there had been ballroom dancing instead of sexual relations."¹⁵² Thus, at least one court has found a departure from the proper standard of conduct, based on the mishandling of the transference phenomenon, even when the improper conduct takes place outside the therapy session.¹⁵³

For the final element of malpractice, the plaintiff must prove that she suffered some harm and that the harm was proximately caused by the therapist's behavior.¹⁵⁴ Courts have accepted the notion that patients who are sexually involved with their therapists are at risk of sustaining some type of emotional damage from the relationship.¹⁵⁵ In many cases, this emotional suffering results in

¹⁴⁷ *Marston*, 329 N.W.2d at 307, 308 (case was reversed and remanded on other grounds); *Medical Protective*, 362 N.W.2d at 178.

¹⁴⁸ *Zipkin v. Freeman*, 436 S.W.2d 753, 757-59, 761 (Mo. 1968) (inappropriate contact occurred over a number of years, spanning a range of social activities; patient resided on psychiatrist's property); *Olson v. Connerly*, 445 N.W.2d 706, 708 (Wis. Ct. App. 1989) (sexual contact occurred outside of office), *aff'd*, 457 N.W.2d 479, 484 (Wis. 1990).

¹⁴⁹ 436 S.W.2d at 757-59, 761.

¹⁵⁰ *Id.* at 757-59. In addition, the therapist advised the patient on her personal financial dealings. *Id.* at 758.

¹⁵¹ *Id.* at 761.

¹⁵² *Id.*

¹⁵³ *Id.*; see also *Olson*, 457 N.W.2d at 480-81.

¹⁵⁴ See *Roy v. Hartogs*, 381 N.Y.S.2d 587, 588 (N.Y. App. Div. 1976); *Omer v. Edgren*, 685 P.2d 635, 637 (Wash. Ct. App. 1984).

¹⁵⁵ See, e.g., *Omer*, 685 P.2d at 638; *L.L. v. Medical Protective Co.*, 362 N.W.2d 174, 178 (Wis. Ct. App. 1984).

tangible costs, such as medical expenses for hospitalization or subsequent therapy, or lost wages.¹⁵⁶ Although traditionally courts have considered such harm difficult to prove, they have generally allowed damages to be stated in terms of mental and emotional suffering, as well as injury to reputation and personal humiliation, without requiring proof of accompanying physical injuries or monetary losses.¹⁵⁷

Once the plaintiff establishes the harm, the causal connection between the sexual relationship and the patient's condition is often established by an expert witness, such as another therapist.¹⁵⁸ For example, in the 1984 case of *Omer v. Edgren*, the Washington Court of Appeals held that, for the purpose of a summary judgment motion, sufficient facts established a causal connection between the therapist's breach of trust and the patient's emotional condition.¹⁵⁹ In *Omer*, the patient, after engaging in a sexual relationship with her psychiatrist, sought treatment from another therapist.¹⁶⁰ The new therapist, acting as an expert witness on behalf of the plaintiff, testified that her suicidal desires were caused by feelings of guilt arising from her relationship with her former therapist.¹⁶¹ The court accepted the current therapist's testimony as sufficient to establish a causal relationship between the prior therapist's conduct and the patient's present harm, and therefore reversed the summary judgment for the defendant and remanded the case for trial.¹⁶² Thus, a plaintiff can prove the causation element of her malpractice claim by providing expert testimony from a therapist who has examined her.¹⁶³

¹⁵⁶ See *Omer*, 685 P.2d at 638 (damages may be awarded despite plaintiff's testimony that she suffered no loss with respect to lost earnings, medical expenses or marital difficulties; amount may be in fact-finders discretion); *Olson*, 445 N.W.2d at 708-09 (damages awarded for future pain and suffering and past medical and hospital expenses).

¹⁵⁷ *Omer*, 685 P.2d at 638. The court noted that although injury flowing from the alleged relationship may be difficult to prove, it "may be as real as that type of injury which can be proven with mathematical certainty." *Id.* See also *Corgan v. Muehling*, 522 N.E.2d 153, 159 (Ill. App. Ct. 1988), *aff'd*, 574 N.E.2d 602 (Ill. 1991).

¹⁵⁸ See, e.g., *Zipkin v. Freeman*, 436 S.W.2d 753, 760 (Mo. 1968) (subsequent examining therapist testified as to the effect of the relationship); *Omer* at 637-38 (Wash. Ct. App. 1984) (subsequent treating therapist testified as to the effect of the relationship).

¹⁵⁹ 685 P.2d at 638.

¹⁶⁰ *Id.* at 636.

¹⁶¹ *Id.* at 637-38.

¹⁶² *Id.* at 638.

¹⁶³ See *Zipkin*, 436 S.W.2d at 760 (court held insurance company liable based on harm established by expert's testimony); *Omer*, 685 P.2d at 637-38 (court accepted expert's testimony and reversed summary judgment granted to defendant).

In addition to malpractice claims, patients have also sought damages for infliction of emotional distress as a result of the therapist's negligence.¹⁶⁴ Courts have handled these cases differently, depending on the current state of tort law in their jurisdictions.¹⁶⁵ Some courts require, or at least prefer, an accompanying physical injury in order to support a claim for emotional distress.¹⁶⁶

For example, in 1989, the Wisconsin Court of Appeals in *Olson v. Connerly* held that a plaintiff could plead a cause of action for negligent infliction of emotional distress only if the therapist's actions resulted in physical injury.¹⁶⁷ In *Olson*, the patient suffered "panic attacks" at the thought of the sexual involvement with her therapist.¹⁶⁸ These panic attacks caused the plaintiff to react physically; the plaintiff suffered extreme abdominal pain, shortness of breath and gagging.¹⁶⁹ Although the court acknowledged that there may be some exceptions to the Wisconsin physical injury rule, such as emotional distress that results from intentional conduct or that is caused by wrongful acts that are inherently likely to cause severe distress, the court did not rest its findings on these exceptions because the case included an accompanying physical injury.¹⁷⁰

Other jurisdictions have examined an emotional distress claim in terms of the "zone of danger" rule, which requires for a cause of action for negligent infliction of emotional distress that the plaintiff must allege that the acts of the defendant put her in reasonable fear for her own safety.¹⁷¹ Even within one jurisdiction, however, there is disagreement regarding the applicability of this rule to

¹⁶⁴ See *Corgan v. Muehling*, 522 N.E.2d 153, 154 (Ill. App. Ct. 1988), *aff'd*, 574 N.E.2d 602 (Ill. 1991); *Hammond v. Lane*, 515 N.E.2d 828, 829 (Ill. App. Ct. 1987); *Olson v. Connerly*, 445 N.W.2d 706, 707 (Wis. Ct. App. 1989), *aff'd*, 457 N.W.2d 479, 484 (Wis. 1990).

¹⁶⁵ See, e.g., *Corgan*, 522 N.E.2d at 159 (plaintiff could recover for emotional distress because she was direct victim of malpractice—"zone of danger" rule inapplicable); cf. *Hammond*, 515 N.E.2d at 830 (plaintiff must show she was within "zone of danger" or feared for her own safety in order to recover for emotional distress); *Olson*, 445 N.W.2d at 712 (plaintiff can recover for emotional distress in light of accompanying physical injury).

¹⁶⁶ See, e.g., *Olson*, 445 N.W.2d at 712. The public policy objective of requiring an accompanying physical injury is to prevent fraudulent claims. See *id.*

¹⁶⁷ *Id.* (court upheld trial court's denial of defendant's motion to dismiss for lack of evidence).

¹⁶⁸ *Id.*

¹⁶⁹ *Id.* The court accepted the plaintiff's claims of physical symptoms based on the corroborating testimony of her psychologist and psychiatrist. *Id.*

¹⁷⁰ *Id.*

¹⁷¹ *Hammond v. Lane*, 515 N.E.2d 828, 830 (Ill. App. Ct. 1987).

sexual exploitation cases.¹⁷² In the 1987 case of *Hammond v. Lane*, the Illinois Appellate Court held that a patient had not successfully pleaded a cause of action for negligent infliction of emotional distress.¹⁷³ In *Hammond*, the patient, who sought treatment for psychological and psychiatric disorders, claimed that she had sexual contact with her doctor on four occasions.¹⁷⁴ In applying the zone of danger rule, the court reasoned that the plaintiff had failed to allege that she was endangered or had feared for her own safety during the sexual contact and therefore the plaintiff did not successfully plead a cause of action for negligent infliction of emotional distress.¹⁷⁵

In 1988, however, the same court held in *Corgan v. Muehling* that to plead an action for psychologist malpractice that results only in emotional distress, the plaintiff need not demonstrate that she was put in fear of physical injury.¹⁷⁶ In *Corgan*, an unregistered therapist who practiced psychology was accused of having sexual relations with his patient during treatment.¹⁷⁷ The patient alleged that the therapist's actions caused her to suffer fear, shame, humiliation and guilt, and that, as a result, she had to undergo intensive psychotherapeutic care.¹⁷⁸

The *Corgan* court stated that a court could not justify requiring the plaintiff to demonstrate physical manifestations of her emotional trauma.¹⁷⁹ The court reasoned that the "zone of danger" rule should apply only to negligence suits brought by injured bystanders, rather than to direct victims of malpractice, such as patients who are sexually exploited by their psychotherapists.¹⁸⁰ The court further reasoned that requiring patients to demonstrate fear of physical injury would make it too difficult for those individuals to plead psychologist malpractice if the only resulting injury was emotional harm.¹⁸¹

¹⁷² See *Corgan v. Muehling*, 522 N.E.2d 153, 159 (Ill. App. Ct. 1988), *aff'd*, 574 N.E.2d 602 (Ill. 1991) (plaintiff not required to demonstrate that she feared physical injury). *But see Hammond*, 515 N.E.2d at 830 (plaintiff must demonstrate that she was endangered or feared for her own safety).

¹⁷³ 515 N.E.2d at 830.

¹⁷⁴ *Id.* at 829.

¹⁷⁵ *Id.* at 830.

¹⁷⁶ 522 N.E.2d at 159.

¹⁷⁷ *Id.* at 154.

¹⁷⁸ *Id.*

¹⁷⁹ *Id.* at 159.

¹⁸⁰ *Id.* at 158-59.

¹⁸¹ *Id.* at 159.

In sum, most suits for sexual misconduct are based on a theory of malpractice.¹⁸² Courts have determined that sexual misconduct is malpractice based on the mishandling of the transference phenomenon and on the standards set by the psychotherapeutic community.¹⁸³ Because the consensus of the psychotherapeutic community is that therapists who engage in sexual relations with patients depart from the standard of professional care, testimony at most trials will likely focus upon whether the sexual conduct actually occurred.¹⁸⁴ In addition to malpractice, patients may successfully plead emotional distress due to the therapist's negligence.¹⁸⁵

C. Insurance Company Responses

Most practicing therapists carry malpractice insurance.¹⁸⁶ A typical policy covers the therapist for "damages arising out of the performance of professional services rendered or which should have been rendered"¹⁸⁷ Most malpractice insurance policies require the insurer to defend the therapist facing a malpractice suit, as well as to pay the damages arising from the suit.¹⁸⁸

In cases of sexual misconduct, insurance companies often bring a declaratory judgment action forcing the court to rule on whether it is liable for coverage.¹⁸⁹ The insurance company typically argues

¹⁸² See, e.g., *Cotton v. Kambly*, 300 N.W.2d 627, 628-29 (Mich. Ct. App. 1980); *Roy v. Hartogs*, 381 N.Y.S.2d 587, 588 (N.Y. App. Div. 1976).

¹⁸³ See, e.g., *Simmons v. United States*, 805 F.2d 1363, 1365 (9th Cir. 1986); *St. Paul Marine & Fire Ins. Co. v. Love*, 459 N.W.2d 698, 700, 702 (Minn. 1990); *Zipkin v. Freeman*, 436 S.W.2d 753, 761 (Mo. 1968); *L.L. v. Medical Protective Co.*, 362 N.W.2d 174, 176, 178 (Wis. Ct. App. 1984).

¹⁸⁴ See *Medical Protective*, 362 N.W.2d at 176 ("Medical authorities are nearly unanimous in considering sexual contact between therapists and patients to be malpractice."). See generally *POPE & BOUHOUTSOS*, *supra* note 2, at 129.

¹⁸⁵ See, e.g., *Corgan v. Muehling*, 522 N.E.2d 153, 159 (Ill. App. Ct. 1988), *aff'd*, 574 N.E.2d 602 (Ill. 1991); *Olson v. Connerly*, 445 N.W.2d 706, 712 (Wis. Ct. App. 1989), *aff'd*, 457 N.W.2d 479, 484 (Wis. 1990).

¹⁸⁶ See, e.g., *Vigilant Ins. Co. v. Kambly*, 319 N.W.2d 382, 384 (Mich. Ct. App. 1982) (dispute as to coverage of psychiatrist's insurance); *Love*, 459 N.W.2d at 699 (dispute as to coverage of psychologist's professional liability insurance); *St. Paul Fire & Marine Ins. Co. v. D.H.L.*, 459 N.W.2d 704, 705 (Minn. 1990) (dispute as to coverage of marriage counselor's professional liability insurance).

¹⁸⁷ *St. Paul Fire & Marine Ins. Co. v. Mitchell*, 296 S.E.2d 126, 127 (Ga. Ct. App. 1982) (emphasis omitted).

¹⁸⁸ See, e.g., *id.*, at 127; *Zipkin v. Freeman*, 436 S.W.2d 753, 754 (Mo. 1968).

¹⁸⁹ See, e.g., *Love*, 459 N.W.2d at 699. This action is separate from the patient's malpractice suit against the therapist. The action is usually, though not always, prior to the main suit. Sometimes, rather than a declaratory judgment action, the therapist sues the insurance

that sexual contact between a therapist and patient is personal, not professional, behavior, and therefore does not constitute malpractice.¹⁹⁰ In most cases, courts have rejected this argument, holding that insurance companies are liable under the policies.¹⁹¹ In response to these rulings, some insurance companies have placed exclusionary provisions for sexual misconduct or caps on damages for sexual misconduct claims.¹⁹²

In upholding the liability of the insurance companies, courts have focused on the language of the malpractice policy, as well as the therapist's mishandling of the transference phenomenon in the course of rendering professional services.¹⁹³ In the 1990 case of *St. Paul Fire & Marine Insurance Co. v. Love*, for example, the Supreme Court of Minnesota held that an insurance company was required to provide coverage for a therapist who engaged in a sexual relationship with his female patient because this conduct constituted malpractice.¹⁹⁴ In *Love*, the plaintiff initially consulted a psychologist to resolve marital difficulties and issues surrounding childhood sexual abuse.¹⁹⁵ She ultimately engaged in sexual intimacies with him for two months.¹⁹⁶ When the patient and her husband, who had

company after presenting his own defense. See, e.g., *Hartogs v. Employers Mutual Ins. Co. of Wis.*, 391 N.Y.S.2d 962, 963 (N.Y. App. Div. 1977).

¹⁹⁰ See, e.g., *Love*, 459 N.W.2d at 699.

¹⁹¹ See, e.g., *id.* at 702; *Zipkin*, 436 S.W.2d at 761. Depending upon the terms of the policy, the insurer will have to defend the therapist (or assume those costs), pay damages to the patient, or both. See, e.g., *Love*, 459 N.W.2d at 702 (insurer liable for damages); *Zipkin*, 436 S.W.2d at 761 (insurer liable to defend insured and pay damages).

¹⁹² See *POPE & BOUHOUTSOS*, *supra* note 2, at 28, 158. For example, one typical mental health counselor's professional liability policy provides:

Sexual Misconduct—The total limit of the Company's liability hereunder shall not exceed \$25,000 in the aggregate for all damages with respect to the total of all claims against any Insured(s) involving any actual or alleged erotic physical contact, or attempt there at proposal thereof: (a) by any Insured or by any other person for whom any Insured may be legally liable; and (b) with or to any former or current patient or client of any Insured, or with or to any relative of or member of the same household as any said patient or client, or with or to any person with whom said patient or client or relative has an affectionate personal relationship.

American Home Assurance Company, 1989 Renewal Form 3 (1989).

¹⁹³ See, e.g., *Love*, 459 N.W.2d at 700; *Zipkin*, 436 S.W.2d at 761. Another court has opted to wait for the facts to be adjudicated at trial, requiring the insurer to render a defense for the therapist, but waiting to order the payment of damages until the claim was resolved at trial. See *St. Paul Fire & Marine Ins. Co. v. Mitchell*, 296 S.E.2d 126, 127, 129 (Ga. Ct. App. 1982).

¹⁹⁴ 459 N.W.2d at 702.

¹⁹⁵ *Id.*

¹⁹⁶ *Id.*

also been a patient, filed suit against the therapist, the insurance company commenced a declaratory judgment action to resolve the coverage issue.¹⁹⁷

The *Love* court reasoned that in order to determine whether the sexual contact was malpractice, it should not only consider the sexual act itself, but also the treatment preceding and subsequent to the act.¹⁹⁸ The court further reasoned that in order for the insurer to be liable, a substantial connection must exist between the professional services, provided or withheld, and the sexual conduct.¹⁹⁹ The court noted that because the sexual relationship arose out of the mishandling of the transference phenomenon, which occurred prior to the actual sexual contact, it was related to the professional treatment.²⁰⁰ In addition, the court noted that the sexual relationship worsened the plaintiff's emotional condition, the very condition for which she sought treatment.²⁰¹ Thus, the *Love* court concluded that the insurer was liable because the sexual activity must have arisen from the transference phenomenon, which is part of the professional treatment; the sexual activity was therefore malpractice.²⁰²

In the 1968 case of *Zipkin v. Freeman*, the Supreme Court of Missouri used similar reasoning in holding that the psychiatrist's insurance company was obligated to defend the malpractice suit and pay damages to the patient.²⁰³ In *Zipkin*, a woman seeking treatment from a psychiatrist for diarrhea and headaches subsequently moved into an apartment over his office, invested in his

¹⁹⁷ *Id.*

¹⁹⁸ *Id.* at 700-01.

¹⁹⁹ *Id.* at 701.

²⁰⁰ *Id.* at 702.

²⁰¹ *Id.* at 701. The court distinguished the present case from a case in which a physician engaged in sexual activities with three young boys who were seeking treatment for routine physical injuries, not emotional problems. *Id.* at 700-01. In that situation, the Supreme Court of Minnesota held that no insurance coverage was available because the "sexual acts had absolutely nothing to do with either the patients' problems or the prescribed medical treatment." *Id.* at 701.

²⁰² *Id.* at 702. The court in *Love* did note that cases may arise where the malpractice does not arise from the mishandling of the transference phenomenon. *Id.* In a similar fact situation, the Supreme Court of Minnesota in *St. Paul Fire & Marine Ins. Co. v. D.H.L.* remanded the case to the trial court so that expert testimony could be offered regarding the transference phenomenon in light of the *Love* decision. 459 N.W.2d 704, 706 (Minn. 1990); see also *St. Paul Fire & Marine Ins. Co. v. Mitchell*, 296 S.E.2d 126, 129 (Ga. Ct. App. 1982).

²⁰³ 436 S.W.2d 753, 761 (Mo. 1968). The court held that the insurance company was responsible for the costs of the therapist's malpractice defense, although the malpractice suit had already taken place and the insurer had refused to defend. *Id.*

financial dealings and became his "mistress."²⁰⁴ The therapist's insurance policy stated that the insurer was liable to pay damages "based on" professional services rendered or that should have been rendered.²⁰⁵ The court interpreted the phrase "based on" to include damages "resulting from, or caused by, or due to," these services.²⁰⁶ The court reasoned that the sexual relationship between the therapist and the patient arose from the mishandling of the transference phenomenon, "a reaction the psychiatrists anticipate and which must be handled properly," and which is clearly part of rendering professional services.²⁰⁷ The court noted that the transference phenomenon was overwhelmingly shown in the evidence and documented by expert testimony.²⁰⁸ Many courts use the mishandling of the transference phenomenon as a means of establishing that sexual contact in a therapy situation is inextricably linked to the providing of professional services.²⁰⁹

Findings of liability for insurance companies have withstood a number of challenges raised by the companies. First, insurance companies often rely on a wide range of public policy objectives, arguing, for example, that wrongdoers should not be able to profit from their own bad acts by escaping payment of damages.²¹⁰ Second, companies have argued that the malpractice insurance policy itself has a specific provision that excludes coverage for the commission of criminal acts.²¹¹ Finally, one company argued that public policy dictates that such an exclusionary provision should be implied in the malpractice policy even if it is not expressly included.²¹²

Courts, however, have not been influenced by the public policy arguments advanced by the insurers.²¹³ In *Vigilant Insurance Co. v. Kambly*, the Michigan Court of Appeals held that none of the public

²⁰⁴ *Id.* at 755, 759.

²⁰⁵ *Id.* at 754.

²⁰⁶ *Id.* at 761.

²⁰⁷ *Id.*

²⁰⁸ *Id.*

²⁰⁹ See, e.g., *id.*; *St. Paul Fire & Marine Ins. Co. v. Love*, 459 N.W.2d 698, 702 (Minn. 1990). But see *Vigilant Ins. Co. v. Kambly*, 319 N.W.2d 382, 384 (Mich. Ct. App. 1982). In *Kambly*, the court held that an insurance company would be liable for malpractice damages if a trial court found malpractice. The *Kambly* court did not discuss whether transference needed to be established for the insurance company to be liable. *Id.*

²¹⁰ *Id.* at 384.

²¹¹ *L.L. v. Medical Protective Co.*, 362 N.W.2d 174, 178 (Wis. Ct. App. 1984); see also *Kambly*, 319 N.W.2d at 385.

²¹² See *Aetna Life & Casualty Co. v. McCabe*, 556 F. Supp. 1342, 1352 (E.D. Pa. 1983).

²¹³ See, e.g., *St. Paul Fire & Marine Ins. Co. v. Mitchell*, 296 S.E.2d 126, 128 (Ga. Ct. App. 1982); *Kambly*, 319 N.W.2d at 385.

policy considerations raised by the insurance company applied to the therapist's actions.²¹⁴ The insurance company first argued that it should not have to indemnify the therapist because an insured should not be permitted to profit from his wrongdoing.²¹⁵ Second, the company argued that to permit recovery would encourage the commission of unlawful acts.²¹⁶ The court responded to the first argument by noting that it was not the wrongdoer who would benefit, but rather the victim, by receiving compensation for her injuries.²¹⁷ The court also rejected the second argument, reasoning that it is unlikely that the therapist was persuaded to engage in sexual relations with his patient in reliance on his insurance policy.²¹⁸ Thus, despite the public policy arguments raised by the insurance company, the court held that the insurance company would be liable if a finding of malpractice results at trial.²¹⁹

In another case, however, a court, basing its decision in part on public policy, did not require the insurance company to pay the costs of the therapist's suit.²²⁰ In the 1977 case of *Hartogs v. Employers Mutual Insurance Co. of Wisconsin*, the Supreme Court of New York held that the insurance company was not required to reimburse the defendant for legal costs after a judgment was rendered against him for having sexual relations with his patient under the guise of therapy.²²¹ In *Employers Mutual*, the psychiatrist brought suit against his malpractice insurer, seeking to recover his costs and expenses in defending a malpractice action.²²² The *Employers Mutual* court reasoned that the therapist's actions were motivated by his own desire for personal satisfaction, rather than by a desire to serve the patient professionally.²²³ The court noted, however, that the patient believed that the doctor's actions constituted medical treatment.²²⁴

²¹⁴ 319 N.W.2d at 382, 385.

²¹⁵ *Id.* at 384.

²¹⁶ *Id.*

²¹⁷ *Id.* at 385.

²¹⁸ *Id.*

²¹⁹ *Id.*

²²⁰ See *Hartogs v. Employers Mutual Ins. Co. of Wis.*, 391 N.Y.S.2d 962, 965 (N.Y. App. Div. 1977).

²²¹ *Id.* At trial it was established that the psychiatrist had attempted to "cure" his patient's lesbianism by personally administering multiple doses of "fornicatus Hartogus" over a period of thirteen months. *Id.* at 963.

²²² *Id.* The psychiatrist plaintiff also sought from his malpractice insurance company legal fees for his bankruptcy proceedings, damages for humiliation arising from the bankruptcy proceedings, and punitive damages. *Id.*

²²³ *Id.* at 964.

²²⁴ *Id.*

Therefore, the court concluded that although the therapist's actions were considered malpractice in the patient's suit against him and the therapist was personally liable for damages, the conduct did not constitute malpractice under the insurance policy.²²⁵ The *Employers Mutual* court refused to indemnify the therapist for his unethical behavior.²²⁶ The court reasoned that, as a matter of public policy, courts should not "allow themselves to be used to enforce illicit or immoral or unconscionable purposes."²²⁷

Insurance companies also contend that the language of the policy excludes coverage for the commission of criminal acts.²²⁸ In the 1984 case of *L.L. v. Medical Protective Co.*, for example, the Wisconsin Court of Appeals held that a policy exclusion for criminal acts did not bar coverage for a victim in a case of sexual misconduct.²²⁹ In *Medical Protective*, the patient appealed from summary judgment that dismissed the malpractice insurance company from an action against her psychiatrist.²³⁰ The patient claimed that the psychiatrist engaged in acts of sexual intercourse with her during therapy.²³¹ The insurance company argued that coverage should be barred by a policy exclusion for "payment of damages . . . if said damages are in consequence of the performance of a criminal act"²³²

The *Medical Protective* court rejected the insurance company's claim that the sexual acts could be considered criminal and thereby excluded from policy coverage.²³³ The court reasoned that the plaintiff had alleged negligence or malpractice, rather than criminal

²²⁵ *Id.* at 964-65.

²²⁶ *Id.* at 965.

²²⁷ *Id.* Another court noted that the *Employers Mutual* court may have been influenced by the fact that the insurer, prior to the psychiatrist's suit for legal fees, had settled out of court with the patient, thereby serving the important policy objective of protecting the victim. See *St. Paul Fire & Marine Ins. Co. v. Mitchell*, 296 S.E.2d 126, 128 (Ga. Ct. App. 1982). Other courts have attempted to distinguish *Employers Mutual* in various ways. See *id.* (distinguished on the basis of different facts); *Aetna Life & Casualty Co. v. McCabe*, 556 F. Supp. 1342, 1351 (E.D. Pa. 1983) (distinguished on the basis of the language of the insurance policy).

²²⁸ *L.L. v. Medical Protective Co.*, 362 N.W.2d 174, 178 (Wis. Ct. App. 1984). The insurance company contended that the "criminal act" was a violation of a general sexual misconduct statute, as opposed to one of the new criminal statutes that specifically applied to psychotherapist-patient sexual relations. See *id.*; see also *Vigilant Ins. Co. v. Kambly*, 319 N.W.2d 382, 385 (Mich. Ct. App. 1982).

²²⁹ *Kambly*, 362 N.W.2d at 179.

²³⁰ *Id.* at 175.

²³¹ *Id.*

²³² *Id.* at 178.

²³³ *Id.* at 178-79.

behavior, in her complaint.²³⁴ The court further reasoned that the language of the insurance policy was ambiguous and did not indicate whether coverage would include acts of malpractice that could also be defined as criminal.²³⁵ The court stated that when the meaning of a policy is unclear, it should be construed in favor of coverage.²³⁶ Finally, the court noted that the professional policy was intended to compensate persons who were injured by the therapist's acts of malpractice.²³⁷ Thus, the court concluded that such an exclusion did not bar the coverage.²³⁸

If an exclusion for criminal or intentional conduct is not explicit in the policy, courts may be hesitant to imply one absent compelling public policy considerations.²³⁹ In the 1983 case of *Aetna Life and Casualty Co. v. McCabe*, the United States District Court for the District of Pennsylvania held that even if the therapist's conduct is intentional, it would not imply in the malpractice policy an exclusion for such behavior.²⁴⁰ In *McCabe*, the patient, who sought help for asthma and anxiety, became sexually involved with her doctor six months after treatment began.²⁴¹ The sexual relationship continued for approximately five years and they lived together during part of this time.²⁴² The doctor continued to prescribe drugs for the patient.²⁴³ After the patient brought suit against the doctor, the insurance company filed a declaratory judgment seeking a declaration of non-coverage under the psychiatrist's malpractice policy.²⁴⁴

Because the policy contained no exclusion, the court considered whether to imply one by examining several factors, such as whether the policy was procured in contemplation of the wrongful act, whether the existence of the policy promoted the wrongful act,

²³⁴ *Id.* at 178.

²³⁵ *Id.* at 179.

²³⁶ *Id.*

²³⁷ *Id.*

²³⁸ *Id.*

²³⁹ See *Aetna Life & Casualty Co. v. McCabe*, 556 F. Supp. 1342, 1352 (E.D. Pa.1983); see also *Vigilant Ins. Co. v. Employers Ins. of Wausau*, 626 F. Supp. 262, 266-67 (S.D.N.Y. 1986). Noting a New York public policy that prohibits insurance coverage for conduct intended to injure, the *Vigilant* court did not find evidence that the therapist intended to harm his patients. *Vigilant*, 626 F. Supp. at 267. The court, therefore, refused to accept the insurance company's argument that public policy barred coverage. *Id.* Awareness of a potential harm, the court stated, is not equivalent to intending that harm. *Id.*

²⁴⁰ 556 F. Supp. at 1352, 1353.

²⁴¹ *Id.* at 1346.

²⁴² *Id.*

²⁴³ *Id.*

²⁴⁴ *Id.* at 1344.

whether denying coverage under the act would be a deterrent, and whether the policy protects the insured from the consequences of his wrongful act.²⁴⁵ Because the case did not implicate the first three considerations, the court noted that the only policy consideration that might be relevant was whether the existence of the insurance policy protects the therapist from the consequences of his wrongful act.²⁴⁶ The court reasoned that although requiring the insurance company to pay damages would relieve the defendant of the financial consequences of his acts, the stronger policy consideration is to compensate innocent victims of malpractice.²⁴⁷ Thus, the *McCabe* court concluded that because the policy did not explicitly exclude coverage for intentional conduct, no waiver should be implied.²⁴⁸

In sum, courts most often hold that general malpractice insurance policies include coverage for sexual misconduct.²⁴⁹ Courts usually base these decisions on the mishandling of the transference phenomenon.²⁵⁰ Many courts will not allow their decisions to be influenced by the public policy considerations raised by the insurance companies.²⁵¹ In addition, courts have found that a specific exclusion for general criminal acts does not bar coverage.²⁵²

D. Criminal Statutes

Prior to the recent criminalization of sexual exploitation by psychotherapists, the most common charge for prosecution for this type of conduct was rape.²⁵³ These cases usually involved extreme situations, such as overt objections by the patient or intercourse without the patient's knowledge.²⁵⁴ In one case, a psychiatrist was

²⁴⁵ *Id.* at 1352-53.

²⁴⁶ *Id.* at 1353.

²⁴⁷ *Id.*

²⁴⁸ *Id.*

²⁴⁹ See, e.g., *St. Paul Fire & Marine Ins. Co. v. Love*, 459 N.W.2d 698, 702 (Minn. 1990); *Zipkin v. Freeman*, 436 S.W.2d 753, 761 (Mo. 1968).

²⁵⁰ See, e.g., *Love*, 459 N.W.2d at 702; *Zipkin*, 436 S.W.2d at 761.

²⁵¹ See, e.g., *St. Paul Fire & Marine Ins. Co. v. Mitchell*, 296 S.E.2d 126, 128 (Ga. Ct. App. 1982); *Vigilant Ins. Co. v. Kambly*, 319 N.W.2d 382, 385 (Mich. Ct. App. 1982).

²⁵² *Kambly*, 319 N.W.2d at 385; *L.L. v. Medical Protective Co.*, 362 N.W.2d 174, 179 (Wis. Ct. App. 1984).

²⁵³ See, e.g., *Bernstein v. Board of Medical Examiners*, 22 Cal. Rptr. 419, 420 (Cal. Ct. App. 1962) (psychiatrist convicted of statutory rape of sixteen-year old girl); *Eberhart v. State*, 34 N.E. 637, 637 (Ind. 1883) (doctor convicted of rape); *State v. Ely*, 194 P. 988, 988 (Wash. 1921) (doctor convicted of rape).

²⁵⁴ *Eberhart*, 34 N.E. at 638 (extremely young patient resisted sexual intercourse); *Ely*, 194 P. at 988-89 (patient did not consent and was unaware of sexual abuse in course of medical examination).

found guilty of statutory rape of a sixteen-year-old girl.²⁵⁵ Commentators have suggested that the relatively low number of criminal prosecutions demonstrated a reluctance by law enforcement agencies to press criminal charges against therapists who engaged in sexual activity with their patients.²⁵⁶

Many professionals, including both researchers and therapists, advocate criminalization of all sexual contact as a means of curtailing the increasing number of therapists who sexually exploit their patients.²⁵⁷ It was not until recently, however, that states began to pass criminal statutes that impose harsh penalties on psychotherapists who become sexually involved with their patients.²⁵⁸ At least seven states, including California, Colorado, Florida, Maine, Minnesota, North Dakota and Wisconsin, have enacted such statutes.²⁵⁹ At least two other states, Massachusetts and New Mexico, are deliberating about whether to pass such legislation.²⁶⁰ The purpose underlying the statutes, according to one court, is to protect vulnerable patients by allowing them to place their trust in competent professionals.²⁶¹

The criminal statutes are often far-reaching, encompassing a broad range of situations of sexual misconduct.²⁶² A typical statute, such as Wisconsin's, applies to all individuals who practice or hold themselves out to practice psychotherapy, whether licensed or not.²⁶³ The Wisconsin statute defines "therapist" to include physi-

²⁵⁵ *Bernstein*, 22 Cal. Rptr. at 420.

²⁵⁶ *Stone*, *supra* note 80, at 1138.

²⁵⁷ *Masters & Johnson, Principles of the New Sex Therapy*, 133 AM. J. PSYCHIATRY 548, 553 (1976).

²⁵⁸ See CAL. BUS. & PROF. CODE § 729 (West 1990); COLO. REV. STAT. § 18-3-405.5 (1986); 1990 FLA. LAWS ch. 70; ME. REV. STAT. ANN. tit. 17-A, § 253 (West Supp. 1990); MINN. STAT. ANN. §§ 609.344, 609.345 (West Supp. 1991); N.D. CENT. CODE § 12.1-20-06.1 (West Supp. 1989); WIS. STAT. ANN. § 940.22 (West Supp. 1990).

²⁵⁹ See CAL. BUS. & PROF. CODE § 729 (West 1990); COLO. REV. STAT. § 18-3-405.5 (1986); 1990 FLA. LAWS ch. 70; ME. REV. STAT. ANN. tit. 17-A, § 253 (West Supp. 1990); MINN. STAT. ANN. §§ 609.344, 609.345 (West Supp. 1991); N.D. CENT. CODE § 12.1-20-06.1 (West Supp. 1989); WIS. STAT. ANN. § 940.22 (West Supp. 1990).

²⁶⁰ See Daniel Goleman, *New Guidelines Issued on Patient-Therapist Sex*, N.Y. TIMES, Dec. 20, 1990, at B21.

²⁶¹ See *State v. Dutton*, 450 N.W.2d 189, 194 (Minn. Ct. App. 1990).

²⁶² For example, the Wisconsin statute states:

Any person who is or 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. Consent is not an issue in an action under this subsection.

WIS. STAT. ANN. § 940.22(2) (West Supp. 1990); see also N.D. CENT. CODE § 12.1-20-06.1 (Supp. 1989).

²⁶³ WIS. STAT. ANN. § 940.22(2) (West Supp. 1990).

cians, psychologists, social workers, nurses, chemical dependency counselors and clergy.²⁶⁴ The statute covers sexual contact that occurs during the therapist-patient relationship, regardless of whether it arises during treatment, consultation, interview or examination.²⁶⁵ The type of sexual contact covered by the Wisconsin statute includes intercourse, oral sex, sodomy and intimate touching.²⁶⁶ Although the Wisconsin statute does not include sexual contact with former patients, other statutes do prohibit such contact when the patient remains emotionally dependent upon the therapist or when the relationship was terminated primarily in order to engage in sexual conduct.²⁶⁷ Thus, these statutes generally define sexual misconduct as encompassing a broad range of sexual behavior and they apply to virtually all types of practicing therapists.

Because most of the statutes regard therapist-patient sex as a felony, the penalties for an offense usually include imprisonment or a fine.²⁶⁸ For example, a therapist who engages in an act of sexual intercourse in Minnesota may be sentenced to imprisonment for up to fifteen years or fined up to thirty thousand dollars.²⁶⁹ Some

²⁶⁴ WIS. STAT. ANN. § 940.22(1)(i) (West Supp. 1990). Other statutes have similar or expanded lists, such as the California statute, which also includes marriage, family, and child counselors; psychological assistants; marriage, family, and child counselor registered interns; and associate clinical social workers. See CAL. BUS. & PROF. CODE § 729 (West 1990).

²⁶⁵ See WIS. STAT. ANN. § 940.22(2) (West Supp. 1990). The Minnesota statute extends the protection of the statute to acts occurring outside of the therapy session if the patient or former patient is still emotionally dependent upon the psychotherapist or if sexual penetration occurred by means of therapeutic deception. MINN. STAT. ANN. §§ 609.344(1)(i), 609.345(1)(i) (West Supp. 1991). North Dakota, however, makes the sexual contact criminal only if it occurs during any treatment, consultation, interview or examination. N.D. CENT. CODE § 12.1-20-06.1 (Supp. 1989).

²⁶⁶ See WIS. STAT. ANN. §§ 940.22(5), 940.225(5)(b) (West Supp. 1990), which states that sexual contact includes: "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 . . ." Most other statutes prohibit similar sexual contacts, but may distinguish the penalties on the basis of the type of sexual act. See, e.g., COLO. REV. STAT. § 18-3-405.5 (1986); MINN. STAT. ANN. §§ 609.344, 609.345 (West Supp. 1991). The Florida statute, however, limits the prohibited sexual contacts to "the oral, anal, or vaginal penetration of another by, or contact with, the sexual organ of another or the anal or vaginal penetration of another by any object." 1990 FLA. LAWS ch. 70(4)(c).

²⁶⁷ See CAL. BUS. & PROF. CODE § 729 (West 1990); MINN. STAT. ANN. §§ 609.344, 609.345 (West Supp. 1991).

²⁶⁸ See, e.g., 1990 FLA. LAWS ch. 70; ME. REV. STAT. ANN. tit. 17-A, §§ 253, 1252(2)(c), 1301(1)(c) (West Supp. 1990). But see CAL. BUS. & PROF. CODE § 729 (West 1990) (statute provides that the first violation is a misdemeanor); COLO. REV. STAT. § 18-3-405.5 (1986) (statute states that sexual contact, as opposed to sexual penetration or intrusion, is a misdemeanor).

²⁶⁹ See MINN. STAT. ANN. § 609.344(2) (West Supp. 1991). Statutes may impose lesser penalties. See, e.g., N.D. CENT. CODE § 12.1-32-01(c) (Supp. 1989) (provides for imprisonment for up to five years and/or a fine of \$5000).

statutes provides stiffer penalties for subsequent violations.²⁷⁰ Other statutes distinguish between the type of sexual act, imposing lesser penalties for "sexual contact," as opposed to "sexual penetration."²⁷¹

Most of the statutes do not allow the defendant to assert consent as a defense to the action.²⁷² According to one court, even a "consensual" sexual relationship violates the therapist's duty to the patient and can therefore be regulated by the state.²⁷³ The elimination of consent as a defense has been strictly enforced, even in cases in which it is not explicitly stated in the statute.²⁷⁴

For example, in the 1990 case of *State v. Josephson*, the Wisconsin Court of Appeals held that consent could not be used as a defense even when the statute did not explicitly forbid it.²⁷⁵ In *Josephson*, the defendant therapist engaged in a sexual relationship with his patient over a period of four years.²⁷⁶ The defendant argued that consent remained a defense to the action because the statute did not explicitly discuss it.²⁷⁷ The *Josephson* court stated that consent is not a defense under the statute merely because the statute is silent with regard to this issue.²⁷⁸ The court reasoned that the legislature could have required the prosecution to prove lack of consent as an element of its case, yet it chose not to.²⁷⁹ In addition, the court held that the statute was not unconstitutionally vague, reasoning that the

²⁷⁰ See, e.g., CAL. BUS. & PROF. CODE § 729 (West 1990) (first offense is misdemeanor; subsequent violations are punishable by imprisonment or fine); 1990 FLA. LAWS ch. 70 (first offense is felony of the third degree; subsequent offenses are felonies of the second degree).

²⁷¹ See, e.g., COLO. REV. STAT. § 18-3-405.5 (1986); MINN. STAT. ANN. § 609.344(2) (West Supp. 1991).

²⁷² For example, the California statute states in part, "in no instance shall consent of the patient or client be a defense." CAL. BUS. & PROF. CODE § 729 (West 1990); see also COLO. REV. STAT. § 18-3-405.5 (1986); 1990 FLA. LAWS ch. 70; MINN. STAT. ANN. §§ 609.344, 609.345 (West Supp. 1991); N.D. CENT. CODE § 12.1-20-06.1 (Supp. 1989); WIS. STAT. ANN. § 940.22 (West Supp. 1990). The Maine statute, however, provides that therapy must be based on "an intimate relationship involving trust and dependency with a substantial potential for vulnerability and abuse." ME. REV. STAT. ANN. tit. 17-A, § 253 (West Supp. 1990).

²⁷³ See *State v. Dutton*, 450 N.W.2d 189, 193-94 (Minn. Ct. App. 1990). In the civil context, at least one court has stated that patients involved in a sexual relationship with a therapist are incapable of giving consent. *Omer v. Edgren*, 685 P.2d 635, 638 (Wash. Ct. App. 1984) (court noted that sexual relationship is an assault on patient who is arguably incapable of giving consent).

²⁷⁴ See *State v. Josephson*, No. 89-2219-CR, 1990 LEXIS, at *7 (Wis. Ct. App. Aug. 14, 1990) (unpublished limited precedent opinion).

²⁷⁵ *Id.*

²⁷⁶ *Id.* at *3.

²⁷⁷ *Id.* at *5.

²⁷⁸ *Id.* at *7.

²⁷⁹ *Id.* at *9.

precise application of the statute is "plain and clear" and gives therapists fair notice of the conduct that the statute proscribes.²⁸⁰

Some controversy has surrounded the elimination of consent as a defense.²⁸¹ Private interest groups, such as the Civil Liberties Union of Massachusetts, have lobbied against this aspect of the criminal legislation, contending that the elimination of consent as a defense treats any person who consults a mental health professional as a child.²⁸² They argue that such a premise is factually and morally wrong.²⁸³ Furthermore, such groups have argued that the government should not be allowed to regulate the private sexual acts of consenting adults.²⁸⁴ They point to a court decision which held that even sexual conduct that all members of the community find offensive cannot be criminalized when engaged in by consenting adults in private.²⁸⁵

At least one of these criminal statutes has withstood challenge as a violation of the psychotherapist's right to privacy.²⁸⁶ In the 1990 case of *State v. Dutton*, the Court of Appeals of Minnesota rejected a therapist's claim that his right to engage in private and consensual sexual activity was protected by the First Amendment of the United States Constitution.²⁸⁷ In upholding the criminal statute, the court noted that the state can regulate private sexual conduct in certain contexts, such as in cases of sodomy and prostitution.²⁸⁸ The court also noted that the line of Supreme Court cases protecting a right to privacy does not protect a therapist from engaging in sexual activity with a patient.²⁸⁹ The court concluded that a sexual relationship between therapist and patient clearly violates the therapist's duty to the patient and can be properly regulated by the police power of the state.²⁹⁰

²⁸⁰ *Id.* at *12.

²⁸¹ See Letter from Harvey A. Schwartz for the Civil Liberties Union of Massachusetts to Senators Paul D. Harold and James T. Brett (May 30, 1990) (discussing the elimination of consent as a defense in proposed in Massachusetts House Bill 5697) (on file with the BOSTON COLLEGE LAW REVIEW).

²⁸² *Id.* The letter states: "The legislation equates every person who consults a health or mental health professional—which by definition ranges from priests to podiatrists, from psychiatrists to dentists—with a child, declaring that these patients are in all cases incapable of saying no." *Id.*

²⁸³ *Id.*

²⁸⁴ *Id.*

²⁸⁵ *Id.* (citing *Commonwealth v. Balthazar*, 318 N.E.2d 478, 480 (Mass. 1974)).

²⁸⁶ *State v. Dutton*, 450 N.W.2d 189, 193 (Minn. Ct. App. 1990).

²⁸⁷ *Id.* at 193-94.

²⁸⁸ *Id.* at 193.

²⁸⁹ *Id.* at 193-94.

²⁹⁰ *Id.*

Absent these specialized criminal statutes, state courts may be reluctant to uphold criminal prosecutions of psychotherapists who engage in sexual misconduct. In the 1991 case of *State v. Leiding*, the Court of Appeals of New Mexico held that a male psychologist who had sexual contact with his male patient could not be prosecuted under a general criminal sexual penetration statute.²⁹¹ In *Leiding*, the defendant psychologist was charged under a statute that criminalized sexual penetration committed through the use of force or coercion.²⁹² The court noted that force or coercion meant that the perpetrator knew or had reason to know that the victim suffered from a mental condition that rendered the victim incapable of understanding the nature or consequence of the act.²⁹³ The court rejected the state's argument that the transference phenomenon was the requisite "mental condition" required by the act.²⁹⁴ The court noted that if the legislature wished to make therapist-patient sex a crime, it should pass specific statutes as other states have.²⁹⁵

In sum, in states without criminalization statutes for sexual misconduct by therapists, egregious sexual misconduct by psychotherapists may be prosecuted as rape or sexual assault.²⁹⁶ An emerging trend reveals states enacting statutes specifically criminalizing most sexual contact between therapist and patient.²⁹⁷ These statutes are often broad, encompassing a wide range of situations that constitute sexual misconduct.²⁹⁸ In addition, these statutes almost always eliminate consent as a defense for the defendant therapist.²⁹⁹ Although these statutes are relatively new, at least one has survived a constitutional challenge.³⁰⁰

²⁹¹ See *State v. Leiding*, 812 P.2d 797, 797 (N.M. Ct. App. 1991).

²⁹² *Id.* at 798.

²⁹³ *Id.*

²⁹⁴ *Id.* at 799.

²⁹⁵ See *id.* at 799, 800.

²⁹⁶ See, e.g., *Bernstein v. Board of Medical Examiners*, 22 Cal. Rptr. 419, 420 (Cal. Ct. App. 1962); *State v. Ely*, 194 P. 988, 988 (Wash. 1921); *Eberhart v. State*, 34 N.E. 637, 637 (Ind. 1883).

²⁹⁷ See, e.g., CAL. BUS. & PROF. CODE § 729 (West 1990); COLO. REV. STAT. § 18-3-405.5 (1986); 1990 FLA. LAWS ch 70; ME. REV. STAT. ANN. tit. 17-A, § 253 (West Supp. 1990); MINN. STAT. ANN. §§ 609.344, 609.345 (West Supp. 1991); N.D. CENT. CODE § 12.1-20-06.1 (Supp. 1989); WIS. STAT. ANN. § 940.22 (West Supp. 1990).

²⁹⁸ See, e.g., N.D. CENT. CODE § 12.1-20-06.1 (Supp. 1989); WIS. STAT. ANN. §§ 940.22, 940.225(5) (West Supp. 1990).

²⁹⁹ See, e.g., CAL. BUS. & PROF. CODE § 729 (West 1990); COLO. REV. STAT. § 18-3-405.5 (1986); 1990 FLA. LAWS ch 70; MINN. STAT. ANN. §§ 609.344, 609.345 (West Supp. 1991); N.D. CENT. CODE § 12.1-20-06.1 (Supp. 1989); WIS. STAT. ANN. § 940.22 (West Supp. 1990).

³⁰⁰ See, e.g., *State v. Dutton*, 450 N.W.2d 189, 193-94 (Minn. Ct. App. 1990).

III. SUFFICIENCY OF LEGAL REMEDIES TO COMBAT SEXUAL MISCONDUCT

The sexual exploitation of patients in psychotherapy is a serious and complex problem. Some women who seek treatment are particularly vulnerable and easily exploited because of their past histories of sexual abuse.³⁰¹ Many of them will experience transference, projecting feelings onto the therapist from past unresolved relationships. Some of these women may even appear to be seductive. In a healthy therapeutic relationship, the therapist would immediately recognize this behavior as transference and use it to help the woman resolve the painful issues of her past.³⁰² A manipulative or exploitative therapist, however, takes advantage of this vulnerability, with especially damaging results.

Therapists who engage in sexual contact with their patients force these women to reenact the trauma, shame and secrecy of childhood as, once again, they are victimized by a male authority figure. These women are exploited and damaged in the same vulnerable area for which they initially sought help.³⁰³ Women who are sexually exploited by their psychotherapists suffer tremendous harm. They are left devastated, feeling vulnerable, depressed, and at times, suicidal. Many find it extremely difficult, in spite of their terrible pain, to seek additional therapy to cope with this emotional trauma. They have lost their ability to place their trust in the hands of a professional. Many need to be hospitalized. In addition, their marriages or intimate relationships are torn apart, and they are left feeling guilty and ashamed.³⁰⁴ In short, therapists who engage in sexual relationships with their patients rarely leave them undamaged.

Currently, a victim of sexual misconduct can seek legal recourse against her psychotherapist in any of three ways. First, an administrative remedy through a professional association or licensing board is clearly limited.³⁰⁵ Professional associations have jurisdiction only over members and can do little to punish the therapist or protect potential victims. Although a licensing board has the power to revoke a therapist's license, the therapist may still be able to practice professionally under a different title. Both administrative

³⁰¹ See *supra* notes 30-33 and accompanying text.

³⁰² See *supra* notes 50-57 and accompanying text.

³⁰³ See, e.g., *St. Paul Fire & Marine Ins. Co. v. Love*, 459 N.W.2d 698, 701 (Minn. 1990).

³⁰⁴ See *supra* notes 61-74 and accompanying text.

³⁰⁵ See *supra* notes 80-107 and accompanying text.

processes are time-consuming and complicated, providing no immediate incentive for the patient. In addition, the board members who serve on investigatory committees may be other psychotherapeutic professionals and therefore biased. Ultimately, in pursuing an administrative remedy, the sexually exploited patient invests much time and energy without receiving much satisfaction.

One of the most commonly pursued remedies for sexual misconduct is a malpractice claim against the therapist. The patient can collect damages for actual hospitalization and psychiatric care, mental and emotional suffering, and infliction of emotional distress. Most courts hold that sexual contact between therapist and patient is malpractice.³⁰⁶ These courts usually base their findings of malpractice on the therapist's mishandling of the transference phenomenon. This process places a burden on the patient to show that the sexual contact arose during the course of treatment. This requirement has not been difficult to meet because the sexual overtures almost always begin during the therapeutic session, and even when the actual contact occurs outside the office, courts have found the therapist liable.³⁰⁷

The advantages of a civil suit are numerous. First, the patient is likely to be empowered by the process of forcing her abuser to account publicly for his behavior, which is something she probably was not able to do with a childhood abuser. In addition, bringing the suit may allow the patient to resolve lingering feelings of guilt and humiliation. Second, the course of the litigation is largely within the patient's control, unlike a criminal prosecution where the state is involved. Third, some therapists may be deterred from engaging in sexual relationships by the threat of a civil suit, although the manipulative therapist may believe he can control his client to keep her from suing. The suit itself will force the therapist to account for his transgressions by requiring him to pay large sums of money as damages. He will also suffer a loss to his reputation and practice. Finally, the patient is able to use the award to rebuild her life by seeking new therapy to heal the profound damage she has suffered at the hands of the exploitative therapist.

The final remedy available to redress sexual misconduct is criminal prosecution under the recent criminalization statutes.³⁰⁸ The

³⁰⁶ See *supra* notes 131-63 and accompanying text.

³⁰⁷ *Zipkin v. Freeman*, 436 S.W.2d 753, 757-59, 761 (Mo. 1968); *Olson v. Connerly*, 445 N.W.2d 706, 708 (Wis. Ct. App. 1989), *aff'd*, 457 N.W.2d 479, 484 (Wis. 1990).

³⁰⁸ See *supra* notes 253-80 and accompanying text.

existing criminalization statutes are similar in their broad definitions of both the illegal sexual contact and the psychotherapists themselves.³⁰⁹ Some statutes include not only psychiatrists and psychologists, but also social workers, marriage counselors and clergy.³¹⁰ Typically, therapists are criminally liable under these statutes for sexual acts that occur during or outside of therapy, and in some cases even after the therapeutic relationship has terminated.³¹¹ Because these criminal statutes are so broad, they cover a wide range of sexual activity between therapists and patients that may result in a variety of different circumstances.

Criminalization of sexual misconduct is a positive trend that recognizes the seriousness of the problem of sexual misconduct by psychotherapists. Such criminalization creates numerous benefits both to victims of the sexual misconduct and to society in general. First, criminal statutes may be useful in deterring certain therapists from engaging in sexual misconduct.³¹² Second, criminalization benefits the victim by publicly punishing the therapist. Finally, criminalization benefits society because therapists who are imprisoned as a result of the criminal statutes are unable to harm additional patients.

One of the key goals of any criminal statute is to deter the targeted behavior in the future. Unlike a civil lawsuit, therapists may be deterred by the threat of criminal prosecution because a third party, the state, initiates the suit rather than the patient. The patient's spouse or subsequent therapist, or even a colleague of the abusing therapist, may report the criminal violation to the public prosecutor. Thus, the threat of criminal prosecution may be more apt to deter a therapist because he may feel that he can exercise no control over the decision of whether to prosecute. Moreover, the threat of imprisonment, or a heavy fine, and a criminal record may be a stronger deterrent than the monetary penalty imposed in a civil suit in which the insurance company might pay the damages.

In addition to being an effective deterrent, criminalization of sexual misconduct will directly benefit the victim. First, the victim is able to witness the punishment of her abuser. For some victims, the financial consequences of a civil trial are not sufficient to punish

³⁰⁹ See *supra* notes 262-67 and accompanying text.

³¹⁰ See CAL. BUS. & PROF. CODE § 728(c)(1) (West 1990); WIS. STAT. ANN. § 940.22(1)(i) (West Supp. 1990).

³¹¹ See MINN. STAT. ANN. §§ 609.344(1)(i), 609.345(1)(i) (West Supp. 1991).

³¹² Larry H. Strasburger et al., *Criminalization of Psychotherapist-Patient Sex*, 148 AM. J. PSYCHIATRY 859, 860 (1991).

the therapist. Under a criminal statute, the therapist faces possible imprisonment or a heavy fine, either of which will result in a criminal record. Criminal sanctions may satisfy the victim's need for retribution. In addition, a victim of sexual misconduct often has unresolved feelings of guilt because she convinced herself that she was somehow at fault. By criminalizing the behavior, the state will assure the victim that society condemns the actions of the therapist and accepts the proposition that she was truly incapable of giving consent.

Finally, criminalization will benefit society by enhancing public safety. If the criminal prosecution results in imprisonment, the therapist will no longer be able to harm innocent patients. A criminal prosecution will also be likely to instigate license revocation proceedings with a state licensing board. In addition, society will be able to see a wrongdoer punished. Future "consumers," as well as the general public, will begin to understand the severity of the problem of sexual misconduct and learn to recognize the appropriate standards of psychotherapeutic care.

Despite the obvious benefits of criminalization, the statutes as drafted do not adequately combat the problem of therapist-patient sex. First, criminalization may inadvertently harm some victims by invading their privacy or impacting negatively upon a civil suit, including their ability to recover damages from the therapist's malpractice insurance policy which excludes coverage for criminal acts.³¹³ Second, the lack of adequate classification in the criminalization statutes between different types of sexual misconduct ignores the complexity of the problem and the goal of deterrence.³¹⁴ Finally, the criminal statutes do not make any attempt to rehabilitate the therapists who are capable of change.³¹⁵

Unlike a civil suit, a criminal prosecution is not initiated by the patient. Some patients may prefer not to "go public" with their

³¹³ See *id.* at 860-61; Jorgenson et al., *supra* note 109, at 730.

³¹⁴ For example, some statutes do not differentiate between different types of therapist-patient sexual relationships. See ME. REV. STAT. ANN. tit. 17-A, § 253 (West Supp. 1990); N.D. CENT. CODE § 12.1-20-06.1 (Supp. 1989); WIS. STAT. ANN. § 940.22 (West Supp. 1990). Other statutes impose different penalties, depending on the frequency or extent of sexual contact. See CAL. BUS. & PROF. CODE § 729(1),(2) (West 1990) (first violation is a misdemeanor, second violation imposes mandatory imprisonment, a fine, or both); 1990 FLA. LAWS ch. 70(1) (first violation is a third degree felony, second violation is a second degree felony); COLO. REV. STAT. § 18-3-405.5(1)(a), (2)(a) (1986) (sexual penetration or intrusion is class 4 felony, sexual assault is class 1 misdemeanor); MINN. STAT. ANN. §§ 609.344(1), 609.345(1) (West Supp. 1991) (sexual penetration is third degree criminal assault, sexual contact is fourth degree criminal sexual conduct).

³¹⁵ See Strasburger, *supra* note 312, at 861.

experience by having to testify for the prosecution and to relive their traumatic experience. Furthermore, the patient may perceive the elimination of consent in these situations as the law treating her as a child. This aspect of the criminal law may confuse the patient. She may feel reassured by the fact that transference rendered her incapable of consenting and therefore not to blame for the experience, yet may also feel demeaned by a law that deems her incapable of making a meaningful decision.

Even if the patient willingly participates in the criminal trial, the trial may negatively impact the patient's civil lawsuit. Due to the defendant's constitutional right to a speedy trial, the criminal prosecution will most likely take place prior to the civil trial. The patient, after having relived the traumatic experience through her testimony in the criminal trial, may be discouraged or unwilling to confront the therapist again. Furthermore, an acquittal of the therapist in the criminal trial may chill the patient's desire to pursue a civil remedy.

Another possible negative effect of criminalization on the civil case may be the patient's inability to collect damages from the therapist's malpractice insurer, who will claim that the policy excludes criminal acts.³¹⁶ In the past, when sexual behavior between the therapist and the patient was not criminalized by the states, courts have rejected this argument, holding that policy exclusions for criminal acts do not apply.³¹⁷ Now, however, with these specific criminal statutes, courts may deny coverage under the therapist's professional liability policy when that policy expressly excludes criminal acts. Even if the insurance policy does not contain such an express exclusion, courts may be motivated to deny coverage based on a public policy that dictates that an insured should not be indemnified for his criminal acts.³¹⁸

In such cases, the innocent victims of sexual misconduct may suffer by not receiving payment of their damages by the defendant's insurance company. If the therapist is unable to pay himself, the patient might not receive monetary compensation at all. Without this award, some patients may be delayed from entering further, much needed therapy. Thus, the criminalization of sexual misconduct could actually negatively impact patients.

³¹⁶ See Strasburger, *supra* note 312, at 860-61; Jorgenson et al., *supra* note 109, at 730.

³¹⁷ See *supra* notes 229-38 and accompanying text.

³¹⁸ See *supra* notes 223-27 and accompanying text.

Another drawback to the existing criminal statutes is the classification of types of sexual contacts between the therapist and patient. Some attempt to draw artificial distinctions between types of sexual contact, imposing greater penalties for "sexual penetration" than for "sexual contact."³¹⁹ This attempt at categorization is meaningless and ineffective in working towards accomplishing the dual goals of deterring therapists from engaging in sexual misconduct, and rehabilitating those who are susceptible to change. Both of these goals are crucial in eliminating the problem of sexual misconduct. These goals can best be understood by two examples of different types of sexual involvement.

Consider first a therapist who carefully plans his sexual involvement with his patient.³²⁰ His actions are deliberate and manipulative. He consciously deceives his patient by telling her that the sexual activity is part of a "relaxation exercise" or "sexual counseling." This therapist will likely engage in sexual relations with numerous patients. In this scenario, the therapist takes advantage of the patient's vulnerability and trust that are part of the transference phenomenon. He is clearly attempting to gratify his own needs, and does not feel that he loved or cared for the patient. The patient in this scenario obviously suffers much emotional or physical harm.

In a second scenario, consider the therapist who, while treating a patient, begins to feel that he is "falling in love" with her.³²¹ He has never before been romantically involved with a patient. As his feelings become stronger during each session, he becomes confused. He wrestles with his conscience, aware that such a relationship presents ethical and legal problems, but he convinces himself that this situation is different because he is experiencing "true love." The patient returns his romantic feelings and a long-term sexual relationship begins. This therapist has either not recognized the patient's transference or has denied that he could fall prey to it, and has failed to acknowledge his own counter-transference. Although he did intend to engage in the sexual activity, he sincerely

³¹⁹ See COLO. REV. STAT. § 18-3-405.5(1)(a), (2)(a) (1986) (sexual penetration or intrusion is class 4 felony, sexual assault is class 1 misdemeanor); MINN. STAT. ANN. §§ 609.344(1), 609.345(1) (West Supp. 1991) (sexual penetration is third degree criminal assault, sexual contact is fourth degree criminal sexual conduct).

³²⁰ See POPE & BOUHOUTSOS, *supra* note 2, at 6-8 (describing a scenario in which the therapist claims he is engaging in sex therapy). Situations in which the therapist uses drugs or physical force would also fall within this category of premeditated action. See *id.* at 12-15.

³²¹ See *id.* at 15-16 (describing scenario in which therapist believes he is falling in love with patient).

believed that it would be beneficial to the patient. This irresponsible, unprofessional and unethical decision can also result in much harm to the patient.

In both scenarios the patient can emerge emotionally traumatized. Although both therapists deserve some type of punishment, the goals of criminalization involve more than just punishment; they also include deterrence and rehabilitation. The therapist who believes he is falling in love will probably not be deterred by the threat of criminal prosecution, because he is lost in a fantasy and not thinking about the consequences of his actions. He may feel that "love conquers all" and that he could never end up in jail for pursuing such a relationship. In short, he merely rationalizes that his situation is different and then he acts.

The therapist who plans his actions, however, may be more likely to fear getting caught. He is aware that his actions are illicit. Thus, he is able to reason through the consequences of his actions. The existence of a statute that specifically prohibits this behavior, eliminates consent as a defense, and threatens imprisonment, serious fines, public exposure and a permanent criminal record, is likely to deter him from engaging in this behavior.

Criminal statutes will be ineffective in working towards a final solution for this serious problem of sexual misconduct by psychotherapists if these statutes either continue to treat all types of sexual misconduct alike, or draw artificial distinctions based on penetration versus contact or frequency of incidents. The goal of the criminal statutes should be to eliminate the problem. Therefore, state legislatures must approach this challenge with a broader, more enlightened view than just seeking to punish. Instead, legislatures must distinguish among the different scenarios of sexual misconduct in more meaningful ways.

One possible solution is for a statute to take into account various factual criteria, such as the role of transference, the number of incidents, the degree of force or manipulation on the part of the therapist, the duration of the relationship, the therapist's record of similar violations in the past, the specific intent of the therapist, and the likelihood of the therapist's successful rehabilitation. The statute can further provide a range of different penalties, depending upon the significance of the above factors.³²²

³²² For example a state might use the following statute:

(a) Any psychotherapist, or any person holding himself or herself out to be a psychotherapist, who engages in sexual contact with a patient or client is guilty

This statutory scheme allows the criminal penalties to be adjusted to further the goals of deterrence and rehabilitation. For the repeat offender or therapist who acted maliciously, a heavy fine or jail sentence may act as a deterrent. This defendant is less likely to be capable of rehabilitation and therefore would likely not benefit from a corrective or educational program. If he is forced to serve time in jail, he will be prevented from harming others in the future.

In contrast, a therapist who experiences a traditional counter-transference situation would not likely be deterred by any criminal penalty. For this therapist, rehabilitation is a more realistic goal. In his case, probation coupled with a mandatory corrective program will educate him about the harm he has caused and deter him from future misconduct, should the state licensing board ever allow him to practice again.

In conclusion, state legislatures considering whether to criminalize therapist-patient sexual conduct need to understand the complexity of the problem and the diverse circumstances in which it may arise. Statutes should differentiate types of therapist-patient relationships and should further not only the goal of punishment but also the goals of deterrence and rehabilitation. These latter goals require that state legislatures draft criminal statutes to draw meaningful distinctions between different types of relationships and that courts apply the criminal penalties accordingly. The manipulative therapist, incapable of rehabilitation, should be subject to imprisonment or a serious fine. The confused or "in love" therapist should be required to undergo a mandatory treatment program.

A final way to address the problem of therapist-patient sex is through education and professional training. In many cases, therapists themselves fail to recognize transference and counter-trans-

of sexual exploitation. Consent of the patient or client is not a defense to this action but may be relevant to sentencing as defined in (b).

(b) The first violation of (a) shall be punishable by a mandatory rehabilitation program. The court, at its discretion, may also impose a fine not exceeding \$___ or order imprisonment of not more than ___ years, or both, based on one or more of the following factors:

- (1) the defendant used physical force to engage in sexual contact;
- (2) the defendant used drugs or other mind altering substances or techniques to engage in sexual contact;
- (3) the defendant used deceit, fraud, or trickery to engage in sexual contact;
- (4) the patient or client knowingly consented to sexual contact

(c) Second and subsequent violations of (a) shall be punishable by a fine not exceeding \$___ or imprisonment of not more than ___ years, or both.

ference as they occur. If these therapists do ask for help from their colleagues, the issues are likely to be minimized or "swept under the rug."³²³ Professional training programs are reluctant to address sexual exploitation.³²⁴ The psychotherapeutic professional community should require preventative training and education programs as part of licensing or certification and continuing education requirements. This training should include exposure to the testimony of patients who have been damaged by sexual contact with therapists and open discussions of counter-transference.³²⁵ This interactive type of program would influence the therapist much more than a passing reference in a training course or a single line in an ethics handbook.

In addition, professional associations and state consumer organizations should place a heavier emphasis on consumer education.³²⁶ Patients could be educated through the use of literature dispensed by the therapist or placed in office waiting rooms.³²⁷ Such widespread acknowledgment and discussion of the problem will not only educate potential victims, but will serve as an ongoing reminder to therapists as well. Preventative and educational programs for all involved should effectively supplement the legal advances in combatting this serious problem.

IV. CONCLUSION

In recent years, the number of patients sexually abused by mental health professionals has grown rapidly. The close emotional bond that forms during therapy may precipitate sexual exploitation by these professionals. Patients may emerge from these relationships emotionally harmed. They are left feeling shocked, humiliated and depressed, and in some cases, even suicidal.

One option available to victims is administrative remedies, which are time-consuming and often ineffective. Alternatively, courts commonly recognize civil causes of action for psychotherapist sexual misconduct and provide victims with financial compensation for their suffering. Finally, criminalization poses some benefits to

³²³ *Id.* at 39.

³²⁴ *Id.* The problem of therapist-patient sex has been "treated with benign and sometimes malicious neglect" and there have been few suggestions for either remedying or preventing the problem. *Id.* at 150.

³²⁵ *Id.* at 151.

³²⁶ *See id.* at 154-55.

³²⁷ *Id.* at 154.

victims. The existing criminal statutes, however, are too broad to achieve the goal of eliminating the problem of sexual misconduct by psychotherapists. The statutes should differentiate between types of sexual misconduct and adjust their penalties accordingly. Therapists who are capable of rehabilitation should be required to undergo treatment, while others should be punished with imprisonment or fines. If these statutes are drafted with an eye towards the complexity of the problem, they may be more successful in eliminating the problem of sexual misconduct by psychotherapists.

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