The ULTIMATE BETRAYAL

GARY R. SCHOENER

...with purity and holiness I will practice my art…Into whatever house I enter I will go into them for the benefit of the sick and will abstain from every Voluntary act of Mischief and Corruption and further from the seduction of Females or males, of freemen and slaves

These words, authored between the 4th and 3rd centuries BC and titled the "Oath of Hippocrates," were sworn to by physicians for more than two millennia. This concern about medical professionals misusing their power to sexually exploit patients dates from the earliest days of medicine.

In 1784, Louis XVI, the King of France, became concerned about the possibility of physicians misusing the newly discovered technique of mesmerism (later named "hypnosis") to sexually exploit female patients and appointed a commission to study this risk. Chaired by American Benjamin Franklin, it included famous doctors and scientists, including Lavoisier, the man who discovered oxygen. This Commission concluded that there was such a risk.

But Codes of Ethics and the swearing of oaths did not solve this problem and so the history of psychotherapy includes many examples of sexual exploitation of patients.

Famed analyst Carl Jung had a romantic involvement with Sabina Spielrein, a young medical student who came to Jung struggling with serious emotional problems and then went on to a brilliant career in psychoanalysis, cut short by her murder by the Nazis on 27 July 1942. During a now famous interchange of letters with Freud, Jung acknowledged his misdeeds, only to have Freud blame Spielrein. (Kerr, 1993) The involvement between June and Spielrein was not a singular one in early analytic circles and there are many other such examples.

While at the University of Toronto, Ernest Jones became the subject of an allegation of sexual involvement with a client. He had not only denied the involvement but attacked the woman's general practitioner who had assisted her in making the complaint. However, his defense was seriously undermined by revelations that he had attempted to pay money to the former patient to stay quiet about the matter.

From its very beginning the field of psychotherapy was characterized by problems with the maintenance of professional boundaries and that of sexual contact.

A BRIEF NOTE ON MY EXPERIENCE

I have been a staff member at the Walk-In Counseling Center (WICC) in Minneapolis, Minnesota, since 1971 and was one of its first volunteers when WICC opened in 1969. WICC is an organization of mental health professionals – psychologists, social workers and the like – who donate their time to provide free services to people who otherwise might not get help.

Being professional and being separate from the major mental health services, perhaps it should be no surprise that people who have had bad experiences with therapists might come to our doors for help. WICC has always had the support of the local professional community and also has received awards such as the American Psychiatric Association's Gold Achievement Award in Hospital & Community Psychiatry.

Personally, even before I was at WICC, two of my first 10 clients in my career had been sexually touched by a therapist. One was a woman and one was a child. Starting in 1974 WICC began working with victims of therapists, and in l976 we began a support group. We and our colleagues ran such groups for 19 years until, fortunately, the number of local victims dropped low enough that we could not fill the groups. We have not solved the problem in Minnesota but we have reduced it substantially.

Beyond work with victims and their families, we also evaluate offending therapists and determine if rehabilitation is possible. In the late 1970's we originated what we call "processing sessions" in which the victim and offender meet under our supervision. This is not the same as mediation so it is not technically "alternative dispute resolution." Dr. Marie Valiquette in Montreal has also used this technique and if there is time later perhaps we can discuss it further.

I testify in licensure cases, criminal cases, civil lawsuits, and hearings related to employment. Eventually this work included Canadian situations and I have testified in a number of matters in Canada. Most of this has involved cases being heard by a college or regulatory body, but I have also served as a expert witness in some civil lawsuits and also in one criminal case involving a therapist's sexual exploitation of a client. I have done training in British Columbia, Alberta, Manitoba, Ontario, New Brunswick, and Nova Scotia.

One last note: For some years I have been associated with Advocateweb which has created a wonderful website on this issue at **www.advocateweb.org**

PSYCHOTHERAPY AS A SETTING FOR EXPLOITATION

The psychotherapeutic relationship is an easy setting for sexual exploitation for reasons which go far beyond the simple fact that it is conducted in private.

- First of all, by definition clients are coming in because they or others have questions about their decision – making if not their sanity.
- They place considerable trust in the therapist
- Who through the process of therapy comes to know a great deal about them which can set the stage for knowing how to manipulate the client.
- The client typically becomes emotionally dependent on the therapist
- The therapist learns many private details of the client's life which can lead to a fear of blackmail if the client files a complaint
- The therapist can accuse the client of misunderstanding his or her motives

TYPES OF OFFENSES

Sexual misconduct and exploitation by therapists can take many forms. A few examples may help broaden our understanding:

(1) **Rape or sexual assault using threats or violence** – while not common in the professional office, there are such cases of traditional force.

(2) **Sexual assault of a patient who is medicated, asleep, or otherwise unable to consent.** A therapist wandering around a hospital can do this.

(3) **Use of hypnosis to undermine ability to resist advances.** The hypnosis may play a therapeutic role in the treatment or be utilized for this purpose**.**

(4) **Representation of sexual contact as some form of treatment – sex by fraud. "**You need to learn to love." Or the therapist claiming to serve as a "sexual surrogate" to help the client improve sexual performance.

(5) **Touch done "accidentally" … on purpose.** A hug turns sexual, or therapy involves "holding" which becomes sexual. Some therapists do this on purpose – it is not an accident

(6) **Frotteurism – sneaky touch.** A male syndrome involving touch with an erect penis, usually clothed, during a hug or when close to a woman.

(7) **Exploitation of transference –** This can involve a highly erotic relationship which is fantasy-laden but involves little or no touch where the therapist causes the client to engage in all sorts of fantasy involving sex.

(8) **Phone sex or internet sex –** The therapist contacts the client by phone or on the internet and engages in sexual discussions designed to satisfy the therapist.

(9) **Development of an ongoing relationship which exists only in the office.** This involves what is justified as a "love" relationship but it exists only in the office, and may not involve even a discussion as to where the relationship is "going."

(10) **Development of a relationship outside the office with a current, or former client.** This is often inaccurately labeled an "affair" for lack of a better term, and may involve actual promises of marriage.

(11) **Sexual harassment.** Unwanted sexual advances and/or other types of sexual harassment which fits the traditional definition. This can include questions and talk about sex which are not part of treatment and which are inappropriate.

"SECONDARY" VICTIMS

The impact of sexual exploitation by therapists on persons connected to the primary victim is often ignored or "invisible." A former staff member at the Walk-In Counseling Center, Jeanette Milgrom, called these "secondary victims." In the 1990's our colleague Ellen Leupker termed them "associate victims."

These include the spouse and the children of the primary victim, who may suffer loses due to the exploitation. For example, the victim may be physically or emotionally absent from the home due to involvement with the therapist. She (or he) may be acting strange and telling lies. Or it may simply be that the condition for which treatment is sought – such as depression – has gotten worse.

Since these people have no idea what is happening, their own reality-testing can be undermined. Some suffer as much as does the primary victim. As for the children, they may lose the support of a parent at a critical time in their own lives. For the primary victim one of the greatest sources of pain can be the knowledge that they deserted – at least for a time – their children. We have found that these secondary or associate victims sometimes need as much help as the primary victim.

One other group of victims are those associated with the offending practitioner. Here again families can be deserted and colleagues can be troubled and confused. The other clients of the offending therapist may be traumatized and confused. The circle of harm is at times very broad.

IMPACT ON THE VICTIM

First of all, although about 75% of cases we have seen are male practitioner and female client, a growing number are female – female, female therapist-male client, or male – male. There are more similarities than differences between these groups.

Impact on the victim varies dramatically case to case. In some, the victim is devastated and in some kills herself. In others she walks away hurt and angry and simply wants the offender to undergo discipline. In all cases, of course, there is a disruption of the counseling or therapy and often the original problems still require help.

It is common for the professional to have provided some legitimate help, but followed it with a confusing mix of therapy and misconduct. The challenge afterwards is to help the client retain his or her gains while moving beyond the exploitation or abuse.

Common problems which result include any or all of the following:

- **Loss of trust in professionals of the same gender as the offender; or loss of trust in all professionals regardless of gender**
- **Depression and suicidal thinking or attempts**
- **Loss of self esteem; confusion about personal identity**
- **Anxiety and/or Posttraumatic Stress Disorder or symptoms**
- **Anger or rage**
- **Grief at the loss of the relationship when it ends**
- **Loss of primary relationships – marriages or even relationships with children**
- **Shame and guilt – about the trust betrayal, or about "not being there" for kids or spouse**

- **Problems in sexual interest or performance**

TYPES OF OFFENDERS

I have attached a listing of some of the types of factors we find in offending professionals, and a diagram on how we do an evaluation. Victims of this sort of abuse or exploitation are often very interested in understanding what is wrong with the offending practitioner. The most common question we get is "Why did he do it?" If there is time, or perhaps during the question session perhaps we can discuss these, but I will go on instead to talk about the situation of the victim dealing with the situation and obtaining both help and justice.

A NOTE ON THE CANADIAN FRAMEWORK

Canada is similar to other former Commonwealth countries in having professional regulation through colleges or councils. This is called self-regulation in that the profession itself runs the college or council – not the government. By contrast, in the USA licensure boards are run by the states and are a unit of government.

As a reality, however, the functioning is not always that different, and some of the problems Canada has had with regulation can also be found in the American system.

Another area of similarity is that psychiatry is regulated as a specialty of medicine rather than by its own board. Furthermore, throughout not only North America but the world, there are always unlicensed and unregulated counselors and therapists.

In terms of addressing the issue of abuse or exploitation by health care professionals, the Canadian focus has been very heavily focused on the issue of sexual misconduct in medicine such as with the reports done in Toronto and British Columbia, and then echoed through the provinces, on sexual exploitation by physicians. The Colleges of Physicians and Surgeons were the focal points for this work, even though in some provinces like Ontario, other professions adopted similar requirements.

The most dramatic changes happened in Ontario where the regulated health professions have declared sexual exploitation of patients as something which can lead to permanent revocation of a license or registration, and where regulated health professions are all mandated to report any cases they learn of.

CRIMINALIZATION

In my home state of Minnesota it is a felony for a psychotherapist to have sexual contact with a client, punishable by 2 years in state prison for the first offense. 24 other states have some sort of law which is similar. Furthermore, even with a former client if sex occurs as a result of therapeutic deception or emotional dependency, it is a crime.

One of the great advantages of criminalization is that the victim, in the USA, may be eligible for funds which are provided to victims of crime. Secondly, this is very helpful in dealing with confused secondary victims like husbands. It permits us to say: "Sir, your wife was the victim of a crime," which helps some people accept and understand what has happened more easily.

CIVIL LAWSUITS

In the states, the long-time existence of lawsuits done with a contingent fee basis – that is where the client does not have to shoulder the costs – has played a major role in having lawsuits. Secondly, the monetary awards can be quite high. This has served to deter some offenders, but especially caused employers to do things which have helped deal with offenders so that they do not remain in the system. Prior to the major lawsuits there was not much of an incentive to change.

THE WHEEL OF OPTIONS

Our center created a "Wheel of Options" many years ago to try to help clients see that they had many options. In each case it is important that the victim, or the advocate, understand what each option can bring about in terms of outcomes, and also what are the burdens on the victim in each case. Some examples:

Criminal complaint: Only possible in some states. Does not require monetary expense by the client. Sometimes personal rights are better protected – one's sexual history can often be protected. But sometimes become public. This can impact, more than any other method, on the ability to practice.

Regulatory complaint: Often a long process, but typically private. Can impact practice and even require rehabilitation. But it cannot help obtain funds to pay for care. Sometimes very frustrating due to the length of time, and depending on the outcome. Alternative dispute resolution has been tried but is difficult because the

regulatory duty is in fact to protect the public – and ultimately that cannot be negotiated with the victim – it is the duty of the regulatory body.

Civil Suit: This is one of the longest procedures, and one can be viciously questioned by the defendants attorneys. Sometimes greater privacy is possible, but there is far more exposure of ones personal life. Monetary gain is possible and of course is the main goal of such a suit. This does not guarantee that the offender will lose the ability to practice.

Mediation or Processing Session: These can help resolve feelings and provide clarity And at times can provide some compensation. They are private.

Private Compensation: If this can be negotiated, it can be private and produce money, but this does not impact on the professional's career or ability to hurt others. This is a type of alternative dispute resolution, and can even include a requirement that the professional go for an evaluation. But it cannot force rehabilitation.

Complaint to Employer of Offender: This can be done quickly and can be relatively private. Some employers act quickly and this can protect others.

The greatest challenge is to assist the victim in moving on and not awaiting the outcome of the complaint.

Gary R. Schoener is a Clinical Psychologist who serves as the Executive Director of the Walk-In Counseling Center, 2421 Chicago Ave. S., Minneapolis, Minnesota 55404. **www.walkin.org** His personal email is: **grschoener@aol.com**

TYPES OF OFFENDERS

Although there are patterns for certain types of offenses and offenders, below, in no particular order, I list factors which may play a major role in a given case. While individual psychopathology may be an issue, not all those who offend sexually do so as a result of a disorder.

(1) Inadequately Trained: This may reflect a general lack of training relative to boundaries or a specific lacunae in the training as regards relationships with clients or patients;

(2) Those who lack good supervision at their worksite or who fail to use the supervision that is available to them: Some job situations lack the necessary supervisory backup to help staff cope with difficulties and challenges.

(3) Those who lack awareness of transference/countertransference in general, or in a given situation: Some professionals are not aware of their areas of vulnerability and lose their boundaries with certain clients.

(4) Those who have excessive need for client or patient approval: Professionals who are insecure and who will do anything to gain client approval have great difficulty setting limits.

(5) Those who are naive and lacking in good social judgment: Some professionals appear to lack the "social intelligence" necessary to be a professional, including at the extreme some with Asperger's disorder.

(6) Practitioners with impaired judgment secondary to addiction or alcoholism: Substance abusers and alcoholics may have judgment that is impaired due to their varying mood states or intoxication.

(7) Psychopathology: Beyond the psychopathology inherent in some of the previous points, it may turn out that the offender has any of the following problems:

> **Schizophrenia or Severe Borderline Condition:** Troubled thinking or a lack of impulse control based on an underlying thinking disorder. They may develop bizarre belief systems. They may believe, for example, that semen has incredible healing properties.
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> **Mood Disorders:** Bipolar disorders can lead to dysfunction due to manic or depressive episodes. An expansive manic can run off with a client on some sort of escapade or be quite grandiose. Depressive illnesses can impair judgment and/or lead the professional to become quite needy and dependent on their client's for support.
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> **Predators with Psychopathology -- Sociopaths or Severe Narcissistic Personality Disorders:** Self centered and exploitative by nature, these professionals seek to manipulate to get their needs met. They may also engage in fraudulent billing, etc. Narcissists resist treatment and sociopaths do not respond to either punishment or treatment.
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> **Impulse Control Disorder:** This can be a sexual impulse control disorder or a more general problem, often combined with an addictive problem. Among the many sexual disorders which are observed in

professionals are:

(a) Sexual Assault & Rape: Sexually aggressive person who commits a forceful assault in the office or in the community;

(b) Sexual Assault of an Incapacitated patient: Semi-conscious or disabled.

(c) Pedophilia or Ephebophilia: Sex with children or adolescents.

(d) Frotteurism: "Sneaky touch" -- touching a patient with penis

(e) Voyeurism: Watching while undressing, keyhole peeping, etc.

(f) Exhibitionism: Exhibiting ones genitals.

(g) Sexual Harassment: Pressure for dates, unwanted kissing & touching, creation of a hostile atmosphere.

(8) Emotionally Needy & Dependent: There are a number of problems associated with low self esteem and high dependency needs, which lead professionals to be highly needy of client acceptance on a long term basis.

(9) The professional as a superhero: Practitioners who are driven to be "perfect" or do everything for clients, ironically, may begin taking risks while rationalizing that they need to try "everything" that might help.

The categories above **are not mutually exclusive. In most cases there are multiple determinants. The key is to determine what the pattern is, if any, and why it occurred. Any assessment must sort out what factors are key in a given case.**

DIAGRAM OF EVALUATION PROCESS