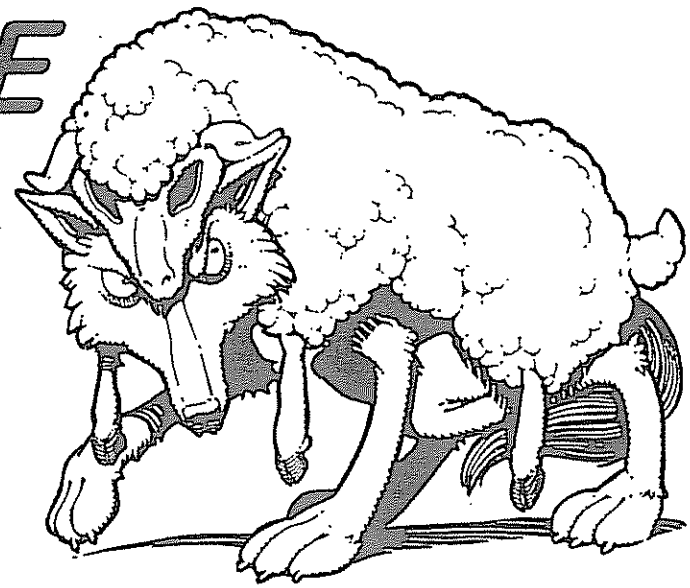
THE DANGEROUS MYTH OF THE PREDATORY THERAPIST



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As an attorney defending therapists, I have personally been involved in handling seventy cases of alleged sexual misconduct between therapists and patients. These cases have included therapists from every school of professional thought and every licensure status. About half of these cases have involved false claims, either claims which were deliberately fabricated or which were the product of extreme distortion on the part of highly disturbed patients.

What has become apparent to me, is that there are a number of myths in the professional community regarding sexual misconduct and who engages in it. The most prevalent myth is that sexual misconduct claims arise primarily from sexually predatory therapists. However, both anecdotal experience and the data that is available do not support this myth. Recently I asked Margaret Bogie of the American Professional Agency to check their claim files and ascertain how many of their insureds accused of sexual misconduct have had more than one claim. According to Ms. Bogie, American Professional Agency's statistics show that over eighty percent of the insureds who have been the subject of a sexual misconduct claim have had only one such claim.

In those instances where sexual misconduct does occur, most of the cases in my personal experience have involved well meaning therapists who have fallen into unfortunate circumstances with particularly dangerous or demanding patients. Thus, it is my belief that the myth of the sexually predatory therapist can blind therapists to dangers and warning signs which would help them avoid becoming involved in sexual misconduct. The purpose of this article is to identify those warning signs, so that therapists who are currently under the illusion that they cannot be the subject of such claims can protect themselves.

One of the accurate truisms about sexual misconduct cases is that sexual relationships between therapists and patients generally do not have much to do with physical attractiveness. In fact, when married therapists are involved with patients, the therapist's spouse is usually far more attractive than the patient with whom the relationship occurs. I believe that the problem lies with the level of adulation that certain patients give to therapists, which borders on worship. This level of adulation has a corrosive and insidious effect on the therapist's otherwise good clinical judgment. Generally, the adulation corrodes the therapist's judgment over a period of time, and when a case reaches the litigation stage it is easy to see in hindsight where the therapist began to go down the wrong path.

The following are a series of warning signs that are gleaned from numerous cases, which should put the therapist on notice that he or she may be encountering a patient who is experiencing sexual feelings for them. It is, of course, axiomatic that the seductiveness of the patient is not a defense, although it can help explain how an unprofessional relationship occurs. Any of these red flags or warning signs should be noted in the file, along with the therapist's reaction to the warning sign. Further, any of them, or several of them in combination, would suggest that appropriate consultation with an experienced peer should be pursued.

(1) The patient expresses overt sexual interest in the therapist either verbally or by conduct.

(2) The patient describes dreams in which the therapist is an actor, particularly dreams of a sexual nature.
(3) The patient begins expressing excessive interest in the therapist's private life, and particularly the therapist's relationship with his or her spouse and children. This may include expressing jealousy or envy of the therapist's spouse.
(4) The patient attempts to give the therapist gifts of a romantic nature. Even gifts as simple as a Valentine card may be a warning sign. It is incumbent on any therapist when faced with such gifts to explore what the gift symbolizes to the patient. Further a conscious decision has to be made whether or not to accept such a gift, and the reason for accepting or rejecting it must be noted in the file. A gift of an inordinate dollar value should be rejected. Gifts of alcohol should be carefully considered, particularly if the patient has a history of alcohol abuse or if alcohol has a particular significance to the patient.
(5) The patient begins to request out-of-office contact, such as sessions in restaurants or other locations. I refer to these as field trips, and field trips must always be justified and the justification noted in the file. Typical valid reasons for field trips include going to a particular location with an agoraphobic patient. Under some circumstances observing an eating disorder patient at meals may be appropriate. Out-of-office contact is always dangerous and should occur rarely and only for sound therapeutic justification.
(6) The patient gives the therapist poetry (often quite bad) with a romantic theme.
(7) The patient appears in seductive attire.
(8) The patient misconstrues a reference to caring for him or her as a patient or loving him or her as a Christian as being a romantic or sexual interest.
(9) The patient appears to be touch-starved and/or repeatedly requests hugs or physical contact.
(10) The patient persistently desires to be special.

There are also warning signs that therapists must be on guard for in their own thoughts and behavior which may evidence that their judgment is becoming eroded. These include the following:

(1) The patient begins appearing in the therapist's dreams or sexual fantasies.
(2) The therapist finds him or herself looking forward to sessions with that patient more than with other patients.
(3) The therapist begins to feel that the patient is different or special.
(4) The therapist begins to feel that the patient understands him or her where others do not. This is not the patient's job, and it is a sign that the relationship has transgressed normal boundaries.
(5) The therapist initiates inquiries into a patient's sexual life or sexual fantasies which are not relevant to the issues therapy is sought for, or the issues then being discussed in therapy.
(6) The therapist pays particular attention to the patient's attire, more so than with other patients.
(7) The therapist begins to pay attention to his or her own attire on the days of sessions with that particular patient.
(8) The therapist is reluctant to discuss or think of the patient in clinical terms. This would indicate that the therapist is already seeing the patient in non-clinical and therefore dangerous terms.
(9) The therapist interprets ambiguous symbols or dreams of the patient to involve the therapist. (In one case we had, virtually every sexual dream or fantasy that a patient had was interpreted by the therapist to refer to him, even though there was no obvious expression of such interest by the patient.)

The most critical and dangerous time for a good therapist who is faced with an adoring patient is when the therapist is going through a life crisis. At these particular points the therapist may be unable to resist the corrosive effect of adulation. Some life crisis that we have seen involved cases where therapists became sexually involved with patients while going through a divorce, business failure, death or lingering illness of a family member, etc.

These issues will be exacerbated by the passage of Civil Code section 51.9, a new statute which creates a special cause of action against professionals, including psychotherapists and specifically MFCCs and LCSWs for sexual solicitations or overtures made to patients. Now, more than ever, it is particularly critical for therapists to be clear in their communication and conduct with patients to avoid assertions of sexual harassment. ⓒ

O. Brandt Caudill, Jr. has been practicing law since 1976 and has specialized in the representation of mental health professionals. Mr. Caudill has handled a number of precedent setting cases involving issues of concern to mental health professionals, such as child abuse reporting immunity. He has authored numerous articles dealing with topics of interest to mental health professionals, including articles on the repressed memory controversy, note taking, vicarious liability, and the administrative hearing process. Mr. Caudill and Dr. Ken Pope have authored a book for the American Psychological Association entitled "Laws & Mental Health Professionals: California" *which is intended to be a comprehensive overview of the law regulation in cases applicable in California. Mr. Caudill has spoken frequently to professional groups on ethical and legal issues. Mr. Caudill is also a frequent speaker at psychology MFCC training programs at educational institutions.*