Psychiatrist-patient relationship- crossing the boundaries of law and ethics
A.Firouzabadi, M.D.
Shiraz University of Medical Sciences

Summary: Sexual contact between psychiatrist and patient has long been considered unethical. The doctor is in a position of power and trust and sexualization of the relationship is a betrayal of the trust. Among psychiatrists who responded to a recent survey 7.1 percent of the male psychiatrists and 3.1 percent of the female psychiatrists acknowledged having had sexual contact with their patients. The vast majority of these offenders reported no or inadequate training in dealing with sexual feeling in therapy. The reluctance of professional training courses to accept and effectively address the issue of sexual feeling in psychotherapy may have prohibited the prevention of therapist-patient sexual contact from developing. This article aim to highlight some aspects of the issue and make suggestions about how they might be handled.

Sexual involvement with patients is not only illegal, but also it is unethical. From at least the time of Hippocrates sexual involvement between patient and healer has been prohibited. The American Psychiatric Association was the first among the medical specialties to address the problem in 1990. American Medical Association clarified the issue by stating that sexual or romantic involvement with a current or former patient is unethical and inconsistent with the physician-patient relationship.

In a recent survey in the U.S. 7.1 percent of the male psychiatrists and 3.1 percent of the female psychiatrists reported having had sexual contact with their patients (1). In Iran, we have no specific data about the incidence of sexual misconduct. Like many other issues, our dominant tendency is denial of the problem. However, it is a reality and for solving a problem we have to be able to see the problem. There is an active resistance to collecting or publishing data showing the scope and consequences of this issue. We may act in ways that keep the “Family Secret”.

The resistance is not limited to us. 25 years ago, H. Greenwald tried to encourage systematic study of therapist-patient sexual intimacies:

“I just raised the question… intending, as a clinical psychologist, that it be studied like any other phenomenon. And just for raising the question, some members circulated a petition that I should be expelled from the Psychological Association”(2).

It seems that psychologists, psychiatrists and social workers engage in sexual intimacies at equivalent rates (3).

According to Glen Gabbard, one of the pioneers in the field of sexual misconduct, few accused therapists will admit that the accusations against them are valid. They employ a wide array of rationalizations to justify their behavior (4):

- Sexual behavior never took place in the office during actual therapy hours.
- The behavior was ethical because the formal therapy relationship had been terminated.
- Sexual relationship was therapeutically indicated and the patient might have committed suicide if they not complied with the patient’s wishes.
- Their feeling is manifestation of true love.
- They were passive victims of seduction.
The unconscious issues activated in any particular therapist-patient dyad depend on the psychological characteristics of the therapist, those of the patient, and the various interaction between the psychological constellations of both therapist and patient. Gabbard explains four mechanisms that could lead to better understanding of this issue:

**Psychopathic exploitation:** some sexual misconduct can be understood as a result of the presence of psychopathy in the therapist. These cases which constitute a relatively small percentage of boundary violation, would also include therapists with severe narcissistic disorder in keeping with the notion that psychopathy is really a subcategory of narcissistic personality disorder. The absence of a mature moral sense in these therapists make it difficult for them to experience other people as separate individual with feelings of their own. Hence, patients who come to them for help are seen merely as object to be used for their own sexual gratification. These therapists often have histories of profound abuse or neglect as children and their behavior is an attempt to turn the tables on their childhood experiences.

**Lovesickness:** One survey of psychiatrists revealed that 65 percent of those who had been sexually involved with patients felt they were in love with the patient (1). The transference-countertransference dimension of the affair makes it symbolically incestuous. The patient may represent a long-lost incestuous parental object for the therapist.

Blum has differentiated erotic from erotized transference (5). In the former, the patient retains an observing ego that is able to distinguish the transference wish from the reality of situation. In the erotized variant, the patient loses the reality and sees the sexual wish for therapist as appropriate.

The erotized transference has its countertransference counterpart in the case of the lovesick therapist. He loses insight or reality testing in such a way that he no longer appreciates the fact that something from the past is being repeated in the present. Gabbard has referred to this phenomenon as a “nonpsychotic loss of reality-testing.”

**Confusion of therapist’s needs with patient’s needs:** Many therapists have felt insufficiently loved as children and they hope that providing love for their patients will result in their being idealized and loved in return. Therapists may hope to regulate their self-esteem through their work with patients. In a study by Vaillant of male physicians and a control group of other professionals, he found that physicians were more likely to feel that they were inadequately nurtured as children (6). Therapists who fall progressively in love with a patient may unconsciously be hoping to provide love for a part of themselves identified with the needy patient.

**Latent hostility:** Therapists occasionally resort to sexual relationships out of despair when their omnipotent strivings to heal the patient have been frustrated. The rage at the patient is thus buried beneath professions of love and caring. Sometimes, therapists who transgress sexual boundaries are acting out some bitterness that belongs elsewhere.
One prominent historical example of this dynamic involved the relationship between Sandor Ferenczi and Freud. Although Ferenczi was analyzed by Freud, he rejected Freud’s technique and developed his own technique. This mode of treatment involved actively indulging patients by hugging and kissing them and attempting to give them the love that they did not receive as children. In a letter to Freud Ferenczi reproached him for not having analyzed his negative transference.

In some patients seductive behavior is a means to punish past and present authority figures. By inducing the physician to stretch patterns of practice and even violate professional ethics, the patient destroys the physician’s stature and integrity. Successful seduction reverses the dynamics of power between doctor and patient.

Familiarity with these dynamics should be part of every psychotherapist’s education. Recognition of these dynamics may serve as early warning signals for one’s vulnerability to involvement. When the therapist begins to feel that love will cure the patient or that crossing professional boundaries may be helpful to a patient, it is time to consult a colleague.

Confronting the reality of sexual abuse is a difficult and stressful task. Part of the problem may be our discomfort with even acknowledging sexual attraction to our patients. Part may be our difficulty handling sexual issues in our training programs and relationship with our students.

This issue should be covered in medical training programs. The students must learn that patient’s dependence on the professional and trust that is necessary for a helping relationship import a certain power to professional that he has the responsibility not to abuse. Although either party may experience sexual feeling the professional is always the one responsible for maintaining the boundaries. We should be aware of indicators of potential problem such as:
- Extension of office hours to see a particular patient.
- Discussion of meeting outside the professional setting.
- Telephone calls or other communications to or from patients about issues unrelated to medical care.
- Inordinate preoccupation with thoughts of the patient.

Regarding the progressive development of counseling centers in our society, we need a realistic approach to the issue. One important aspect is the competence of persons who work as therapists in these centers. Which organization is responsible for evaluation and how it should be performed?

Sexual contact is the most extreme and traumatic form of boundary violation. However, finding the balance between closeness and separateness can be most effectively accomplished by studying some of the more subtle nonsexual boundary issues (7). Under what conditions does a professional accept gifts or social invitations? To what extent is touch between professional and patient acceptable? To what extent are dual relationships acceptable? Is it acceptable for the professional to disclose personal information to the client? How are these considerations of boundary issues translated into ethical and legal standards for professional behavior?
References: