

Management of professional sexual misconduct: Evaluation and recommendations

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P Assalian, M Ravart. Management of professional sexual misconduct: Evaluation and recommendations. *J Sex Reprod Med* 2003;3(3):89-92.

Despite condemnation by ethical codes, published guidelines and policies for all the helping professions, sexual exploitation by health and mental health professionals remains a prevalent but poorly understood problem. It is estimated that half of all mental health clinicians will evaluate and/or treat at least one person who was sexually exploited by a previous psychotherapist, physician, psychiatrist or other health or helping professional. Because these sex offenders are professionals, they are more frequently subject to moral indignation, societal disgust, shame and negativity than other sex offenders. Following their arrest and the interruption, or termination, of their practice, these offenders are particularly at risk for major depressions, emotional breakdowns and suicide. Given the hope to maintain or the expectation to return to their professional practice, the evaluation process may be complicated by the offender's use of deception and denial, and avoidance of self-revelation and self-examination. Considering the nature of the offense, the degree of psychopathology and overall occupational functioning, reintegration in the offender's professional practice may or may not be recommended. For others, modification of their professional roles may be indicated.

Key Words: *Dangerousness; Evaluation; Professional sexual misconduct; Recommendations*

Etiological explanations on the ethical failures of professionals are diverse. The sexual misconduct is rarely simply attributed to the presence of a psychiatric diagnosis. Through the evaluation process, immediate and deeper causes are examined. Comorbid Axis I and II disorders and other significant psychological conflicts and problems (such as an underlying sexual compulsive disorder), and situational factors that are directly and indirectly associated with the behaviour, need to be identified. Evaluating the degree of dangerousness and the risk for reoffending, and making recommendations for the clinical and social management for each case, frequently poses significant challenges to the evaluator, who is often requested to not only consider the professional's mental health and treatment needs, but to also recommend preventive measures and safeguards when reintegration into the workplace is feasible. Considering that precise and appropriate diagnoses, treatment and monitoring are available, the prognosis of professional sexual misconduct cases is usually good. This analysis will specifically address these issues and review the clinical and social

La prise en charge de l'inconduite sexuelle professionnelle : L'évaluation et les recommandations

Malgré leur condamnation par les codes d'éthique, les directives publiées et les politiques de toutes les professions visant à secourir autrui, l'exploitation sexuelle par des professionnels de la santé mentale demeure un problème prévalent mais mal compris. On estime que la moitié de tous les cliniciens de la santé mentale évalueront ou traiteront au moins une personne qui a déjà été victime d'abus sexuels infligés par un psychothérapeute, un médecin, un psychiatre ou un autre professionnel de la santé ou visant à secourir autrui. Puisque ces délinquants sexuels sont des professionnels, ils font plus souvent l'objet d'une indignation morale, d'un dégoût sociétal, de honte et de négation que les autres délinquants sexuels. Après leur arrestation et l'interruption de leur pratique ou leur renvoi, ces délinquants sont particulièrement susceptibles de souffrir d'une grave dépression ou d'un effondrement affectif et de se suicider. Étant donné l'espoir qu'a le délinquant de conserver ou de reprendre sa pratique professionnelle, le processus d'évaluation peut être compliqué par les tromperies et le déni du délinquant, ainsi que par l'évitement d'une révélation de soi et d'un auto-examen de sa part. Compte tenu de la nature de l'infraction, du degré de psychopathologie et du fonctionnement global au travail, la réintégration du délinquant à sa pratique professionnelle peut être recommandée ou non. Pour les autres, une modification à leur rôle professionnel peut être indiquée.

variables to consider when evaluating professional sexual misconduct.

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There is nothing new about sexual contact between health and mental health professionals and their patients. Among physicians, the oath of Hippocrates, which dates back to the 4th century BC, explicitly prohibits this form of contact by stating "Into whatever houses 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 female or males, of freemen and slaves" (1). Despite condemnation by ethical codes, published guidelines and policies for all the helping professions, sexual exploitation by professionals remains a prevalent but poorly understood problem. Abel et al (2) estimate that half of all psychiatrists will evaluate and/or treat at least one patient who was sexually exploited by a previous therapist or other health or helping professional.

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The process of professional self-disclosure of sexual misconduct can be very complex and difficult. There is a need to provide specialized therapeutic programs and for professional ethical boards to establish individualized responses to this problem (3). Carnes (4) remarks that most professionals will avoid seeking treatment voluntarily before, during or after the acting out process due to motivational problems and fear of subsequent punitive responses (eg, litigation, loss of license, career and reputation, marital separation and family breakdown). Levine et al (5) and Risen and Althof (6) highlight the complex nature of treating these cases, given legal reports and procedures, the involvement of professional association review boards and the negative impact of the media. Because these sex offenders are professionals, they are more frequently subject to moral indignation, societal disgust, shame and negativity than nonprofessional sex offenders. Upon arrest, they may more often be at risk for major depressions, emotional breakdowns and suicide. The therapeutic relationship may be complicated by deception, denial, and avoidance. Considering precise and appropriate diagnoses, treatment and monitoring, the prognosis of sexual misconduct cases is usually good (2,5,7).

Professional sexual misconduct is globally defined as the acting out of various inappropriate and/or abusive verbal and/or nonverbal sexual behaviors initiated and/or maintained by the professional toward a patient, client or subordinate in the workplace (eg, associated coworkers and assistants toward whom the subject exercises a position of authority). The professional position of power and authority, and role of trust, all play a role in the sexual acting out process. The behaviors vary across a continuum, ranging from simple, unwanted but persistent sexual comments and remarks, to repetitive verbal advances and sexual harassment, to actual physical behaviors, including inappropriate hugging and kissing, and sexual touching, rubbing, exhibitionism, voyeurism, masturbation, oral sex, and coital sexual relations (8). The offender's behaviour may be pressured and forceful, it may have an obsessive-compulsive quality to it, and is usually planned and organized. Offenders may blame the victim, minimize their behaviour and express no victim empathy.

Professional sexual misconduct can manifest itself in a variety of situations. Some case examples include:

- a male surgeon who presents a history of intrusive sexual questions and inappropriate sexual remarks toward certain female nurses;
- a male physician and professor who has a history of sexual liaisons with a number of female medical students;
- a male psychiatrist who has a history of sexual relations with an adult female patient;
- a male family medical doctor with serious professional boundary problems: who maintains social relations with male patients and intimate sexual relations with a number of his female patients;
- a sexually addicted obstetrician-gynecologist who is sexually provocative and impulsive in his comments, attitudes and behaviours toward some of his adult female patients;
- a female family doctor who develops a sexual affair with a male patient who had consulted her for moral and emotional support;
- a male plastic surgeon who has a history of sexual liaisons with some female postsurgical patients;
- a chiropractitioner with a history of sexual touching and coital relations with two female patients;
- a dentist who has a history of rubbing his pelvis and genitals against adult female patients;
- a psychiatric social worker who is overly implicated in child protection cases presents a history of emotional and sexual relationships with impoverished, dependent female clients towards whom he feels devoted to help 'save' and 'care for' their children; and
- a male psychologist who has a history of sexual relations with adult female patients.

Sexual misconduct has also been well-described among many helping professionals who are members of the clergy and religious leaders. Priests, ministers, pastors, preachers, rabbis and religious leaders of other denominations have been accused of and treated for sexual behaviour problems with members of their churches, mosques, synagogues and congregations. This population will not be addressed in the present paper.

Information on the prevalence of health and mental health professional sexual misconduct is available, but the data, in our opinion, represents an underestimation of the reality, because cases of professional sexual misconduct, much like child sexual abuse and other sexual offenses, are under-reported. However, some alarming findings have been reported. Anonymous data collected on 114 psychiatrists found that 10% admitted having engaged in some form of sexual/erotic contact with their patients (9). Gartrell et al (10) presented data from an anonymous survey compiled on over 1300 psychiatrists. They found that 6.4% acknowledged having had sexual contact with one of their own patients, and one-third of this group had acted out on more than one person. In this study, the authors defined sexual contact as any form of physical contact that arouses or satisfies sexual desire in the patient, physician or both. Results suggest repeat offenders usually believe in the therapeutic value of sexual relations with patients as a form of corrective emotional experience geared at healing or changing the patient. In another survey on nearly 1900 family practitioners, obstetrician-gynecologists, internists, and surgeons, 9% of the sample acknowledged having had sexual contact with one of their own patients (11). Boundary violations and sexual misconduct are estimated to occur in 3% to 10% of the overall physician population (3). Surveys of psychologists and social workers have observed similar results (12).

Irons and Schneider (13,14) present clinical information on 137 health care professionals (97% were male) referred for allegations of professional sexual misconduct, 85% of whom were physicians. Among the offenders, 66% had one or more comorbid mental disorders with sexual compulsive and/or addictive features. Compulsive sexual disorders and substance abuse are prominent among these offenders and should be considered in treatment. In their sample, 54% of the subjects presented sexual problems and deviations (paraphilic and/or nonparaphilic, compulsive sexual disorders), while 31% had a serious substance abuse disorder. Levine et al (5) present characteristics on 31 professionals; the majority were members of the clergy, physicians and teachers. Twenty-three per cent were repeat offenders, having engaged six or more times in

their behaviour. Paraphilia was diagnosed in 26% of the cases, while 29% presented nonparaphilic compulsive sexual disorders. Some form of character disorder was noted among 58% of the sample.

Assessment process

Professional sexual misconduct should be considered in the presence of various inappropriate and/or abusive verbal and/or nonverbal sexual behaviours initiated and/or maintained by the professional toward a patient, client or subordinate in the workplace. Professional sexual misconduct and harassment promotes a conflicted work atmosphere, and the acting out represents a loss of personal control, with repetitive, compulsive behaviours, despite adverse consequences. These characteristics in the offender's attitude and behaviour are similar to drug and alcohol abuse in the workplace. Risen and Althof (6) note that therapists who evaluate professionals accused of sexual misconduct should be competent in managing issues of boundaries and boundary crossing, intimacy disorders and sexual compulsivity, in addition to traditional psychological problems of depression, substance abuse and personality disorder.

The *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV) (15) does not recognize professional sexual misconduct as a clinical syndrome. Consequently, there is no clear diagnostic category under which such cases can be classified. Considering the nature, context, history and severity of the behaviour, these cases may be differentiated and subsumed under the following diagnostic categories: Paraphilia Not Otherwise Specified (NOS) (DSM-IV code 302.9), Sexual Disorder NOS (DSM-IV code 302.9), Impulse-Control Disorder NOS (DSM-IV code 312.30), Occupational Problem (DSM-IV code V62.2), or Sexual Abuse Of An Adult (DSM-IV code V61.1). A diagnosis of Sexual Paraphilia (DSM-IV code 302.9) is considered inappropriate, unless the sexual misconduct clearly involves paraphiliac behaviours and object choices (eg, evidence of fetishism, exhibitionism, voyeurism or sadism). It is important to note that a professional who incidentally engages in an act of sexual misconduct with a client due to an untreated mental disorder (eg, manic episode, psychosis, alcohol/drug intoxication) may not warrant one of the aforementioned diagnoses. Among these professionals, the prognosis is usually favourable upon treatment of the primary Axis I disorder. Presence of comorbid Axis II personality disorders should also be assessed and considered in evaluating the dangerousness of an offender.

Professionals diagnosed with Paraphilia NOS may present with long-standing sexually abusive behaviour patterns, more typically with their clients but also with others outside of work. There may be a history or presence of other paraphilias (eg, fetishism, exhibitionism). The sexual misconduct is often described by the victim as having deviant and perverse elements (eg, psychodrama role-play, therapist repetitively verbalizing his sexual fantasies while having sex with his client, picture-taking and making personal sexual videos). Offenders in this group usually evidence more serious psychopathology and a higher risk potential than those from other diagnostic groups. They are often more difficult to treat and fortunately represent the minority of the cases.

Professionals who warrant Sexual Disorder NOS diagnoses usually present a history of nonparaphilic, compulsive sexual behaviours (eg, hyperactive sexual desire, excessive use of pornography, sexualization of intimate relationships, repetitive

sexual liaisons and extramarital affairs). These offenders may or may not present a history of sexually abusive behaviour patterns with others. There are no paraphilic features to the presenting behaviour or nature of the professional-client relationship, but the offender's behaviour and sexual problem may present obsessive-compulsive features. The diagnosis of Impulse-Control Disorder NOS may also be considered among such cases. Here, the sexual misconduct in the professional setting is viewed as a failure to resist an impulse, drive or temptation to perform an act that is harmful to the person or to others. Finally, diagnoses of Occupational Problem or Sexual Abuse Of An Adult may be considered if the offender presents no history of paraphilic or nonparaphilic sexual behaviour problems. Here, the professional may develop a sexual relationship with the victim or behave in a sexually inappropriate manner, but his behaviour is clearly not directly associated to an underlying psychosexual or psychiatric disorder. We can expect the degree of psychopathology in these cases is less significant than among the other diagnostic categories.

Professionals accused of sexual misconduct overall fall into three general groups: Denier, Rationalizer and Repentant (16). For professionals who deny accusations, psychometric instruments such as the Minnesota Multiphasic Personality Inventory may be administered to provide objective data on the offender's use of denial mechanisms and will indicate if one is attempting to 'look good' in the exam. Polygraph measures may also be taken and are more readily employed among general sex offender treatment facilities in the United States. The rationalizers strongly tend to minimize their actions and avoid full responsibility for their behaviour. However, they may show remorse and victim empathy and they are treatable. The repentant group are the best treatment candidates. They take full responsibility for their behaviour and present themselves as sincerely regretful and remorseful, and are willing to involve themselves in therapy to understand their behaviour and change.

In the general assessment of adult sex offenders, we discriminate between 'affective' and 'predatory' types. The sexual misconduct of an affective offender is typically associated with unresolved emotional problems (eg, neurotic countertransferences and dependency issues, resentments and hostility toward women, recent separation and feelings of abandonment/solitude, stress and depression, alcohol/drug abuse). Conversely, the predatory offender generally presents a major personality disorder, with psychopathic/antisocial features, or a mixed personality disorder, with narcissistic, borderline and histrionic features. The sexual misconduct is part of a lifestyle of using and exploiting others to meet one's needs. The latter group of professionals are indeed more dangerous and at risk for reoffending.

Based on the description of the offense and the nature of the professional relationship with the victim, offenders may be further classified into the following useful typology: incidental, interpersonal, narcissistic, exploitive, angry and sadistic types. We find this typology helpful in providing a more indepth understanding of the behaviour and in determining the treatment plan. Incidental offenders refer to those who have impulsively behaved in a sexually inappropriate manner and their is only one known occurrence of the behaviour (eg, a boss with no prior history of sexual misconduct began to suddenly kiss and make unwanted sexual advances to a female employee with whom he was dancing at an office party). Interpersonal

offenders include professionals who are motivated to establish a close, intimate and long-lasting relationship. The investment in the relationship seems genuine, without clear signs of exploitation or abuse (eg, a consensual lawyer-client relationship develops over time into an emotional and sexual relationship where both feel strongly on the goodness of their relationship). Narcissistic offenders include professionals who may or may not be seeking a close, emotional relationship. However, their behaviour more strongly suggests strong needs for attachment, admiration, approval, validation, love and attention. Compensatory types include professionals who are more opportunistic and impulsive, and who basically offend to fulfill unmet needs for physical closeness, affection and sexual relations. Exploitive offenders include professionals who purposely use their position of authority and power to achieve their behaviour and fulfill their needs (eg, control, power, domination). Anger types include those who persistently sexually harass and offend against women. As per the nature of their behaviour, these individuals evidence strong feelings of hostility, rage and resentment toward women. Finally, sadistic offenders correspond to those who enjoy using their power and authority to control and dominate the victim, with marked pleasure out of being cruel and provoking suffering.

Based on the evaluation and treatment progress, reintegration of the offender into their professional practice may or may not be recommended, considering the nature of the offense, the degree of psychopathology and overall occupational functioning. For many, modification of their professional roles may be indicated, with considerations pertaining to treatment recommendations before and/or after they resume their professional practice. Irons and Schneider's (13) descriptive study on 137 health care professionals report 58% of their sample were judged professionally impaired and required to terminate their practice, 25% were unimpaired and 10% were potentially impaired, both required treatment and/or supervision at work, while 7% of the cases were inconclusive. Elsewhere, Levine et al (5) reported that about 50% of the 31 professionals they assessed were considered safe to return to work, typically with a recommendation of treatment and monitoring/supervision of their professional activities, while 47% were recommended to no longer practice their professional roles.

The offender's occupational functioning is evaluated through consideration of his overall psychological and psychosocial functioning and capacity to show good judgment and meet the skills and demands of his profession. How has the offender adjusted to his presenting problem, and what changes have occurred following the misconduct? Has the professional's mental and physical health deteriorated, or have the events activated a positive change in the offender's life

(eg, abstinence from alcohol/drugs, more committed to family)? Has the offender implicated himself in the therapeutic process and what is the treatment status and outcome? The professional organization of the offender should examine the appropriateness of the practice setting and, if necessary, monitor the offender's practice style. For re-entry into their practice, additional supervision and training may be indicated, and the professional must clearly demonstrate a capacity to establish and maintain appropriate professional boundaries.

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