David Axelrod, M.D.
Commissioner

Board for Professional Medical Conduct

Corning Tower • Empire State Plaza • Albany, NY 12237 • (518) 474-8357

C. Maynard Guest, M.D.
Executive Secretary

April 7, 1992

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Lokendra K. Singh, M.D.
1332 Union Street
Schenectady, NY 12308

RE: License No. 160408

Effective Date 4/10/92

Dear Dr. Singh:

Enclosed please find Order #BPMC 92-28 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect upon receipt of this letter or seven (7) days after the date of this letter, whichever is earlier.

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order.

Board for Professional Medical Conduct
New York State Department of Health
Empire State Plaza
Tower Building-Room 438
Albany, New York 12237-0614

Sincerely,

C. Maynard Guest

C. Maynard Guest, M.D.
Executive Secretary
Board for Professional Medical Conduct

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	
OF	:	ORDER
LOKENDRA K. SINGH, M.D.	:	"BPMC #92-28"

----------X

Upon the Application for Consent Order of LOKENDRA K. SINGH, M.D., which Application is made a part hereof, it is

ORDERED, that the Application and the provisions therein are hereby adopted and it is further

ORDERED that this Order shall take effect as of the date of the personal service of this Order upon the Respondent or seven days after mailing by certified mail.

SO ORDERED,

DATED: 2 April 1992

Charles J. Vacanti

CHARLES J. VACANTI, M.D.
Chairperson
State Board for Professional
Medical Conduct

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF LOKENDRA K. SINGH, M.D.	APPLICATION FOR CONSENT ORDER

STATE OF NEW YORK)
ss.:
COUNTY OF SCHENECTADY)

LOKENDRA K. SINGH, M.D., being duly sworn, deposes and says:

1. I was authorized to practice medicine in New York State on or about October 1, 1984, by the issuance of license No. 160408 by the New York State Education Department. I am currently registered with the New York State Education Department to practice medicine for the period January 1, 1991 through December 31, 1992 at Mental Health Clinic, 1101 Nott Street, Schenectady, New York 12308.

2. I understand that the New York State Board of Professional Medical Conduct has charged me with sixteen specifications of professional misconduct. A copy of the Statement of Charges is annexed hereto, made a part hereof, and marked as "Exhibit A."

3. I hereby admit guilt to the sixteen specifications of professional medical conduct set forth in the Statement of Charges.

4. I hereby agree to the penalty of a five year suspension of my license to practice medicine, a stay of the suspension after six months and upon condition that I satisfy the conditions set forth in paragraph 5 below, and a four and one-half year period of probation under the Terms of Probation set forth and attached hereto as "Exhibit B."

5. I agree that prior to the stay of the suspension of my license

(a) I shall undergo, at my own expense, a psychiatric evaluation and an assessment of my need, if any, for treatment by a Board certified psychiatrist licensed to practice medicine in New York State, who shall be subject to approval in advance by the Director of the Office of Professional Medical Conduct [OPMC], who shall be aware of and have a copy of this Application and who shall submit said evaluation and assessment to OPMC; and

(b) I shall select a Board certified psychiatrist, licensed to practice medicine in New York State, as a monitor of my practice of medicine, who shall be subject to the approval of OPMC,

who shall be aware of and have a copy of this Application and who shall submit a written acknowledgement to OPMC that he or she will monitor my practice of medicine, whether in private or institutional settings, in accordance with the Terms of Probation.

6. I understand that the admissions contained herein can only be used in proceedings brought pursuant to New York Public Health Law §230 and/or New York Education Law §6530 or used by the professional disciplinary agencies of other states or federal governmental agencies.

7. I understand that, in the event that this Application is not granted by the Board, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct charged against me, such Application shall not be used against me in any way and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary proceeding; and such denial by the Board shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by the Board pursuant to the provisions of the Public Health Law.

8. I agree that, in the event the Board grants my Application, as set forth herein, an order of the Chairperson of the Board shall be issued in accordance with the same.

9. I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner.

Lokendra K. Singh

LOKENDRA K. SINGH, M.D.
Respondent

Sworn to before me this
31st day of March, 1992.

NOTARY PUBLIC

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER	:	APPLICATION
OF	:	FOR
LOKENDRA K. SINGH, M.D.	:	CONSENT
	:	ORDER

The undersigned agree to the attached Application for Consent Order of the Respondent and to the proposed penalty based on the terms and conditions thereof.

Date: 3.31.92

LOKENDRA K. SINGH, M.D.
Respondent

Date: 3.31.92

NICHOLAS J. GRASSO, Esq.
Attorney for Respondent

Date: 3-31-92

E. MARTA SACHEY
Associate Counsel
Bureau of Professional Medical Conduct

Date: April 1, 1992

KATHLEEN M. TANNER
Director, Office of Professional Medical Conduct

Date: 2 April 1992

CHARLES J. VACANTI, M.D.
CHAIRPERSON, State Board for Professional Medical Conduct

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
LOKENDRA K. SINGH, M.D.	:	CHARGES

----------X

LOKENDRA K. SINGH, M.D., the Respondent, was authorized to practice medicine in New York State on October 1, 1984 by the issuance of license number 160408 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991 through December 31, 1992 at Mental Health Clinic, 1101 Nott Street, Schenectady, New York 12308-2425.

FACTUAL ALLEGATIONS

A. Respondent, from approximately November 10, 1988 through February 22, 1990 provided psychiatric care to Patient A [identified in the Appendix] at his office at 1332 Union Street, Schenectady, New York 12308.

1. Respondent, on several occasions from approximately September 1989 through December, 1989 during Patient A's appointments at his office, told Patient A that

he did not have a good marriage or words to such effect.

2. Respondent, in approximately mid January, 1990 at the hospital [idenfified in the Appendix] where Patient A was employed as a registered nurse, engaged in the following conduct:

   (i) Respondent told Patient A "I'm really attracted to you" or words to such effect.

   (ii) Respondent told Patient A "you're giving me an erection" or words to such effect.

   (iii) Respondent engaged in physical contact of a sexual nature with Patient A, including kissing and hugging Patient A and fondling Patient A's genital area and breasts through her clothing.

   (iv) Respondent told Patient A, after engaging in the aforesaid physical contact, "I guess we need to get together but where" and told Patient A that he had an apartment house, suggesting that as a place, or words to such effect.

3. Respondent, on approximately the afternoon of January 18, 1990, called Patient A at her home and asked her if she could come to his office at 7:00 p.m. that evening, telling Patient A "We better take care of our problem" referring to further sexual contact, or words to such effect.

4. Respondent, on approximately the evening of January 18, 1990 at his office, for the purpose of engaging in physical contact of a sexual nature with Patient A, told Patient A the address of an apartment house he then owned at 1503-1505 Foster Avenue, Schenectady, New York [hereinafter "apartment house"] and told Patient A to follow him there. Respondent,

in his automobile, led Patient A, in her automobile, to the apartment house.

5. Respondent, on approximately the evening of January 18, 1990 at the apartment house, engaged in sexual intercourse with Patient A.

6. Respondent, on approximately January 18, 1990 at the apartment house told Patient A that he would be getting a divorce in about one and one-half years when his children graduated from high school or words to such effect.

7. Respondent, on approximately February 5, 1990, during Patient A's appointment at his office, engaged in the following conduct:

   (i) Respondent engaged in physical contact of a sexual nature with Patient A, including kissing and hugging Patient A and fondling Patient A's breasts and genital area through her clothing.

   (ii) Respondent, while he fondled Patient A's genital area, told Patient A "from now on wear a dress" or words to such effect.

SPECIFICATION OF CHARGES

FIRST THROUGH SIXTH SPECIFICATIONS

CONDUCT EVIDENCING MORAL UNFITNESS

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(20) (McKinney Supp. 1992) [formerly N.Y. Educ. Law §6509(9) and 8NYCRR §29.1(b)(5)] by reason of his conduct in the practice of medicine which evidences moral unfitness to practice medicine, in that Petitioner charges:

1. The facts in Paragraphs A and 2(i), A and 2(ii), A and 2(iii), and/or A and 2(iv).
2. The facts in Paragraphs A and 3.
3. The facts in Paragraphs A and 4.
4. The facts in Paragraphs A and 5.
5. The facts in Paragraphs A and 6.
6. The facts in Paragraphs A and 7(i) and/or A and 7(ii).

SEVENTH THROUGH NINTH SPECIFICATIONS

SEXUAL PHYSICAL CONTACT

IN THE PRACTICE OF PSYCHIATRY

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(44) (McKinney Supp. 1992) [formerly N.Y. Educ. Law §6509(9) and 8NYCRR §29.4(a)(5)] by reason of his, in the practice of psychiatry, engaging in physical contact of a sexual nature with a patient, in that Petitioner charges:

7. The facts in Paragraphs A and 2(iii).
8. The facts in Paragraphs A and 5.

9. The facts in Paragraphs A and 7(i).

TENTH THROUGH FIFTEENTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

ON A PARTICULAR OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(4) (McKinney Supp. 1992) [formerly N.Y. Educ. Law §6509(2)] by reason of his practicing the profession of medicine with gross negligence, in that Petitioner charges:

10. The facts in Paragraphs A and 2(i), A and 2(ii), A and 2(iii), and/or A and 2(iv).
11. The facts in Paragraphs A and 3.
12. The facts in Paragraphs A and 4.
13. The facts in Paragraphs A and 5.
14. The facts in Paragraphs A and 6.
15. The facts in Paragraphs A and 7(i) and/or A and 7(ii).

SIXTEENTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON

MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(3) (McKinney Supp. 1992) [formerly N.Y.

Educ. Law §6509(2)] by reason of his practicing the profession of medicine with negligence on more than one occasion, in that Petitioner charges:

16. The facts in Paragraphs A and 1, A and 2(i), A and 2(ii), A and 2(iii), A and 2(iv), A and 3, A and 4, A and 5, A and 6, A and 7(i) and/or A and 7(ii).

DATED: Albany, New York
March 27, 1992

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional Medical
Conduct

TERMS OF PROBATION

LOKENDRA K. SINGH, M.D.

EXHIBIT B

1. Respondent, during the period of probation, shall conduct himself in all ways in a manner befitting his professional status and shall conform fully to the ethical and professional standards of conduct imposed by law and his profession.

2. Respondent shall submit written notification to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, New York State Health Department, Corning Tower Building, 4th Floor, Empire State Plaza, Albany, New York 12237 [hereafter "OPMC"] of Respondent's residence, telephone number, and of any change in Respondent's employment, practice, residence or telephone number, within or without New York State.

3. Respondent shall submit to OPMC, no later than the first three months of the period of probation, written proof from the Division of Professional Licensing Services (DPLS), New York State Education Department (NYSED), that Respondent has paid all registration fees due and owing to the NYSED and Respondent shall cooperate with and submit whatever papers are requested by DPLS with regard to said registration fees.

4. Respondent shall submit to OPMC, no later than the first two months of the period of probation, written proof that (a) Respondent is currently registered with the NYSED, unless Respondent submits written proof that Respondent has advised DPLS, NYSED, that Respondent is not engaging in the practice of medicine in New York State and does not desire to register, and that (b) Respondent has paid any fines which may have previously been imposed upon Respondent by the Board or by the Board of Regents.

5. Respondent, during each year of the period of probation commencing with the year in which the suspension of license is stayed, shall successfully complete a continuing medical education course or equivalent course or study in the area of medical/psychiatric ethics, which course or study shall be approved in advance by OPMC.

6. Respondent shall undergo psychiatric treatment, if such treatment is recommended by the psychiatrist referred to in paragraph 5(a) of the Application for Consent Order and for so long as recommended by that psychiatrist or any subsequent treating psychiatrists. Any subsequent treating psychiatrists shall be subject to the approval of OPMC, shall be aware of and have a copy of the Application for Consent Order, and shall submit to OPMC a written acknowledgement that he or she will provide treatment to Respondent in accordance with the Terms of Probation.

7. Respondent shall cause any psychiatrist providing treatment to him under the Terms of Probation to submit to OPMC written quarterly reports the first year of probation and biannual reports thereafter regarding Respondent's status, progress, compliance with treatment needs, and need for further treatment.

8. Respondent shall assure that his practice of medicine, whether in private or institutional settings, be monitored by the Board Certified psychiatrist referred to in Paragraph 5(b) of the Application for Consent Order. Any subsequent monitor of Respondent's practice shall be aware of and have a copy of the Application for Consent Order, and shall submit to OPMC written acknowledgement that he or she will monitor Respondent's practice of medicine in accordance with the Terms of Probation.

9. Respondent shall cooperate with the monitoring of his practice of medicine by the monitor. The monitoring shall include random review of Respondent's patient records from both his private and institutional practice and discussion with Respondent of his treatment of randomly selected patients and may include, at the discretion of the monitor, any other reasonable means of monitoring Respondent's practice.

10. Respondent shall cause the monitor of his practice of medicine to submit to OPMC written quarterly reports the first year of probation and biannual reports thereafter regarding Respondent's practice of medicine.

11. Respondent shall assure that at absolutely all times when a female patient is present on Respondent's office premises and Respondent is also present that a member of Respondent's office staff is also present on the premises.

12. Respondent shall assure that copies of the following material, attached collectively as Exhibit C, be prominently displayed individually in his office waiting room and that copies of such material be made available to patients on request:

    a. "THE PRINCIPLES OF MEDICAL ETHICS, WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY," Section 2, Paragraph 1 (1989 Edition)

    b. Joseph T. Smith, M.D., JD, "Therapist - Patient Sex: Exploitation of the Therapeutic Process", PSYCHIATRIC ANNALS, Jan. 1988.

    c. Joan Sweeney, "Sex Between Patients, Therapists Found Harmful", Los Angeles Times, Apr. 9, 1983.

13. Respondent shall notify OPMC of the names of all members of his office staff, the members' employment hours and duties, and of any changes in the members of the staff or of their employment hours or duties. Respondent shall cause each member of his office staff to submit to OPMC, biannually, affidavits attesting to the following:

    a. That the staff member is aware of and has seen a copy of the Application for Consent Order;

    b. That to the best of the staff member's knowledge a staff member has been on the office premises at all times when a female patient and Respondent have been present on the premises;

    c. That the staff member has never entered or left the office premises when there has been a female patient and Respondent present on the premises but no staff member has been present; and

    d. That the material identified in Paragraph 12, above, has been prominently displayed in the office waiting room and that copies of such material have been made available to patients on request.

14. Respondent understands that payment for the services of persons, treatment, and/or other matters referenced in the Terms of Probation is Respondent's responsibility.

15. Respondent, so long as there is full compliance with every term herein, may practice his profession in accordance with the Terms of Probation; provided, however, that upon receipt of evidence of noncompliance with or violation of any of these terms, the Director of the Office of Professional Medical Conduct and/or the Board may initiate a violation of probation proceeding and/or such other proceeding against Respondent as may be authorized pursuant to the Public Health Law.

EXHIBIT C

[material referenced in Paragraph C
of Terms of Probation]

SECTION 2

A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

1. The requirement that the physician conduct himself/herself with propriety in his/her profession and in all the actions of his/her life is especially important in the case of the psychiatrist because the patient tends to model his/her behavior after that of his/her therapist by identification. Further, 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. Sexual involvement with one's former patients generally exploits emotions deriving from treatment and therefore almost always is unethical.

Contemporary Psychiatry

Robert I. Simon, MD, Section Editor

Therapist-Patient Sex: Exploitation of the Therapeutic Process

By JOSEPH T. SMITH, MD, JD

Should You Sleep With Your Therapist?" (*Vogue*, Jan 1987, pp 78-80), "The Sensuous Psychiatrist" (*New York Magazine*, June 1972, pp 52-56), "One Analyst's Touching Tale" (*New York Post*, Nov 11, 1969, p 71), are just a small sample of articles gleaned from various popular magazines regarding the involvement of psychotherapists and sexual activity with their patients as a purported part of treatment. Does this sort of activity actually go on? If so, how frequently? Is it clinically appropriate? How does it take place? What is the effect of this type of arrangement on the therapeutic process? These are a few of the questions confronting mental health professionals and organizations who, in the past ten to 15 years, have begun to confront the issue of sexual activity in therapy.

In 1986, a national survey of psychiatrists revealed that approximately 7% of the respondents indicated that they have engaged in some form of erotic contact with at least one patient.[1] This figure is probably conservative given the fact that most cases go unreported, a percentage of exploitive practitioners are multiple offenders, and there has been a steady increase in the litigation of these types of cases.[2] In addition, the termination of future liability insurance coverage by two major insurers of mental health professionals[3] coupled with increased reporting of this type of misconduct by state disciplinary boards, clearly demonstrates that this type of behavior is a significant problem within the mental health profession.

THERAPY PROCESS

The practice of psychotherapy involves much more than the mere application of psychological theory and techniques. The nature of the psychiatrist-patient relationship engenders a unique partnership built on trust, respect, and confidentiality that is possibly only rivaled by the priest and confessing parishioner. By analyzing the infinitely complex ways in which people interact, social scientists attempt to separate the factors that seem to promote emotional well being from those that maintain instability, maladaptive life patterns, and ill health.[4]

The purpose of psychotherapy is to help the patient to develop a more effective and fulfilling means of experience and interacting with the world.[5] Despite obvious quantitative and procedural differences between the medical and psychotherapeutic system of treatment, seasoned practitioners of both invariably attest to the positive value and essential need for developing a strong, therapeutic alliance with their patients.[6]

The interaction between psychotherapist and client represents the mechanism by which the effects of treatment are actualized. It emanates from several different but fundamental issues. The client brings into therapy, either consciously or unconsciously, the expectation that help is possible.[7] Similarly, psychotherapy inherently prescribes that the psychotherapist and client work together in ways that, explicitly or implicitly, they believe will be curative and beneficial. The activities between patient and therapist are

Dr. Smith is a Forensic Psychiatry Consultant, Potomac, Maryland. Address reprint requests to Joseph T. Smith, MD, JD, 11505 LeHavre Drive, Potomac, MD 20854.

essentially limited to verbal interaction and active listening.

■ Sexual Feelings

A patient's sexual feelings and thoughts are a common by-product of the therapy process. Not surprisingly then, the psychiatrist or therapist may use a patient's expressed sexual feelings, seductive behavior, and even sexually latent dreams as sources of information to be evaluated in understanding the patient.

A basic rule of legitimate psychotherapy practice is that any patient's feeling, gesture, or mannerism is to be understood and verbally processed with the patient but not acted upon. Psychotherapists do not allow themselves to become objects for patients to abuse in acting out their aggressions. By the same token, they do not permit themselves to become objects for sexual acting out.

■ Transference/Countertransference

As the patient's personality unfolds, invariably the patient's feelings and desires are unconsciously filtered through the therapist. This process is the essence of the therapeutic relationship and is clinically referred to as the transference phenomenon. It is this unconscious process that enables treatment to either become beneficial through the sensitive interpretation and guidance of the therapist, or destructive via the exploitation of the implicit trust of the patient by the therapist.

Feelings of positive transference, countertransference (the therapist's unconscious feelings toward the patient), patient attempts at sexual seduction, and interactions with clients in social settings are all experiences that psychotherapists must deal with on a regular basis. Unfortunately, dealing with the impulses and emotions aroused by a sexually or personally attractive client is not something learned in school or during one's training. Yet for the psychotherapist to succumb to these feelings or take advantage of a patient's vulnerabilities violates the trust and care that define the therapeutic process and fiduciary relationship.

■

For the psychotherapist to take advantage of a patient's vulnerabilities violates the trust and care that define the therapeutic process.

■ Treatment Parameters and Sexual Acting Out

The goal of psychotherapy, when confronted with a patient who is manifesting love transference feelings, is to help the patient understand the mental defense mechanisms of displacement and idealization that may be taking place. Admittedly, this is sometimes easier said than done, particularly if countertransference feelings are strong and the therapist's normal clinical defense mechanisms are weak or limited. When this scenario occurs, the likelihood for sexual exploitation is great.

Sexual intimacy between a therapist and patient constitutes a violation of the physical and fiduciary parameters of therapy. Therapeutic milieu has been described as a "human container . . . which sets the boundaries of the relationship, creates the rules of interaction . . . and offers an effective hold and means of security for the participants . . ."[8]

Sexual intimacy in this context can be described as any touching, fondling, kissing, or erotic acts (including intercourse), which occur between a patient and therapist. The relationship at this point is a sexual one.[9] A nonerotic, supportive, and friendly hug or greeting at an appropriate occasion are typically not considered sexual intimacies. Intentionality and awareness of consequences, as well as the setting of limits for nonsexual relations must always be a part of this picture. A therapist is not a cold, detached robot but an empathetic and sensitive human being. Thus, a friendly, supportive pat on the shoulder during a time of grief, for example, does not constitute sexual intimacy.

When sexually intimate interaction occurs, treatment ceases to be therapeutic and becomes an exercise in the personal gratification of the therapist. While there are many ways this exploitative transformation may occur, Pope and Bouhoutsos in their book, *Sexual Intimacy Between Therapist and Patient*, have constructed ten common scenarios in which exploitation might occur.[10] While their conclusions are not scientifically based, their insights are instructive (Table 1).

PROHIBITIONS AND CONSEQUENCES

The conventional wisdom regarding sexual involvement between physicians and their patients is aptly reflected in a portion of the Hippocratic Oath:

> In every house where I come, I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seductions and especially from the pleasures of love with women and men.[11]

Similar interdictions may be found throughout the development of modern medicine. For example, during the middle ages,[12] in the writings of Freud,[13] and up to the present day codes of ethics of every major mental health profession,[14] prohibitions have existed. Despite the unswerving condemnation of this practice by professional organizations, licensing boards, and most practitioners, it appears to be taking place with greater frequency than many commentators originally suspected.

To control this problem and provide some form of redress for patient-victims, a number of administrative and legal courses of action may be pursued.

Almost without exception, the courts have taken a dim view of any form of exploitation of a patient,

whether deliberately or through negligence. Such activity represents a dereliction of the duty of care owed by all psychotherapists and is subject to liability. A psychotherapist who engages in sexual activity with a patient during therapy may be subject to civil, criminal, and/or licensure revocation proceedings. The legal theories on which a cause of action may be brought include malpractice, breach of contract, intentional tort, assault and battery, fraud or deceit, rape, and licensure and professional proceedings based on violations of professional ethics and appropriate statutes.

The type of cause of action initiated is usually determined by the nature and circumstances of the alleged exploitation. The most common avenue of legal redress for an exploited client is to sue the offending psychotherapist for medical negligence. As Professor Robert I. Simon, MD, aptly states in his book, *Clinical Psychiatry and the Law*, "sex between the psychiatrist and his or her patient is malpractice per se."[15] That is, sexual activity between therapist and patient is inherently substandard medical practice and is civilly actionable if the client can demonstrate that the sexual activity proximately caused some type of injury. This point applies to nonmedical psychotherapists as well.

Depending on the nature of the exploitation and competency of the patient, criminal charges may be brought against an exploitive therapist. In a few states, eg, Michigan, sexual activity between physician and patient is criminally actionable pursuant to state statute. In most jurisdictions, however, criminal charges will generally only be considered if some physical coercion was employed by the therapist, such as tranquilizing medication to subdue the patient, or if the patient was legally incompetent (a minor or legally incompetent adult).

A third avenue of redress for the patient is an administrative licensure and disciplinary review of the therapist by the state regulatory board. This proceeding is based on violations of applicable professional ethics and statutes and may result in a temporary or permanent loss of a practitioner's license.

A final consequence of a more financial nature is the issue of whether a professional liability insurer will defend or pay damages in a civil action alleging sexual exploitation. There is no uniformity among the courts and insurance carriers on this question. The critical issue seems whether the sexual activity is concluded by the courts to be below a standard of medical treatment and therefore considered malpractice. A carrier may be forced to defend the psychiatrist or offending psychotherapist, but if he or she is found guilty, the carrier is not required to pay damages. Other carriers will only

TABLE 1
Ten Common Scenarios of Sexual Exploitation

Scenario	Criterion
1. Role Trading	Therapist becomes the "patient" and the wants and needs of the therapist become the focus.
2. Sex Therapy	Therapist fraudulently presents therapist-patient sexual intimacy as a valid treatment for sexual or other kinds of difficulties.
3. As If . . .	Therapist treats positive transference as if it were not the result of the therapeutic situation.
4. Svengali	Therapist creates and exploits an exaggerated dependence on the part of the patient.
5. Drugs	Therapist uses cocaine, alcohol, or other drugs as part of the seduction.
6. Rape	Therapist uses physical force, threats, or intimidation.
7. True Love	Therapist uses rationalizations that attempt to discount the clinical/professional nature of the relationship with its attendant responsibilities.
8. It Just Got Out of Hand	Therapist fails to treat the emotional closeness that develops in therapy with sufficient attention, care, and respect.
9. Time Out	Therapist fails to acknowledge and take account of the fact that the therapeutic relationship does not cease to exist between scheduled sessions or outside the therapist's office.
10. Hold Me	Therapist exploits patient's desire for nonerotic physical contact and possible confusion between erotic and nonerotic contact.

Cited from Pope K, Bouhoutsos J.[10]

TABLE 2
Sexual Exploitation by Health Care and Other Profressionals: An Overview of the Scope of the Caselaw*

Type of Profession	Nature of Litigation																			
	Civil				Criminal				Prof. Sanction				Insurance				Total			
	Patient won	Professional won	N/A No judgment	Total	Prof. convicted	Prof. acquitted	N/A no verdict	Total	License revoked	License retained	N/A no disposition	Total	Sex covered	Sex not covered	N/A no disposition	Total	Patient	Professional	N/A	Total
Non-Psychiatric Doctors†	7	2	3	12	17	6	1	24	14	2	4	20	2	1	0	3	40	11	8	59
Psychiatrists	23	2	1	26	0	0	0	0	6	1	0	6	6	5	3	14	34	8	4	47
Psychologists	7	0	2	9	1	1	0	2	4	2	0	10	0	0	0	0	12	3	2	17
Other Health Care Professionals‡	6	2	2	10	1	1	0	2	0	0	0	0	0	0	0	0	7	3	2	12
Chiropractor					0	1	1	5	0	0	5						5	0	1	6
Dentist	2	0	0	2	0	0	2	2	2	0	1	3	1	0	0	1	5	0	3	8
Social Worker	2	0	1	3	0												2	0	1	2
Clergy	0	2	2	4													0	2	2	4
Attorney/Judge	0	0	1	1					11	0	0	11					11	0	1	12
Totals	47	8	12	67	19	8	4	31	42	5	5	52	9	6	3	18	117	27	24	168

*Caselaw—cases adjudicated or settled and cited in a legal reporter or citation service.
†General physician, Ob-Gyn, plastic surgeon, neurosurgeon.
‡Physician assistant, psychotherapist, marriage counselor.
N/A—Case addressed a procedural matter, and, therefore, no decision was rendered regarding the overall disposition of the claim.
Excerpted from Smith J, Bisbing S: Sexual Exploitation by Health Care Professionals: Caselaw Summary & Analysis. *Potomac, MD, Legal Medicine Press, 1987.*

insure the psychotherapist's defense if he or she denies the charges, while at least one carrier's policy explicitly precludes coverage for any allegations of sexual activity.

IMPORTANT DISTINCTIONS

Various research studies polling physicians, psychiatrists, and psychologists in different parts of the country conclude that from 2% to 12% of those responding to the inquiry have engaged or do engage in some form of erotic contact with their patients. Unfortunately, these studies are limited by the total size of the subject pool and actual number of participants responding. It seems evident, in light of the growing number of cases being brought to court and reported to disciplinary boards and claims filed with professional liability insurers, that the prevalence of this activity is very likely *underestimated*, with either more exploitive therapists in practice than previously projected or more patients being abused by therapists who engage in this activity with more than one client.

Moreover, this is not a problem restricted to the mental health profession. This type of exploitation can and does occur in a variety of professional relationships where trust, confidentiality, and unbridled personal disclosures are fundamental elements. For example, social workers, a variety of medical specialists, dentists, lawyers, judges, and even the clergy are not immune from this type of abusive practice (Table 2).

In addition, therapist-patient sexual activity, although overwhelmingly described as the male therapist exploiting the female patient,[2] is not solely confined to this dichotomy. In fact, there have been lawsuits involving male therapists and male adolescent clients and female therapists with male and female clients.[16]

At one time there was a small minority of practitioners who considered, under certain circumstances, that sex with a patient could be therapeutic. However, this position is no longer publicly advocated and this idea is not currently endorsed by any respectable medical or mental health organization or body.

Concomitantly, the courts have consistently concluded that sexual activity between therapist and patient is an

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'The patient sees the psychotherapist not as he really is but as an amalgamation of what he is and all these distortions and fantasies. Transference is necessary to therapy but dangerous in the hands of the immature, charlatans or people who are slipping.'

90% Undergoing Treatment Suffered Ill Effects, Study Reports

Sex Between Patients, Therapists Found Harmful

By JOAN SWEENEY, *Times Human Behavior Writer*

In the recent movie "Lovesick," actor Dudley Moore portrays a psychiatrist who has an affair with a young woman patient. He leaves his wife for her, presumably to live happily ever after.

But in real life, such endings are rarely happy, a new report indicates.

Of 559 patients who were sexually intimate with their psychotherapists, the study found that 90% suffered ill effects. Either the patient's therapy or personal adjustment was harmed or both.

"We conclude that sexual intimacy in therapy is harmful, for 9 out of 10 patients in this sample were adversely affected," wrote the five authors of the paper in the April issue of Professional Psychology: Research and Practice, published by the American Psychological Assn.

The report, financed by the California State Psychological Assn., is the first to examine the effects of such sexual intimacy on a large number of patients—500 women, 33 men and 17 whose gender was not stated. The overwhelming majority of the cases—92%—involved intimacy between male therapists and female patients. In 88% of the cases involving male patients, the therapists were also male.

Many mental health professionals liken sexual relations between therapists and their patients to incest. They note that a therapist becomes a powerful parent figure for the patient, who in turn may develop a childlike dependence and trust. Just as in incest, the betrayal of this trust adds to the emotional trauma the patient suffers.

"It's the same as in other traumatic sexual areas such as incest. It's something they (patients) never really get over," said Jacqueline Bouhoutsos, former president of the California State Psychological Assn. and a clinical professor of psychology at UCLA. She is one of the report's authors.

One woman patient, who asked that her name not be used, said in an interview, "It's affected every part of my life . . . the pain of having trusted someone and then having that trust broken."

Another woman, who also asked not to be identified, said that her psychiatrist had initiated sexual involvement with her in the course of therapy.

"He said this was going to help me become less inhibited in all aspects of my life," she recalled.

When their four-year sexual involvement ended, "I felt a sense of complete abandonment," she said. "It was devastating. I became severely depressed."

But she did not seek help from another therapist.

"I was too damaged even to consider trusting to see somebody else again," she explained. "I never did again, and I wouldn't. Trusting other people is difficult (for me, now), especially trusting authority figures."

Her case is not unusual. Many patients who become sexually involved with their therapists not only fail to receive help for the problems that they sought therapy for, but they become too distrustful to seek it elsewhere.

"The patient is talking about the most intimate details of life so the situation is made conducive to intimacy," Bouhoutsos said in an interview. "But the therapist utilizes this relationship to help the patient work through these areas of difficulty and does not take advantage of the need of the patient in this way, which is a betrayal."

Dr. Robert Moore, a San Diego psychiatrist and a consultant to the American Psychiatric Assn.'s ethics committee, noted that a patient may be more vulnerable to emotional involvement because of a phenomenon known in psychiatric circles as transference. In this, a patient transfers fantasies and intense emotional conflicts involving significant people in his or her life to the analyst, who becomes a substitute figure for these other people. This process helps the client attain insight into the relationship between past experience and current behavior and to work through conflicts.

"The patient sees the psychotherapist not as he really is but as an amalgamation of what he is and all these distortions and fantasies," Moore said. "Transference is necessary to therapy but dangerous in the hands of the immature, charlatans or people who are slipping."

Bouhoutsos said that earlier studies have suggested that about 5.6% of male therapists and .6% of female therapists may

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THERAPY: Sex Found Harmful

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become sexually involved with their patients.

Even though the code of ethics of the American Psychiatric and Psychological Assns. and of the National Assn. of Social Workers all prohibit sexual intimacy, the number of ethics committee and legal actions stemming from such cases has been climbing in recent years.

It is thought that the rising number of actions may not reflect an increase in the number of such incidents actually occurring, but rather in the number of patients filing complaints.

In California, the law was changed in 1981 to make sexual activity with patients a specific cause for license revocation. Last month, state Sen. Diane Watson (D-Los Angeles) introduced a bill that would also make such activity during medical or psychological examination or treatment a crime.

In addition to bringing disciplinary actions before state licensing boards or professional associations, some patients have filed civil damage suits. In one well-publicized 1981 malpractice case, a La Jolla psychiatrist was ordered to pay $4.6 million to a patient with whom he had sexual relations. To avoid appeals in the case, the patient subsequently settled with the doctor's insurance company for $2.5 million.

Although professional associations and most mental health workers regard sexual intimacy with patients as a taboo, a few therapists have argued that it can be helpful.

However, Moore said, no legitimate school of thought holds that it is beneficial.

"It's important for potential patients to realize this is not part of accepted practice," Bouhoutsos said. "Should this occur, they should rapidly get out of the situation."

For the current paper, she and her four co-authors sent a questionnaire to 4,385 licensed psychologists in California asking for anonymous data on patients who had reported sexual intimacy with a previous therapist.

Of the 704 psychologists who responded, 318 reported that they had treated 559 such patients. Although the second therapists were all psychologists, the previous therapists who had engaged in sexual intimacy included psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors and others.

The authors acknowledged several weaknesses in the research. For example, it excluded any patients who either felt that they did not need additional psychotherapy or were too traumatized to seek a second therapist. In addition, the study relied on memories that had been filtered through both the patients and the subsequent therapists.

Despite this, the authors wrote: "These data are still the best available and will suffice until a better net can be fashioned to collect a better sample."

The questionnaire also did not define sexual intimacy in order to see what the psychologists and patients considered sexually intimate behavior. In 58% of the cases sexual intercourse was involved. Another 21% did not specify what the intimacy was. For 3%, only a therapist's verbal suggestion of sexual contact was sufficiently upsetting to cause the patient to seek another therapist. Other cases involved fondling, caressing, petting or kissing, the study said, noting that courts have ruled sexual misconduct can take place without actual intercourse.

The patient's therapy was adversely affected in 87% of the cases.

"When sex began, therapy ended," Bouhoutsos said. But 78% of the patients continued to pay the therapist's fees.

"Patients were paying to have themselves damaged," she said.

In addition, she said, "the patient frequently took over the role of therapist. The therapist started talking about his own problems. The patient then in an effort to help would begin to concentrate on his (the therapist's) problems rather than on her problems.

"In rare instances the therapist ended the relationship, but usually it was the patient," she said.

In 34% of the cases, the patient suffered such adverse personality effects as increased depression, loss of motivation, impaired social adjustment, significant emotional disturbance, suicidal feelings or behavior and increased alcohol or drug use.

Eleven percent of the 559 cases were subsequently hospitalized and 1% committed suicide.

Although 6% of the patients in the study sought out another therapist immediately, 48% found it difficult to resume therapy. They were suspicious and distrustful of therapists and had difficulty establishing a new relationship with one.

"The more intense the sexual involvement, the greater the likelihood that patients had difficulty returning to therapy rather than quickly seeking help," the authors wrote. "Sexual contact was especially disruptive if it began early in the relationship and if it had been initiated by the therapist."

In addition to Bouhoutsos, the other researchers on the current study are Jean Holroyd, a professor in the UCLA Department of Psychiatry and Biobehavorial Sciences, and three psychologists in private practice in the Los Angeles area—Hannah Lerman, Bertram R. Forer and Mimi Greenberg.

The paper did not examine whether practitioners of some types of therapy were more prone to sexual intimacy with patients, but Bouhoutsos said an earlier study that looked at five different therapy orientations had found no correlation.

Bouhoutsos said that a support group is now being established through the UCLA Psychology Clinic for patients who have been sexually involved with therapists and have been harmed by the experience. The telephone number for information on this "Post Therapy Support Program" is (213) 825-2305.

actionable offense for which no plausible defense exists. Rationales proposed by exploitive therapists, such as treatment ended before the sex began, patient consent, or the sexual activity occurred outside the therapy milieu, have all been unsuccessful to date in defending a legal action for sexual exploitation.

SUMMARY

From a clinical perspective, sex with a patient is therapeutically unjustified in view of the fact that sexual feelings are common products of therapy and that complex, nonsexual issues are frequently presented in the form of sexual desires. Sex with patients is further unwarranted because of the difference in influence between the participants and the fact that sexual intimacy has never been established as a valid therapeutic approach that can be taught and learned. Healthy sexual experience, by contrast, is mutual, but the therapeutic relationship is not mutual. It is dedicated solely to the interest of the patient. Therefore, it is the therapist's job to help the patient discover gratification in real life.

Patients who instinctively realize the relationship may be successfully treated by therapists who are not afraid of the patient's impulses, who can be warm and incorruptible at the same time. Patients who receive realistic gratifications from therapy will learn to bear the frustration of their sexual desires and to express them in a more appropriate way outside of therapy.

For the therapist who oversteps the ethical and therapeutic boundaries of the treatment process, there is increasing risk of a variety of consequences that *only* the practitioner can be held accountable for. The exploitive therapist taints not only his or her own integrity and reputation, but invariably damages the reputation of the mental health profession as a whole.

To combat this abuse, some organizations, such as the American Psychiatric Association, are considering further steps, in addition to disciplinary measures, to address this problem.[17] Moreover, exploited patients who traditionally eschewed any acknowledgment of their plight are beginning to air publicly the nature and process of this problem through published accounts of their exploitive experience.[18-20]

This is a problem that is not going to go away, but seems to be gathering steam as an increasingly frequent cause of legal action and disciplinary review for medical and mental health professionals.

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