

January 1989

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Recommended Citation

Laurie A. Morin, *Civil Remedies for Therapist-Patient Sexual Exploitation*, 19 Golden Gate U. L. Rev. (1989).
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CIVIL REMEDIES FOR THERAPIST-PATIENT SEXUAL EXPLOITATION

Laurie A. Morin¹

“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 seduction, and especially from the pleasures of love with women and men.” HIPPOCRATES, Physician’s Oath

I. OVERVIEW OF THE PROBLEM

Since ancient times, society has recognized that physicians, to whom we entrust our physical and emotional health, must be held to a high standard of conduct. Sexual relationships between physicians and their patients have been considered forbidden since at least the 5th century, B.C., when Hippocrates authored the sacred oath by which all physicians are bound even to this day.²

In more recent times, Sigmund Freud, the father of modern psychiatry, taught his followers that once sexual contact between therapist and patient begins, the therapeutic relationship is destroyed. Freud believed that no kind of erotic contact — not even an “innocent” kiss — should be initiated in the therapeutic relationship, because it might confuse the patient and

1. M.P.A., Northeastern University, 1980; J.D., Northeastern University School of Law, 1983; currently Executive Director, Tobacco Products Liability Project, Northeastern University School of Law, Boston, Massachusetts. Any expertise which I have acquired in this area, I owe to my former colleagues and clients at the Boston law firm of Stahlin, Bergstresser and Cole. Thanks also to the many therapists who have generously shared their expertise in this area with me, especially Gary R. Schoener, Licensed Psychologist and Executive Director of the Minneapolis Walk-In Counseling Center and Estelle Disch, a feminist therapist and Certified Clinical Sociologist who leads workshops for survivors of therapist sexual abuse at Tapestry, Inc. in Cambridge, Massachusetts.

2. R. BULGER, *IN SEARCH OF THE MODERN HIPPOCRATES* 9-11 (1987).

lead to the "danger" of further erotic intimacy.³ Freud's concerns appear to have been validated by a recent study of the characteristics of "erotic" practitioners, which concluded that a physician's attitudes and practices regarding nonerotic behavior with patients (e.g. hugging, kissing and affectionate touching) may help to predict those who would also engage in erotic (e.g. sexual) behavior.⁴

3. In a letter written by Freud to a colleague in 1931, he says:

. . . You have not made a secret of the fact that you kiss your patients and let them kiss you; . . .

Now I am assuredly not one of those who from prudishness or from consideration of bourgeois convention would condemn little erotic gratifications of this kind. . . . But that does not alter the facts . . . that with us a kiss signifies a certain erotic intimacy. We have hitherto in our technique held to the conclusion that patients are to be refused erotic gratifications. You know too that where more extensive gratifications are not to be had milder caresses very easily take over their role, in love affairs, on the stage, etc.

Now picture what will be the result of publishing your technique. There is no revolutionary who is not driven out of the field by a still more radical one. A number of independent thinkers in matters of technique will say to themselves: why stop at a kiss? Certainly one gets further when one adopts 'pawing' as well, which after all doesn't make a baby. And then bolder ones will come along who will go further to peeping and showing — and soon we shall have accepted in the technique of analysis the whole repertoire of demiviergerie and petting parties, resulting in an enormous increase of interest in psychoanalysis among both analysts and patients. The new adherents, however, will easily claim too much of this interest for himself, the younger of our colleagues will find it hard to stop at the point they originally intended, and God the Father Ferenczi gazing at the lively scene he has created will perhaps say to himself: may be after all I should have halted in my technique of motherly affection *before* the kiss. Sentences like 'about the dangers of neocatharsis' don't get very far. One should obviously not let oneself get into the danger. I have purposely not mentioned the increase of calumnious resistances against analysis the kissing technique would bring, although it seems to me a wanton act to provoke them.

3 JONES, *THE LIFE AND WORK OF SIGMUND FREUD* 163 (1953), cited in *Roy v. Hartogs*, 85 Misc. 2d 891, 895, 381 N.Y.S. 2d 587, 590 (Sup.Ct. 1976)(Markowitz, P.J., concurring).
See also, K. POPE & J. BOUTOUSTOS, *SEXUAL INTIMACY BETWEEN THERAPISTS AND PATIENTS* 29-30, (Praeger Medical Series No. 5, 1986)[hereinafter cited as POPE & BOUTOUSTOS].

4. Kardener, Fuller and Mensch, *Characteristics of "Erotic" Practitioners*, 133:11 *AM. J. PSYCHIATRY* 1324 (1976). The study concluded: "It would appear that the freer a physician is with nonerotic contact, the more statistically likely he is to also engage in erotic practices with his patient." *Id.* at 1325. Erotic practices are not limited to sexual

Despite these admonitions, research conducted by a number of researchers since the early 1970's has revealed that a substantial number of therapists have had erotic contact with their patients.⁵ For example, in a recent nation-wide survey of psychiatrists, more than 6% of the respondents admitted that they had engaged in sexual contact with patients.⁶ Another study found that 10.9% of male and 1.9% of female psychologists have had some kind of erotic contact with their patients.⁷ Civil actions involving sexual intimacies account for about 45% of the total paid out over the last ten years by the American Psychological Association's professional liability coverage provider.⁸

Because the reported instances of therapist-patient sexual contact overwhelmingly involve male therapists with female patients,⁹ one recent analysis compared the problem with other

intercourse; they may also include kissing, fondling, nude swimming and other sexual activities. Plaut & Foster, *Roles of the Health Professional in Cases Involving Sexual Exploitation of Patients*, SEXUAL EXPLOITATION OF PATIENTS BY HEALTH PROFESSIONALS 5, 7-10 (Praeger Medical Series No.4, 1986). Other kinds of boundary violations (e.g. dating, taking vacations together, or otherwise getting too involved in a patient's personal life) may also constitute malpractice, *Id.*, but are beyond the scope of this article.

5. See, e.g., Kardener, Fuller and Mensch, *A Survey of Physicians' Attitudes and Practices Regarding Erotic and Nonerotic Contact with Patients*, 130 AM. J. PSYCHIATRY 1077 (1973)[hereinafter cited as Kardener]; Holroyd and Brodsky, *Psychologists' Attitudes and Practices Regarding Erotic and Nonerotic Physical Contact with Patients*, 32:10 AM. PSYCHOLOGIST 843 (1977)[hereinafter cited as Holroyd]; Bouhoutsos, Holroyd, Lerman, Forer and Greenberg, *Sexual Intimacy Between Psychotherapists and Patients*, 14:2 PROF. PSYCHOLOGY: RESEARCH AND PRACTICE 185 (1983)[hereinafter cited as Bouhoutsos]; Gartrell, Herman, Olarte, Feldstein and Localio, *Psychiatrist-Patient Sexual Contact: Results of a National Survey, I: Prevalence*, 143:9 AM. J. PSYCHIATRY 1126 (1986)[hereinafter cited as Gartrell].

6. Gartrell, *supra* note 5 at 1128. "Sexual contact" in this study was defined as "contact which was intended to arouse or satisfy sexual desire in the patient, therapist, or both." *Id.* at 1127. 74% of the instances reported included genital contact; in the remaining cases the sexual contact consisted of kissing, fondling, and/or undressing. *Id.* at 1128.

7. Holroyd, *supra* note 5 at 846-847. The study also found that 5.5% of male and 0.6% of female licensed Ph.D. psychologists surveyed admitted to sexual intercourse with patients. *Id.* Since all the cited figures are based entirely on therapist self-report, they can safely be assumed to represent minimal estimates of incidence. Gartrell, *supra* note 5 at 1129; Schoener, Milgrom and Gonsiorek, *Sexual Exploitation of Clients by Therapists*, WOMEN AND MENTAL HEALTH 64 (1984).

8. Ethics Committee of the American Psychological Association, *Trends in Ethics Cases, Common Pitfalls, and Published Resources*, 43:7 AMERICAN PSYCHOLOGIST 564, 567 (July 1988)[hereinafter cited as *Trends in Ethics Cases*].

9. See, e.g., Gartrell, *supra* note 5 at 1126 (88% of the sexual contacts occurred between male psychiatrists and female patients). See also the statistics cited at notes 6-8, *supra*. Based upon these statistics, this article will use male pronouns to refer to therapists and female pronouns to refer to patients. However, the author wishes to acknowl-

kinds of harm done to women, such as marital abuse and sexual harassment in the workplace.¹⁰ The commentator argues that sexual exploitation of women patients by their therapists occurs because women in general are conditioned to accept subordinate social roles. The psychiatric community as a whole values such subordinate behavior in women, and thus has been slow to acknowledge the problem of sexual exploitation.¹¹

Irrespective of the gender issue, one of the most disturbing revelations of these studies is the pattern of repeat offenses and the attitudes underlying them.¹² The overwhelming majority of therapists believe that sexual contact between patient and therapist is always inappropriate during the course of treatment.¹³ By contrast, psychiatrists who acknowledge having had sexual contact with one or more patients in a recent survey differed markedly from their peers in their attitudes.¹⁴ The offenders were much more likely to allow for exceptions to the general rule;¹⁵ for example, they were more likely to believe that sexual

edge that sexual exploitation may be just as damaging where the genders of the parties are reversed or when the therapist and patient share the same gender.

10. LeBoeuf, *Psychiatric Malpractice: Exploitation of Women Patients*, 11 HARVARD WOMEN'S LAW JOURNAL 83, 85 (1988)[hereinafter cited as LeBoeuf].

11. *Id.* at 84-85. Much of the clinical literature supports this view, underlining the culpability of society and of most psychotherapists for perpetuating a stereotype of femininity which often leads to abuse. See, e.g., Pope & Bouhoutsos, *supra* note 2 at 49-51; Holroyd, *supra* note 5 at 843.

12. Holroyd, *supra* note 5 at 847, reported that 80% of the psychologists who admitted to sexual intercourse had done so with more than one client. Gartrell's study indicated that 33.3% of the offenders had been involved with more than one patient, with one psychiatrist reporting involvement with as many as twelve patients. Gartrell, *supra* note 5 at 1128.

13. Herman, Gartrell, Olarte, Feldstein and Localio, *Psychiatrist-Patient Sexual Contacts: Results of a National Survey, II: Psychiatrists' Attitudes*, 144:1 AM. J. PSYCHIATRY 164, 165 (1987)[hereinafter cited as Herman]. 98% of the respondents believed that sexual contact between patient and therapist is always inappropriate during therapy sessions or concurrent with treatment, and 97.4% believed that such contact is usually or always harmful to the patient. "Although 'always harmful' was not offered as a forced-choice option on this question, it was written in by 13% of the respondents. Many commented spontaneously that they considered such behavior equivalent to rape." *Id.* at 165.

14. *Id.* at 166-167.

15. *Id.* The most widely reported exception was for sexual relations after termination of therapy. 74% of the offenders believed that sexual relations could be appropriate after termination; only 27.4% of the nonoffenders thought so. *Id.* at 166. The survey indicated that there is a wide range of opinion and considerable confusion among therapists on the matter of sexual relationships after termination. *Id.* at 167-169. See also, *infra* notes 69-73 and accompanying text.

contact could be appropriate if the therapist "fell in love" with the patient,¹⁶ and a considerable minority believed that sexual relations could sometimes be appropriate as a form of therapy.¹⁷ Repeat offenders (who comprised approximately one-third of the offenders who responded) were particularly likely to believe in the therapeutic value of sexual relations with patients.¹⁸

Just as troubling was the offenders' apparent lack of perception of the harm invariably caused by their conduct, and their overwhelming lack of regret for the consequences to the patient. Most offenders who responded to the survey believed that their relationships with patients were at best "mutually satisfying," and at worst "innocuous."¹⁹ Only 9.5% recognized that their patients experienced the sexual relationship as harmful,²⁰ and only one offender who answered the survey expressed regret based on an understanding of the meaning of the sexual contact to the patient.²¹ For the most part, the respondents who expressed regrets were concerned about the consequences of the relationship to their own personal and career goals.²²

16. Herman, *supra* note 13. 21.4% of the offenders as opposed to 3.5% of the non-offenders. *Id.* at 166.

17. *Id.* Nearly 10% of the offenders thought that sexual relations could sometimes be appropriate as a therapeutic intervention during treatment sessions, whereas only 1% of the nonoffenders thought so. Moreover, 19% of the offenders said that sexual contact could sometimes be beneficial to patients, compared with 1% of the nonoffenders. *Id.* at 166.

18. *Id.* "The majority of the offenders who condoned sexual relations within the treatment setting or concurrent with treatment - and who accepted such therapeutic indications as enhancing a patient's self-esteem, providing a corrective emotional experience, or changing a patient's sexual orientation - were also repeaters." *Id.* at 167.

19. *Id.* For example, a 55-year old man, in practice for 24 years, who had sexual contact with three female patients, characterized his most recent relationship as "a loving relation to a healthy human being I'd come to know," and said that it "in *no way* had the usual sordid tinge." Another male therapist who had sexual relations with two male former patients wrote that he learned from the experience and no harm was done that he could see, although former patients were now off his list of prospective sexual partners. *Id.* at 167.

20. *Id.*

21. *Id.* This man, who had become involved with a patient during his psychiatry clerkship as a medical student, saw the involvement as having "no therapeutic intent, simply a loss of impulse control on my part, not in love but in lust." He later felt great remorse at his patient's disappointment in him, but was too ashamed to seek consultation. *Id.* at 167.

22. *Id.* at 167. For example, a 30-year old man who became sexually involved with a patient during residency wrote that he had been devastated by the experience, and couldn't believe the risks he had taken with his marriage and his career. He was not so certain about the effect of his sexual relationship on his patient, since "[h]er life was

This callous disregard flies in the face of what is known about the devastating consequences to most patients who engage in sexual relationships with their therapists.²³ Depression and low self-esteem, two of the most common problems which lead women to seek therapy, are typically exacerbated by such a relationship.²⁴ In addition, sexual involvement with a therapist adds to the patient's confusion and can lead to marked ambivalence and extreme mood swings as feelings come into conflict.²⁵ These symptoms can lead to suicidal feelings or behavior, increased drug or alcohol use, and in extreme cases to hospitalization and/or suicide.²⁶

When the relationship ends, patients generally suffer a confusing range of emotions. Many feel guilty about the relationship and blame themselves for what happened.²⁷ They may alternate between grief at the loss and anger at the abuse of trust.²⁸ Some patients are afraid to tell their families or friends, so they become increasingly depressed and isolated.²⁹ If they do tell, they

terribly chaotic to begin with, with multiple moves, suicide attempts, substance abuse, etc." *Id.* at 167.

23. Pope & Bouhoutsos, *supra* note 2 at 57-68. "The usual clinical picture includes a loss of trust, poor self-concept, problems with expression of anger, loss of confidence in the patient's own judgment, feelings of guilt, ambivalence about the damaging relationship, and difficulty in establishing a relationship in any subsequent therapy." *Id.* at 64. For two first-hand accounts of the devastating consequences which these relationships have on their victims, see, E. Plaisil, *THERAPIST* (1985) and L. Freeman & J. Roy, *BETRAYAL* (1976)[hereinafter cited as J. Roy] ("The true story of the first woman to successfully sue her psychiatrist for using sex in the guise of therapy.")

24. Schoener, *supra* note 7 at 65. The authors work at the Minneapolis Walk-In Counseling Center (WICC), a pioneer in providing short-term counseling and advocacy services to victims of sexual exploitation by therapists since 1974. *Id.* at 63.

25. *Id.*

26. Pope & Bouhoutsos, *supra* note 2 at 61. Many clinicians believe that the sequelae of therapist-patient sexual involvement form a distinct clinical syndrome with both acute and chronic phases, identified by some clinicians as post-traumatic stress disorder. *Id.* at 63-64. One study showed that 90% of the patients had adverse effects. *Id.* at 61. They were more despondent, less motivated, had impaired social adjustment, and were significantly more emotionally disturbed. There was an increase in drug or alcohol use, suicidal behavior and hospitalization, as well as a worsening of sexual, mental or intimate relationships, mistrust of the opposite sex and sexual impairment. In addition, they never received therapy for their original problems once the sexual relationship started. *Id.* Many victims who are seriously traumatized spend a lifetime undoing the damage. *Id.*

27. Schoener, *supra* note 7 at 64.

28. *Id.* at 64-65.

29. *Id.*

may not be believed, or may be blamed for what happened.³⁰ Whether they tell or not, the problems caused by the sexual relationship can have devastating consequences for their spouses and children, the unseen secondary victims of the therapist's abuse of trust.³¹

Perhaps the most universal symptom of therapist-patient sexual relationships is a massive loss of trust in the therapist, in the profession, and often in the fairness of life itself.³² This loss of trust makes it difficult for the patient to ever get help for the problems which first brought her to therapy, or to resolve the problems caused by her relationship with the therapist.³³ Even if a patient knows she needs help, she may not know where to turn, and may be afraid that her confidentiality will not be maintained.³⁴ These factors make it difficult, if not impossible, for some patients to seek assistance in getting redress until many years after the injury has occurred.³⁵

30. *Id.* at 66.

31. Schoener & Milgrom, *A Walk-In Counseling Center Approach to Therapist Sexual Misconduct*, in *SEXUAL EXPLOITATION OF PATIENTS BY HEALTH PROFESSIONALS* 152, 156-157 (Praeger Medical Series No. 4, 1986). The authors report that sexual contact with a therapist tends to accelerate marital break-ups in shaky marriages, and children often suffer from the emotional unavailability of one or both parents. Employers may also be affected by temporarily reduced work performance on the part of the victim or her family members. *Id.* at 156-157.

32. See, e.g., Sonne, Meyer, Borys and Marshall, *Clients' Reactions to Sexual Intimacy in Therapy*, 55 *AM. J. ORTHOPSYCHIATRY* 183-186 (April 1985). In their experience with a post-therapy support group at the UCLA Psychology Clinic, the authors report that the effects of the therapists' betrayal seem to generalize into a more global lack of trust. The victims seem to have lost their view of the world as a fair and just place in which individuals and institutions could be counted on. "They expressed disgust with psychotherapy licensing boards, training institutions, and the professions. Similarly, most women felt ambivalent toward the legal system, pointing to the unfair treatment received by rape and incest victims." *Id.* at 185. See also, Pope & Bouhoutsos, *supra* note 2 at 65.

33. See, e.g., Pope & Bouhoutsos, *supra* note 2 at 63-65; Apfel and Simon, *Sexualized Therapy: Causes and Consequences*, in *SEXUAL EXPLOITATION OF PATIENTS BY HEALTH PROFESSIONALS* 143, 146-147 (Praeger Medical Series No. 5, 1986).

34. See Schoener, *supra* note 7 at 66.

35. See Pope & Bouhoutsos, *supra* note 2 at 130. "Frequently patients are so damaged by their sexual involvement with the therapist that they are unable to face what has occurred to them. They may have strong ambivalence about the therapist. This feeling of guilt or complicity keeps them from even considering filing a complaint or lawsuit. Sometimes the therapist has told them that sexual contact is part of the therapy, or has blamed them for his or her loss of interest, and they feel so responsible for the damage they have suffered that they don't realize that the therapist has the responsibility. These patients do not know nor can they allow themselves to consider the possibility that the therapist's sexual conduct is malpractice." *Id.* at 130.

Many therapists who specialize in this area believe that filing a complaint against the offending therapist can be an important, positive and healing experience for patients who have been sexually involved with their therapists.³⁶ For those patients who eventually seek redress against the therapist, there are a number of avenues available.³⁷ However, civil litigation is the only remedy which can provide money damages to compensate the patient for her pain and suffering, and pay the costs of extensive therapy which is often needed to undo the damage done by the illicit relationship.

This article explores the clinical and legal issues raised in civil actions brought by patients against their therapists for sex-

36. See, e.g., Pope & Bouhoutsos, *supra* note 2 at 110.

37. Many therapists belong to professional societies which have formal complaint procedures. See note 47, *infra*. Although these organizations do not have authority to revoke a therapist's license, they may expel or suspend him, notify other members of what happened, or require the therapist to get supervision or training to retain his membership. These measures might limit the therapist's career opportunities and patient referrals, and prevent him from perpetuating the abuse. See, e.g., Pope & Bouhoutsos, *supra* note 2 at 115-116.

If the therapist is licensed, a complaint filed with the appropriate licensing agency could result in suspension or revocation of the therapist's license. [All 50 states license psychiatrists and psychologists, more than half license social workers, and some license other professionals as well.] Although a suspension or revocation means that the therapist can no longer hold himself out as a member of his profession, in most states he could continue to offer services as an unlicensed counselor. See, e.g., Pope & Bouhoutsos, *supra* note 2 at 117-118. See also, FLA. STAT. ANN., §490.012, 490.014 (West 1988) ("No provision of this chapter [licensing psychologists] shall be construed to limit the practice of medicine, osteopathy, nursing, clinical social work, marriage and family therapy, mental health counseling, or other recognized businesses or to prevent qualified members of other professions from doing work consistent with their training, so long as they do not hold themselves out to the public as possessing a license . . .").

Minnesota has enacted a registration statute designed to deal with the problem of unlicensed practitioners, which requires all "mental health service providers" (a broad term which encompasses any type of assessment, treatment or counseling) to register with a board which can take disciplinary action (including revocation of the right to practice) if they engage in sexual contact with a patient or former patient or other specified forms of misconduct. MINN. STAT. ANN. § 148B.40 *et seq.* (West 1989).

In addition, some states have enacted specific criminal statutes which make therapist patient sexual contact during the course of treatment a felony or misdemeanor. See, e.g., WIS. STAT. ANN. §940.22 (West 1989); MINN. STAT. ANN. §609.344-609.345 (West 1989); MICH. COMP. LAWS ANN. §750.90 (West 1968); FLA. STAT. ANN. §490.0111-490.012 (West 1988); COLO. REV. STAT. §18-3-405.5 (1988); N.H. REV. STAT. ANN. §632-A:1 *et seq.* (1986).

Finally, a victim of therapist sexual exploitation may file a common law action against the offending therapist for malpractice, intentional tort, or breach of contract, see discussion at Section IIA of text, and in some states may have a statutory civil cause of action against the therapist, see note 48, *infra*.

ual exploitation.³⁸ Section II provides an overview of the various substantive theories of liability and defenses, as well as special procedural difficulties and problems of proof in sexual abuse cases.³⁹ It suggests that the "consent" defense is an inappropriate analytical framework in a malpractice action based upon therapist sexual exploitation. The real dispute should center around the parameters of a therapist's duty to his patient outside of the formal therapeutic setting. Section III examines the statute of limitations problem, and suggests a statutory approach to ensure a victim's remedy is preserved until she is both intellectually and psychologically able to understand and seek redress for the injuries inflicted by the offending therapist.

II. THEORIES OF LIABILITY, DEFENSES AND PROBLEMS OF PROOF

A. MISHANDLING OF THERAPEUTIC RELATIONSHIP AS MALPRACTICE

In 1968, Ada Margaret Zipkin was awarded \$17,000 for injuries resulting from her psychiatrist's mishandling of the therapeutic relationship.⁴⁰ Several years later, in a highly publicized

38. For purposes of this article, "therapist-patient sexual exploitation" includes any erotic contact between a therapist and patient which results from the therapist's mishandling of the therapeutic process. "Therapist" includes psychiatrists, psychologists, marriage and family counselors, ministers, and other licensed and unlicensed professionals who hold themselves out as competent to render advice and treatment for emotional and/or psychological problems. Despite the confusion among clinicians, *see* note 15, *supra*, this article assumes that the therapist's duty to the patient may continue beyond the termination of formal therapy sessions, and that in some circumstances it may constitute malpractice for a therapist to engage in a sexual relationship with a former patient. *See* discussion at Section IIC of text and notes 69-73, *infra*.

39. This section does not attempt to duplicate the work of other commentators who have reviewed the substantive law of sexual exploitation. *See* LeBoeuf, *supra* note 9. Instead, using the seminal case of *Roy v. Hartogs*, 85 Misc. 2d 891, 381 N.Y.S. 2d 587 (Sup.Ct. 1976), as the primary illustration, this section analyzes some of the conceptual and practical problems encountered in pursuing a civil claim for damages based upon a therapist's sexual exploitation of his patient.

40. *Zipkin v. Freeman*, 436 S.W. 2d 753 (Mo. 1968). This case did not specifically turn on allegations of sexual contact, although a sexual relationship was at least implied by the testimony, which included allegations of nude swimming parties. Dr. Freeman's misconduct consisted of misusing the therapeutic relationship to induce the plaintiff to attend social events with him, leave her husband and move into a farm owned by him, and steal property from her husband, among other things. Mrs. Zipkin testified that she fell in love with Dr. Freeman, put her faith and trust in him, and did or said anything he told her was good for her. Expert testimony was introduced that Dr. Freeman's "treatment" of the plaintiff was a distortion of the transference phenomenon which caused the

case, Julie Roy became the first woman in the United States to successfully sue her psychiatrist for engaging in sex with her as a form of therapy.⁴¹ These ground-breaking cases established that mishandling of the therapeutic relationship — especially by engaging in a sexual relationship with a patient — is a basis for a claim of malpractice or gross negligence. Courts across the coun-

plaintiff serious (and perhaps permanent) emotional harm. *Id.* at 759-760.

Prior to the *Zipkin* case, most of the handful of reported cases had been brought by husbands who suffered damages as a result of their wives' sexual relationship with a therapist. *See, e.g.*, *Horak v. Biris*, 130 Ill. App. 3d 140, 474 N.E. 2d 13 (1985) (husband sued social worker who had been the couple's marriage counselor and had engaged in sexual relations with the wife); *Anclote Manor Foundation v. Wilkinson*, 263 So. 2d 256 (Fla. Ct. App. 1972) (husband recovered damages for hospital costs of his ex-wife where hospital psychiatrist had told the patient he was going to divorce his wife and marry her).

In many jurisdictions, these types of cases were prohibited by "heart-balm" statutes, which barred civil liability for alienation of affections, seduction and criminal conversation. *See, e.g.*, *Nicholson v. Han*, 12 Mich. App. 35, 162 N.W. 2d 313 (1968) (husband's suit for breach of contract, malpractice, assault and battery and fraud against marital counselor who engaged in sexual relations with his wife was in substance an action for alienation of affections barred by statute). *See also*, A. Stone, *Sexual Exploitation of Patients in Psychotherapy*, in *LAW, PSYCHIATRY & MORALITY* 191, 197 (1984). Although some defendants have argued that the heart-balm statutes also bar any action by the spouse who engaged in the sexual relationship, most courts have rejected that argument. *See, e.g.*, *Cotton v. Kambly*, 101 Mich. App. 537, 300 N.W. 2d 627 (1980); *Roy v. Hartogs*, 85 Misc. 2d 891, 897, 381 N.Y.S.2d 587, 592 (Sup.Ct. 1976) (Riccobano, J., dissenting).

41. *Roy v. Hartogs*, 381 N.Y.S. 2d 587, 85 Misc. 2d 891 (Sup.Ct. 1976). [The facts in this note and notes 50-52, *infra*, are drawn largely from the plaintiff's own account, *see J. Roy, supra* note 23.] Julie Roy was thirty years old in 1969 when she entered therapy with Dr. Renatus Hartogs, seeking help for a serious depression following her divorce. Shortly after she began therapy, Dr. Hartogs began asking Ms. Roy to have sex with him, telling her that it would cure her fear of men and alleged "homosexuality." (She had engaged in a short-lived relationship with another woman following her divorce.) Slowly, Dr. Hartogs drew Ms. Roy into a sexual relationship with him, encouraging her to continue by telling her that she was making progress in her therapy. In general, their sessions lasted only about ten minutes, including the sex. When Ms. Roy tried to talk to Dr. Hartogs about her problems or the fact that she was still feeling depressed, he would tell her it wasn't important. After about a year and a half, prompted by Ms. Roy's increasing demands for more time with him, Dr. Hartogs abruptly terminated the relationship and refused to see her for therapy any longer. *J. Roy, supra* note 23, ch. 3-4.

During the following year, Ms. Roy was so distraught that she quit her job, refused to talk to anyone, and had to be hospitalized twice to prevent suicide. She only turned to the legal system for help when she finally realized that there was no other way to avenge herself for the harm that had been done to her by Dr. Hartogs. Despite the assistance of extremely competent counsel who believed in her case and did their best to protect her, Ms. Roy's experience with the legal system illustrates some of the problems commonly faced by victims of sexual exploitation who decide to seek legal redress for their injuries; i.e., lengthy delays, grueling discovery, "blaming the victim," and difficulties in collecting any damages that are awarded. *See, infra* notes 50-52 and accompanying text.

try have uniformly accepted this analysis,⁴² often adopting the clinical explanation that sexual relationships with clients constitute a mishandling of the “transference phenomenon”.⁴³ The “transference” explanation is only one of many plausible theories for a claim of malpractice. In most jurisdictions, all that is required to establish malpractice is expert testimony that the therapist’s conduct was a departure from standard and accepted practice and that this conduct caused the patient harm.⁴⁴ This legal framework leaves room for plaintiffs’ experts to offer alternative explanations for the malpractice; for example, abuse of the power imbalance which is inherent in the therapeutic rela-

42. *See, e.g.*, *Simmons v. United States*, 805 F.2d 1363 (9th Cir. 1986); *Vigilant Insurance Co. v. Employers Insurance Wausau*, 626 F. Supp. 262 (S.D.N.Y. 1986); *Aetna Life & Casualty Co. v. McCabe*, 556 F. Supp. 1342 (E.D. Pa. 1983); *Waters v. Bourhis*, 40 Cal. 3d 424, 709 P.2d 469, 220 Cal. Rptr. 666 (1985); *Horak v. Biris*, 130 Ill. App. 3d 140, 474 N.E. 2d 13 (1985); *L.L. v. Medical Protective Co.*, 122 Wis. 2d 455, 362 N.W.2d 174 (Wis. Ct. App. 1984), *review denied*, 122 Wis. 2d 783, 367 N.W.2d 223 (1985); *St. Paul Fire & Marine Insurance Co. v. Mitchell*, 164 Ga. App. 215, 296 S.E.2d 126 (1982); *Cotton v. Kambly*, 101 Mich. App. 537, 300 N.W. 2d 627 (1980); *Roy v. Hartogs*, 85 Misc. 2d 891, 381 N.Y.S. 2d 587 (Sup.Ct. 1976); *Seymour v. Lofgreen*, 209 Kan. 72, 495 P.2d 969 (1972); *Zipkin v. Freeman*, 436 S.W.2d 753 (Mo. 1968).

43. “Transference” is a psychological term used to describe a patient’s projection of her feelings regarding a significant other (typically a parent) onto the therapist. *See, e.g.*, *Simmons v. United States*, 805 F.2d 1363 (9th Cir. 1986).

Transference is the term used by psychiatrists and psychologists to denote a patient’s emotional reaction to a therapist and is ‘generally applied to the projection of feelings, thoughts and wishes onto the analyst, who has come to represent some person from the patient’s past. . . .’ Transference is crucial to the therapeutic process because the patient ‘unconsciously attributes to the psychiatrist or analyst those feelings which he may have repressed towards his own parents. . . . [I]t is through the creation, experiencing and resolution of these feelings that [the patient] becomes well.’ . . . The proper therapeutic response is countertransference, a reaction which avoids emotional involvement and assists the patient in overcoming problems. . .

When the therapist mishandles transference and becomes sexually involved with a patient, medical authorities are nearly unanimous in considering such conduct to be malpractice. *Id.* at 1364-1365.

Once they have concluded that there is malpractice, most courts have had little difficulty recognizing that “by introducing sexual activity into the relationship, the therapist runs the risk of causing additional psychological damage to the patient.” *L.L. v. Medical Protective Co.*, 122 Wisc. 2d 455, 462, 362 N.W. 2d 174, 178 (1984).

44. *See, e.g.* *Roy v. Hartogs*, 85 Misc. 2d 891, 893, 381 N.Y.S. 2d 587, 588 (S.Ct. 1976)(allegations that harm was caused to plaintiff by defendant’s failure to treat with professionally acceptable procedures stated a viable cause of action for malpractice).

tionship even if transference has not taken place.⁴⁵

Such expert testimony should not be difficult to obtain, since the vast majority of respected mental health professionals believe it is an abuse of trust for a therapist to have sexual relations with a patient.⁴⁶ In fact, in response to concerns raised by recent studies of the prevalence of therapist-patient sexual contact, the ethics codes of the major mental health associations have been revised to clearly prohibit therapist patient sexual contact.⁴⁷ Some state legislatures, in recognition of the problem,

45. The duty not to abuse this power imbalance has been described by numerous clinical commentators, who see it as the core of the therapeutic contract. *See, e.g.,* Herman, *supra* note 13 at 168:

Patients enter therapy in need of help and care. By virtue of this fact, they voluntarily submit themselves to an unequal relationship in which their therapists have superior knowledge and power. Transference feelings related to the universal childhood experience of dependence on a parent are inevitably aroused. These feelings further exaggerate the power imbalance in the therapeutic relationship and render all patients vulnerable to exploitation. The promise to abstain from abusing this position of power for personal gratification is central to the therapeutic contract; violations of this promise destroy the basic trust on which the therapeutic process is founded. *Id.* at 168.

Because the power dynamic created in the therapist-patient relationship resembles the parent-child relationship, many clinicians have compared the prohibition against sexual contact with patients to the incest taboo. *See, Id.* at 168; Pope & Bouhoutsos, *supra* note 2 at 23.

46. *See, e.g.,* Herman, *supra* note 13 at 168. Although historically a minority of therapists have advocated sexual contact with patients as a therapeutic modality, Herman notes that such beliefs have always been considered unorthodox and have generated great controversy. *Id.* Many commentators openly scoff at the notion that sex with a patient could ever be therapeutic.

The physician's protestation that by being his patient's lover he is really proving he cares and is therefore offering a valuable gift is best viewed as an emotional Trojan horse that conceals not only his own needs but hostility and antipathy toward his patients as persons and their struggle for emotional well-being. In responding to his patients' erotic fantasies, the physician can only finally prove to be a horrendous disappointment when, by the dictates of his life circumstances, he must ultimately reassert his own realities. Kardener, *Sex and the Physician-Patient Relationship*, 131:10 AM.J. PSYCHIATRY 1134, 1136 (October 1984).

See also LeBoeuf, *supra* note 10 at 91-92; Pope & Bouhoutsos, *supra* note 2 at 27, 58-60.

47. *See, Pope & Bouhoutsos, supra* note 2 at 30-31, which quotes the following relevant sections of the ethics codes:

"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

have enacted statutes explicitly creating a civil cause of action for therapist-patient sexual exploitation.⁴⁸

B. THRESHOLD CONSIDERATIONS

Despite widespread recognition by the courts that a therapist's sexual contact with a patient may constitute malpractice,⁴⁹

the objectivity necessary for control. Sexual activity with a patient is unethical." (American Psychiatric Association 1985)

"Psychologists are continually cognizant of their own needs and of their potentially influential position vis-a-vis persons such as clients, students and subordinates. They avoid exploiting the trust and dependency of such persons. . . . Sexual intimacies with clients are unethical." (American Psychological Association 1981)

"The social worker should under no circumstances engage in sexual activities with clients." (National Association of Social Workers 1980)

"Sexual relationships between analyst and patient are antithetic to treatment and unacceptable under any circumstance. Any sexual activity with a patient constitutes a violation of this principle of ethics." (American Psychoanalytic Association 1983)

"A therapist will attempt to avoid relationships with clients which might impair professional judgment or increase the risks of exploiting clients. Examples of such relationships include: Treatment of family members, close friends, employees, or supervisees. Sexual activity with clients is unethical." (American Association for Marriage and Family Therapy 1982)

48. See, e.g., MINN. STAT. ANN. §148A.01-148A.06 (West 1989); WISC. STAT. ANN. §895.70 (West 1989); CAL. CIV. CODE §43.93 (West 1989). The Minnesota statute creates a cause of action not only against the offending therapist, MINN. STAT. ANN. §148A.02, but also against the therapist's employer [or former employer] for failing to request [or disclose] information about known sexual contact by the therapist, or failure to take reasonable action against a psychotherapist known to have engaged in sexual contact with a patient, MINN. STAT. ANN. §148.03.

49. See note 42, *supra*. Although most of the decided cases have adopted a malpractice analysis, there are several other viable causes of action available to plaintiffs, including various intentional tort theories (e.g. assault and battery, intentional infliction of emotional distress, and fraudulent concealment) as well as breach of contract claims. See LeBoeuf, *supra* note 10 at 108-110. In most circumstances, there is little to be gained from alleging the intentional tort theories, since proof of "intent" or "recklessness" places a much greater burden on plaintiffs than proof of malpractice.

For example, proof of intentional infliction of emotional distress requires, at a minimum, a showing of "recklessness", e.g. that the therapist acted "knowing or having reason to know of facts which would lead a reasonable man to realize . . . that his conduct creates an unreasonable risk of . . . harm to another [and] that such risk is substantially greater than that which is necessary to make his conduct negligent." RESTATEMENT (SECOND) OF TORTS §500 (1964). Moreover, the plaintiff must establish that the therapist's conduct was so severe that no reasonable person could be expected to endure it. RESTATEMENT (SECOND) OF TORTS §46 comments a and j (1964). The "outrageousness" of the therapist's conduct may arguably arise from his abuse of his position of authority or power over the plaintiff, but even this is more difficult to prove than simple negligence. RESTATEMENT (SECOND) OF TORTS §46 comment e (1964).

In the most extreme and outrageous cases of abuse, proof of an intentional tort may assist the plaintiff in paving the way for an award of punitive damages, which in most

plaintiffs face a number of obstacles to a successful civil action. First, it is common for the therapist to deny that the sexual conduct occurred, thus turning the case into a battle of credibility.⁵⁰ The therapist has the advantage in this battle, not only because he is a trusted professional, but also because he can use his superior training to brand the patient "crazy" and claim that she imagined or "made up" the sexual relationship.⁵¹ Because the plaintiff has put her emotional and sexual health in issue, the

jurisdictions requires a finding of something akin to "recklessness". *But see*, *Roy v. Hartogs*, 85 Misc.2d 891, 894, 381 N.Y.S. 2d 587, 589 (Sup.Ct. 1976), where the court overturned the jury's award of punitive damages because the weight of the evidence did not justify the jury's finding that the defendant's conduct was so wanton or reckless as to permit an award for punitive damages.

50. *See* LeBoeuf, *supra* note 10 at 97-100; Pope & Bouhoutsos, *supra* note 2 at 131. The *Roy* case aptly illustrates this problem. During discovery, although Dr. Hartogs appeared for a deposition, he refused to answer any questions on the ground that he might incriminate himself. Then, mid-way through the trial, his attorneys indicated that he was planning to testify on his own behalf. During a hasty mid-trial deposition, Dr. Hartogs claimed that he had been unable to have sexual intercourse since 1965 because of a hydrocele (a gross enlargement of the testicle). *J. Roy*, *supra* note 23 at Chapters 8-9. The judge permitted plaintiff to get a mid-trial medical evaluation of the defendant's condition by a prominent New York urologist, who testified that he had never heard of a case of impotence caused by a hydrocele, and that the draining of a hydrocele was a ten minute office procedure which any doctor could perform. However, defense attorneys used Dr. Hartogs' testimony to great advantage at trial, questioning Ms. Roy about the abnormality and implying that she had "made up" the sexual relationship to get even with Dr. Hartogs for terminating her therapy. *Id.*

As Dr. Hartogs discovered, the "denial" defense can be a dangerous one for the therapist. Once he testifies that he has never engaged in sexual relations with a client, the plaintiff may be permitted to introduce testimony from other patients who were also sexually involved with the therapist. *See*, *Roy v. Hartogs*, 85 Misc.2d 891, 893, 381 N.Y.S. 2d 587, 588-589 (Sup.Ct. 1976)(After Dr. Hartogs testified that he was unable to have sexual relations with Ms. Roy because of his hydrocele, plaintiff was permitted to introduce witnesses who testified that he had engaged in sex with them during that same period of time.) *Id.*

Other victims of the therapist's sexual abuse may also be permitted to testify to establish other relevant facts, such as motive, opportunity, intent, etc. *See* Fed. R. Evid. 404(b). One plaintiffs' attorney goes so far as to place an advertisement in local papers seeking former patients of the defendant to compare treatment experiences. D. Burnstein, *Sexual Malpractice Litigation*, in *SEXUAL EXPLOITATION OF PATIENTS BY HEALTH PROFESSIONALS* 49, 57 (Praeger Medical Series No. 4, 1986). At the very least, even if the other victims never reach the witness stand, they provide the plaintiff's attorney with a powerful negotiating tool in trying to reach settlement of the case before trial.

51. *See* LeBoeuf, *supra* note 10 at 98. In the *Roy* trial, Dr. Hartogs testified that Ms. Roy had told him she enjoyed telling lies about people and had desires for retaliation and revenge, that she was hostile and distrustful of him because he was a man, and that he terminated her therapy because he felt he could not help her. According to Dr. Hartogs, Ms. Roy was an incurable catatonic or paranoid schizophrenic who could not distinguish between delusion and reality. *See* *J. Roy*, *supra* note 23 at 194-210. This testimony was corroborated by the lone psychiatric expert called by the defendant. *Id.* at 232-234.

therapist is entitled to discovery on virtually every aspect of her psychological history, as well as wide-ranging questions about her past sexual behavior.⁵²

In addition to denying that the conduct occurred, the therapist may argue that the patient was already psychologically damaged and thus was not harmed by her relationship with the therapist.⁵³ For an expert who did not evaluate the patient's condition before the illicit relationship, it can be difficult to assess how much of the plaintiff's emotional problems were caused by the therapist's conduct, and how much pre-existed the therapeutic relationship. This can become the basis for reducing any damages awarded to the plaintiff.⁵⁴ Likewise, if the therapist is uninsured or the insurer denies coverage, the plaintiff may be left without an adequate remedy.⁵⁵

52. See, e.g., Burnstein, *supra* note 50 at 56. Once again, the *Roy* case illustrates. During the four years between the filing of her complaint and the trial, in between hospitalizations for a debilitating depression, Ms. Roy was subjected to three grueling days of depositions, at which she was questioned not only about her sexual relationship with Dr. Hartogs, but also about her sex life outside of therapy and "lesbian" relationship, her subsequent therapy and hospitalizations, and her use of the drugs which Dr. Hartogs had prescribed for her. The same kinds of questions were repeated at trial. See *J. Roy, supra* note 23 at 125-132.

The Minnesota statute, see note 48, provides a partial remedy to this problem, stating that evidence of the plaintiff's sexual history is not admissible in an action for sexual exploitation except when the court determines in a pre-trial hearing that the history is relevant and its probative value outweighs its prejudicial effect. MINN. STAT. ANN. §148A.05 (West 1989). Accord, CAL. CIV. CODE §43.93(d)(West 1989).

53. See, e.g., *Roy v. Hartogs*, 85 Misc.2d 891, 381 N.Y.S.2d 587 (Sup.Ct. 1976); Burnstein, *supra* note 50 at 56.

54. See, e.g., *Roy v. Hartogs*, 85 Misc. 2d 891, 381 N.Y.S. 2d 587 (Sup.Ct. 1976). Despite Dr. Hartogs' denials, the jury believed Ms. Roy's version of the story, and awarded her \$250,000 in compensatory and \$100,000 in punitive damages. The trial judge reduced the compensatory damages to \$50,000, stating that based upon his observations of Ms. Roy during the trial, he did not believe that she had sustained any permanent emotional damage as a result of Dr. Hartogs' conduct. *J. Roy, supra* note 23 at 257-262. Dr. Hartogs appealed the decision and filed for bankruptcy. On appeal, the New York Supreme Court further reduced the compensatory damages to \$25,000 and eliminated the punitive damages. 85 Misc.2d at 893-894, 381 N.Y.S.2d at 589. They found that the compensatory award for aggravation of Ms. Roy's mental disorders was excessive because there was no evidence that Dr. Hartogs' conduct had caused a permanent worsening of her condition or a permanent impairment of her inability to work. *Id.* Moreover, they found that the weight of the evidence did not support a finding that Dr. Hartogs' conduct was so wanton or reckless as to permit an award for punitive damages. *Id.* However, in negotiations during the pendency of Dr. Hartogs' appeal, his insurance company had agreed to pay the \$50,000 compensatory damages. *J. Roy, supra* note 23 at 263. See, *Hartogs v. Employers Mutual Insurance Co. of Wisconsin*, 89 Misc. 2d 468, 391 N.Y.S. 2d 962 (Sup.Ct. 1977).

55. In response to the burgeoning cases, the major malpractice insurers have at-

As the *Roy* case illustrates, a civil action based upon therapist-patient sexual exploitation requires great fortitude on the part of both the client and attorney. At the initial consultation, it is incumbent upon the interviewing attorney to advise a prospective client about the nature of the process, and to encourage an honest and thorough examination of the facts before any decision is made to proceed with litigation. In most cases, it is helpful to get the client's permission to discuss the issues with any present treating therapist, both to see whether that person will support the litigation, and to get an honest assessment of the client's ability to withstand the rigors of pretrial and trial scrutiny. At a minimum, the attorney should gather all relevant

tempted to eliminate coverage for sexual misconduct from their policies. The American Psychological Association insurance policy expressly excludes coverage for sexual activity. See Stone, *supra* note 40 at 202. Since May 1, 1985, the American Psychiatric Association Plan has excluded coverage for "undue behavior" although the policy will continue to provide legal defense for psychiatrists accused of such behavior. See Simon, *Sexual Misconduct of Therapists: A Cause for Civil and Criminal Action*, TRIAL 46, 50 (1985).

Even prior to initiating these express exemptions, the insurers attempted to deny coverage for sexual misconduct by arguing that intentional conduct such as sexual relations with patients fell outside the scope of "professional services rendered." See LeBoeuf, *supra* note 10 at 106, n. 113. Although this does not prevent potential plaintiffs from pursuing or even winning their claims, it may make for a hollow victory if the insurer refuses to pay and the therapist is insolvent. *Id.* at 106, n. 115.

Courts which have considered this issue have come to inconsistent conclusions. See LeBoeuf, *supra* note 10 at 106-108. Most courts seem to agree that, in the absence of an express exclusion, if the jury finds that the conduct was negligence or malpractice, the conduct falls within the scope of professional services and should be covered. See, e.g., Zipkin v. Freeman, 436 S.W.2d 753, 756, 761-762 (Mo. 1968) (an insurance company which insures psychiatrists "in the exercise of reasonable care in the operation of its business" should know "that transference pertains to psychiatry and is important in treatment." However, the court limited recovery to the \$5,000 maximum for "any one claim or suit", rejecting the plaintiff's argument that she was entitled to recover on three separate policies for three separate years.) See also, Aetna Life and Cas. Co. v. McCabe, 556 F. Supp. 1342, 1351 (E.D. Pa. 1983) (where jury found that defendant was negligent in his treatment, it fell within policy language covering professional conduct). The new policies with express exclusions have yet to be tested in the reported decisions, but at least one court has denied recovery under the new policies. See LeBoeuf, *supra* note 10 at 108, citing Sphere Insurance Company v. Rosen, Civ.A.No. 85-2654 (E.D. Pa. May 16, 1986).

Under the old policies, most courts require the insurer to defend, but some courts have permitted insurers in a subsequent action to seek indemnification from the therapist on the ground that the conduct was intentional. See, e.g., Aetna Life and Cas. Co. v. McCabe, 556 F. Supp. 1342, 1351 (E.D. Pa. 1983); Hartogs v. Employers Mutual Liability Co., 89 Misc. 2d 468, 391 N.Y.S. 2d 962 (Sup.Ct. 1977); St. Paul Fire & Marine Ins. Co. v. Mitchell, 164 Ga. App. 215, 296 S.E.2d 126 (1982). Moreover, some courts have ruled that public policy precludes an insurer's liability for punitive damages. Aetna Life and Cas. Co. v. McCabe, 556 F. Supp. 1342 (E.D. Pa. 1983).

mental health records and request an expert evaluation of the former therapist's conduct, the client's injuries, and any other factors which may affect the viability of the case. Only upon completing this review can the attorney assist the client in making an informed decision whether or not to proceed.

C. THE CONSENT DEFENSE

One potential defense to therapist exploitation cases merits special consideration, because it has a certain common sense appeal which may appear legally justifiable without careful scrutiny. This is the "consent" defense, which has two important variations.⁵⁶ At one end of the spectrum, the therapist may argue that the sex was an integral part of therapy, the patient was informed about the risks and voluntarily agreed to the conduct—the traditional "informed consent" defense in medical malpractice cases.⁵⁷ At the other extreme, the therapist might argue the sex was independent of the therapeutic relationship, the patient freely consented to the sexual relationship, and it should be treated like any other relationship between two consenting

56. See Stone, *supra* note 40 at 202-204. In the *Roy* case, the dissent, who did not believe that the therapist's conduct was malpractice, also raised the possibility that the plaintiff's consent to the relationship should bar her lawsuit:

In the case at bar, although the plaintiff was suffering from a number of emotional problems her competency was never placed in issue. Is it not fair to infer, therefore, that she was capable of giving a knowing and meaningful consent? For almost one and a half years while this 'meaningful' relationship continued, the plaintiff was not heard to complain. Upon the defendant terminating the relationship, this lawsuit evolves. *Roy v. Hartogs*, 85 Misc.2d 891, 897, 381 N.Y.S.2d 587, 591 (Sup.Ct. 1976)(Riccobono, J. dissenting).

Judge Riccobono went on to say that the action should be barred as one of seduction, and that the civil courts were not the appropriate forum for addressing the therapist's misconduct. *Id.*, 85 Misc.2d at 897-898, 381 N.Y.S.2d at 591-592. The majority upheld the malpractice claim without commenting on the consent issue. *Id.*, 85 Misc.2d at 893, 381 N.Y.S.2d at 588.

See also, LeBoeuf, *supra* note 10 at 102-106, which notes that some courts distinguish between sex in the guise of therapy and sex which the defendant admits was purely for his own gratification. Courts which make this distinction usually hold that consent is not an available defense when the sex is done as part of therapy, because the plaintiff was consenting to treatment rather than sex. *Id.* at 102, citing *Jacobsen v. Muller*, 181 Ga. App. 382, 386 n. 2, 352 S.E. 2d 604, 608 n. 2 (1986)(Deen, P.J., concurring). However, they leave open the possibility that consent may be a defense to sex which is not a part of the therapy. LaBoeuf, *supra* at 102-106.

57. See Stone, *supra* note 40 at 202-203.

adults.⁵⁸

The courts have had little trouble finding liability in the former situation, reasoning that the patient may have consented to "therapy", but this consent does not carry over to conduct which most experts agree is not proper therapy.⁵⁹ The latter situation is more problematic. Most courts which have considered the issue have viewed it in terms of "capacity" to consent, reasoning that a patient who has gone to therapy for treatment of emotional or psychological problems is not capable of fully granting or withholding consent from her therapist.⁶⁰ This theory finds support in the clinical literature, which suggests that the nature of the therapist patient relationship (in which the therapist is always significantly more knowledgeable and powerful than the patient)⁶¹ makes it clinically impossible for a patient to give voluntary and informed consent to the sexual relationship.⁶² In clinical terms, it is the therapist's rather than the patient's duty to avoid the sexual contact.⁶³

Although the theory that a patient lacks capacity to consent to a sexual relationship with her therapist is compatible with clinical explanations of the nature of the therapeutic relationship, some feminist commentators fear it advances the stereotypical view of women as powerless, dependent, and incapable

58. *Id.*

59. To obtain a valid "informed consent" from a patient for sex under the guise of therapy, the therapist would have to disclose both the nature of the treatment and the extent of the harm involved. RESTATEMENT (SECOND) OF TORTS §892B comment i (1977). It would be an unusual case indeed where a therapist informed a patient, prior to commencement of a sexual relationship, that this "treatment" might cause the devastating consequences discussed in Section I of the text.

LeBoeuf, *supra* note 10 at 102-106, argues that the "under guise of treatment" distinction is an arbitrary one which does not take into account the fact that there would be no sexual relationship if there were no therapeutic relationship. *Id.* at 103. Obtaining sexual acquiescence by presenting the sex as therapy is only one form of coercion practiced by exploitive therapists. *Id.* at 105-106. LeBoeuf argues that it serves no legally justifiable purpose to permit recovery when the therapist represents the sex as part of treatment, but to deny recovery under other circumstances. *Id.*

60. See LeBoeuf, *supra* note 10 at 100-102, and cases cited. See also, RESTATEMENT (SECOND) OF TORTS §892A(2) comment b (1977). "If, however, the one who consents is not capable of appreciating the nature, extent or probable consequences of the conduct, the consent is not effective. . .". *Id.*

61. See, Pope & Bouhoutsos, *supra* note 2 at 23-24, 124.

62. See LeBoeuf, *supra* note 10 at 100-102. See also Pope, *supra* note 2 at 122, 132.

63. See Pope, *supra* note 2 at 124.

of making their own decisions.⁶⁴ Further, in some jurisdictions, lack of capacity to consent is difficult to prove, requiring that the plaintiff be unable to manage her affairs or comprehend her legal rights and liabilities.⁶⁵ If a plaintiff has been able to continue working and has not been otherwise incapacitated, the court may be skeptical about an argument that she lacked capacity for the specific purpose of consenting to a sexual relationship with her therapist.⁶⁶

D. A QUESTION OF DUTY

In any event, if the cause of action against the therapist is framed as malpractice rather than an intentional tort, the "consent" defense is inappropriate.⁶⁷ The underlying issue of real concern in such cases is a "duty" question; i.e., does a therapist have a duty to refrain from sexual relations with a patient - even

64. See LeBoeuf, *supra* note 9 at 101-102.

65. See, 51 AM.JUR.2D, *Limitation of Actions* §187 and cases cited. Compare, RESTATEMENT (SECOND) OF TORTS [[892(A)(2)(a)comment b (not capable of appreciating the nature, extent or probable consequences of the conduct). See, e.g., *Decker v. Fink*, 47 Md. App. 202, 422 A. 2d 389, 392 (1980).

66. The other legal theories for countering a consent defense, i.e., fraud and duress, have similar limitations. See RESTATEMENT (SECOND) OF TORTS §892B (1977). If a plaintiff is induced by fraud, mistake or duress to consent to a harmful or offensive contact, the consent is not effective. Thus, where the therapist represented to the patient that the sexual contact would be beneficial, and the patient relied on that representation in consenting to the sexual relationship, the consent may be ineffective. RESTATEMENT (SECOND) OF TORTS §892B comment h (1977). Likewise, if the plaintiff is compelled to consent by the exercise of the therapist's will, her consent will be ineffective. RESTATEMENT (SECOND) OF TORTS §892B comment j (1977). However, the forms of duress which courts have generally required to render consent ineffective "are quite drastic in their nature and . . . clearly and immediately amount to an overpowering of the will," as in force or threats of force. RESTATEMENT (SECOND) OF TORTS §892B comment j (1977). Although a clinical argument can be made that the nature of the therapeutic relationship renders these defenses applicable, the usual sexual exploitation case does not fit the strict standards traditionally applied by courts in evaluating claims of fraud and duress.

67. See, Pope & Bouhoutsos, *supra* note 2 at 132. Under basic principles of black letter law, consent is a defense only to intentional torts. RESTATEMENT (SECOND) OF TORTS §49 (1964). The analogous principle in negligence actions is "assumption of the risk." RESTATEMENT (SECOND) OF TORTS §892A comment a (1977). Assumption of the risk requires that the plaintiff must fully understand the particular risk of harm which may be caused by the defendant's conduct, and must appreciate its unreasonable character. RESTATEMENT (SECOND) OF TORTS §496C 496D (1964). These conditions clearly do not apply in the usual sexual exploitation case, where the patient is unaware of the nature and extent of the risk of injury. In fact, this standard is loosely comparable to the "informed consent" to treatment standard, which the courts have had no trouble rejecting in these circumstances. See *supra* note 59 and accompanying text.

outside of the therapeutic setting or after the termination of the formal therapist-patient relationship?

With regard to sexual relationships which take place during the course of treatment (even if the actual sex takes place outside of the therapy sessions), the clinical commentators are in agreement that such sexual contact cannot be separated from the therapeutic relationship and that any sexual contact therefore constitutes malpractice.⁶⁸ With regard to post-termination sex, there is widespread disagreement among clinicians whether, and under what circumstances, a sexual relationship may be permissible.⁶⁹

Some therapists believe that such a relationship may be permissible with the passage of time, especially if it is to pursue a "serious, committed" relationship which leads to love and marriage.⁷⁰ Other commentators scoff at the idea of such distinctions, taking the position that the prohibition against sexual contact is permanently established with the initial encounter and cannot be abrogated by termination.⁷¹ Numerous authors

68. In recognition of these clinical standards, the Minnesota and California statutes specifically provide that it is not a defense to the action that sexual contact occurred outside a therapy or treatment session or off the premises regularly used by the therapist for therapy or treatment sessions. MINN. STAT. ANN. §148A.02(2)(West 1989); CAL. CIV. CODE §43.93(c)(West 1989). See also, Simon, *supra* note 55 at 49 (citing two unreported decisions which rejected the argument that therapy had been terminated before the sexual relationship began).

69. See, e.g., Herman, *supra* note 13 at 167; Schoener, *Some Observations on Sexual Relationships Between Client and Therapist After Therapy Ends*, Presented at the Annual Convention of the American Psychological Association, Washington, D.C. (August 24, 1986)[hereinafter cited as Schoener]. Schoener points out that the professional codes of ethics are essentially silent on the question of post-therapy sex, and conceptual articles and research are virtually non-existent. *Id.* at 2.

70. See, e.g., Herman, *supra* note 13 at 168 (discussing the views of Perr and Marmor). The apparent rationale for their view is that therapists are only human, and sometimes cannot master their own counter-transference feelings. *Id.* Perr and Marmor would require the therapist who finds himself in this situation to terminate the professional relationship and refer the patient elsewhere for treatment. *Id.* See also, *Trends in Ethics Cases*, *supra* note 8 at 567-569; Schoener, *supra* note 69 at 2.

71. See Herman, *supra* note 13 at 168 (discussing the views of Anderson and Brodsky); *Trends in Ethics Cases*, *supra* note 8 at 568. Herman adopts this view in unequivocal terms:

Neither transference nor the real inequality in the power relationship ends with the termination of therapy. In our opinion, the notion that exceptions to the rule of abstinence can be allowed in the name of love or marriage reveals either a naive romanticism or an insufficient understanding of the nature of

compare the prohibition against sexual contact with patients to the incest taboo. Just as sexual contact with a child "does not become acceptable one year after the daughter has left home", these commentators believe that sex with a former patient does not become acceptable at some magic time after the formal therapeutic relationship has ended.⁷²

Because of the widespread disagreement among clinicians, it is impossible to articulate a bright-line test for evaluating when the therapist's duty to a former patient ends. As in any malpractice action, expert testimony will be required on the issue, and the trial may turn into a "battle of the experts". The clinical literature, however, does suggest some relevant considerations in determining when a therapist's sexual conduct with a former patient breaches his professional duty. These considerations revolve around the nature of the particular therapeutic relationship, as well as the circumstances surrounding the termination of therapy and the beginning of the sexual relationship.⁷³

Minnesota, which enacted one of the first statutes creating a civil cause of action for therapist-patient sexual exploitation, attempted to resolve this ambiguity by defining both a time limit

the therapeutic relationship or both. Similarly, pragmatic efforts to define a post-termination waiting period, after which sexual relations might be permissible, disregards both the continued inequality of the roles of the therapist and former patient and the timelessness of unconscious processes, including transference. Herman, *supra* note 13 at 168.

72. See, e.g., Herman, *supra* note 13 at 1168: "This analogy accurately describes both the psychodynamics and the reality of the power relationship." See also Kardener, *Sex and the Physician-Patient Relationship*, 131 AM. J. PSYCHIATRY 1134, 1135 (1974).

73. See Schoener, *supra* note 69 at 5-8. As Schoener points out, even the initial determination of when the therapy actually ended is a difficult one. "Was a followup phone call 6 months later a psychotherapeutic interaction? Was that brief, impromptu followup consultation in private during a chance social meeting a continuation of the psychotherapy relationship?" *Id.* at 5.

Schoener suggests that the following factors are relevant in evaluating whether post-termination sex is clinically appropriate: 1) Was there "therapeutic deception"; e.g. did the therapist tell the patient that the sex was part of treatment or otherwise appropriate? (2) Was there a real termination: e.g. was the end of therapy discussed, was there a break in emotional involvement, or was the termination for the purpose of allowing a sexual or romantic involvement? (3) Did the therapist and patient obtain outside consultation (preferably as a couple) to determine whether the sexual relationship was an improper continuation of the therapeutic relationship? (4) Who initiated the sexual relationship? (5) What was the length and level of therapeutic involvement (and the concomitant power inequity)? (6) What were the particular emotional vulnerabilities of the client? *Id.* at 7-8.

and the circumstances which would make a psychotherapist's sexual contact with a former patient actionable.⁷⁴ If the sexual contact begins within two years after the termination of therapy, the statute provides a cause of action if the former patient was "emotionally dependent" on the therapist or the sexual contact occurred by means of "therapeutic deception".⁷⁵

Both of the operative conditions are defined in terms of the therapist's knowledge and intentions. A former patient is considered to be "emotionally dependent" if the therapist knows or has reason to believe (based upon the nature of the relationship) that she is unable to withhold consent to sexual contact.⁷⁶ Likewise, "therapeutic deception" comes into play if the therapist makes a representation that sexual contact is consistent with or part of the former patient's treatment.⁷⁷ These considerations may be appropriate, but they fail to take into account the patient's subjective perceptions and the more subtle kinds of pressure which may be brought to bear simply by the inequality of the relationship. Moreover, they appear to minimize the therapist's duty to use his superior clinical knowledge to protect former patients from relationships which they may not be emotionally prepared to handle.

The Minnesota statute is a good starting point in providing protection to victims of psychiatric sexual exploitation, but it seems unfair to place the burden of proving the therapist's knowledge and intentions on the plaintiff, who has no way of proving them other than the therapist's own testimony. One alternative approach would be to adopt a subjective standard based upon the patient's perceptions of the relationship. Under this standard, the plaintiff could testify as to her own feelings of dependency rather than trying to establish what the therapist knew about her feelings of dependency. This testimony could be buttressed by expert testimony of "emotional dependency" based upon clinical observations of the plaintiff's condition.

74. MINN. STAT. ANN. §148A.02(1) and (2)(West 1989).

75. MINN. STAT. ANN. §148A.01(3)(West 1989) ("Former patient" means a person who was given psychotherapy within two years prior to sexual contact with the psychotherapist); §148A.02(2) (a cause of action exists for "former patients" if they were "emotionally dependent" upon the psychotherapist or the sexual contact occurred by means of "therapeutic deception").

76. MINN. STAT. ANN. §148A.01(2)(West 1989).

77. MINN. STAT. ANN., §148A.01 (8)(West 1989).

It is possible to envision a standard where capacity to consent does not even come into play. If the patient testifies she was emotionally dependent upon the therapist, and if expert testimony establishes the transference phenomenon or the power imbalance was still operating, the burden would shift to the therapist to establish he did not know (and did not have reason to know) that his sexual conduct exploited the patient's trust.

III. STATUTES OF LIMITATIONS

As was discussed in Section I, *supra*, the psychological dynamics of the patient-therapist relationship often make it impossible for the patient to face the implications of her relationship with the therapist until many years after the conduct has occurred.⁷⁸ It is not uncommon for a patient to delay several years before she seeks legal redress for her injuries, thus giving rise to a statute of limitations defense.⁷⁹

Historically, laws limiting actions are the creation of statutes; without these statutory restrictions, an injured person would face no time restrictions in seeking redress for an injury.⁸⁰ Statutes of limitations are designed to protect potential defendants from perpetual liability, and to avoid the dangers of "stale" claims where evidence has been lost and witnesses' memories have faded. In interpreting the statutes, courts have to balance these policies with the legitimate interests of injured parties in seeking redress for their grievances.⁸¹ A number of equitable exceptions to the statute of limitations have been established by the courts to protect the interests of potential plaintiffs who, for good reason, have been inhibited from prompt legal action.⁸² Although these exceptions may be sufficient to protect victims of sexual exploitation in certain circumstances, they are subject to

78. See Pope & Bouhoutsos, *supra* note 2 at 130.

79. *Id.*

80. See 51 AM. JUR. 2D *Limitation of Actions* §135 (1970); Salten, *Statutes of Limitations in Civil Incest Suits: Preserving the Victim's Remedy*, 7 HARV. WOMEN'S L.J. 189, 206-208 (1984)[hereinafter cited as Salten]. Although the time periods imposed by statutes of limitations vary considerably from state to state, there are a number of principles of interpretation which have gained widespread acceptance across the jurisdictions. These principles will be discussed in general terms in this article; however, reference to the laws of a particular state are essential to analyze any particular case.

81. See Salten, *supra* note 80 at 206-208.

82. *Id.* at 207.

vagaries of interpretation which may leave many victims without a remedy.

A. THE DISCOVERY RULE

In personal injury actions, the time period during which a plaintiff is permitted access to the courts is generally measured from the date when the cause of action "accrues" or "arises". Historically, this date has been measured from the time the negligent act occurs and some injury is sustained, regardless of whether or not substantial damages have occurred.⁸³ To ease the harshness of this rule, a growing number of jurisdictions have adopted a "discovery" rule, which provides that the statute of limitations does not begin to run until a prospective plaintiff learns or reasonably should have learned the defendant's conduct has caused her harm.⁸⁴

Most courts which have adopted a discovery rule seem to view it as a limited exception.⁸⁵ In most jurisdictions it is not sufficient for the plaintiff to claim she did not know the legal basis for her claim, or that she was not aware of the extent of her injuries.⁸⁶ What sets the statute of limitations running is knowledge of the fact that she was injured, and in some jurisdictions, knowledge of their causal connection with the defendant's conduct.⁸⁷

The question of when a victim of therapeutic sexual exploitation became aware of her injuries and their cause is a complex one. Most patients are already in emotional or psychological distress when they seek therapy. They may not immediately perceive that their emotional health is deteriorating. Even if they are aware that they are feeling worse, they may not link the deterioration to the therapist, especially during the pendency of the sexual relationship. Because of the psychological mecha-

83. See, 61 AM. JUR. 2D, *Physicians, Surgeons & Other Healers* §319 (1981); 51 AM. JUR. 2D, *Limitation of Actions* §135-136 (1970); Salten, *supra* note 80 at 207.

84. See 61 AM. JUR. 2D, *Physicians, Surgeons & Other Healers* §321 (1981); Salten, *supra* note 80 at 213-219.

85. See Salten, *supra* note 80 at 213, n. 143.

86. See, 61 AM. JUR. 2D, *Physicians, Surgeons & Other Healers*, §321, n. 78, 81 (1988 Supp.).

87. See Salten, *supra* note 80 at 213, n. 142; and note 93, *infra*.

nisms of repression and denial, a victim may be intellectually aware of her injuries without being psychologically able to understand their implications or to act on that knowledge. Despite these difficulties, most courts which have analyzed the statute of limitations issue in sexual exploitation cases have attempted to fit it into the discovery rule framework.⁸⁸

A groundbreaking Pennsylvania case, in which a jury awarded the plaintiff \$665,000 for her therapist's negligence in improperly administering drugs and engaging in a sexual relationship with her, illustrates.⁸⁹ The plaintiff, Gale Greenberg, had sought treatment from the defendant, Donald McCabe, in June 1986 when she was suffering from a neurotic condition diagnosed as the "harried housewife syndrome".⁹⁰ Dr. McCabe told her at the initial visit that she had a lot of sexual hang-ups, and initiated an ongoing sexual relationship with her within six months of the beginning of therapy.⁹¹ As a part of the therapy, he also administered drugs to the plaintiff which she claimed caused permanent psychosis and organic brain damage.⁹²

The therapeutic relationship lasted from June 1968 through February 1974, and suit was filed on January 5, 1976. There was no dispute that Pennsylvania's two year statute of limitations applied; however, the defendant argued it had begun to run long before the termination of the therapeutic relationship. The district court, ruling on a motion for directed verdict, concluded that there was a legitimate issue of fact for the jury as to whether the plaintiff had filed her claim within the statute of limitations.⁹³

88. See, e.g., *Simmons v. United States*, 805 F. 2d 1363 (9th Cir. 1986); *Decker v. Fink*, 47 Md. App. 202, 422 A. 2d 389 (1980); *Greenberg v. McCabe*, 453 F. Supp. 765 (E.D. Pa. 1978), *affirmed* 594 F. 2d 854 (3rd Cir. 1979), *cert. denied* 444 U.S. 840; *Seymour v. Lofgreen*, 209 Kan. 72, 495 P.2d 969 (1972).

89. *Greenberg v. McCabe*, 453 F. Supp. 765 (E.D. Pa. 1978), *affirmed* 594 F.2d 854 (3rd Cir. 1979), *cert. denied* 444 U.S. 840.

90. *Id.* at 770.

91. *Id.*

92. *Id.*

93. *Id.* at 770. In making its decision, the court clarified the standard to be applied to discovery rule cases under Pennsylvania law. First, it rejected defendant's argument that knowledge of the injury alone is sufficient to start the statute running, ruling that the limitations period does not begin to run until the plaintiff knows or reasonably should know the cause of the injury. *Id.* at 767. Second, although mental disability does not toll the statute of limitations under Pennsylvania law, the court ruled that the plain-

The court's analysis began by acknowledging that the plaintiff knew she was suffering from mental illness of some sort prior to the relevant cut-off date, but held that was not dispositive of the issue, since she had some mild neurosis when she first went to the defendant.⁹⁴ The dispositive issue was "whether plaintiff as a matter of law knew or should have known . . . of deterioration in her mental condition that was caused by the defendant's conduct, in light of all the circumstances (including the mental state she was in as a result of Dr. McCabe's conduct)."⁹⁵ Even under this generous interpretation of the discovery rule, the court had to engage in some elaborate analysis to uphold the jury's verdict.

At trial, the plaintiff testified that Dr. McCabe told her in 1968 that it was "wrong" for them to have a sexual relationship, a fact which defendant claimed put her on constructive notice of his improper treatment. The court rejected that argument, reasoning that the jury might have concluded the defendant's statement reflected a moral judgment rather than his opinion that it was improper psychiatric care. Further, this statement was contradicted by the defendant's statements that the relationship would aid Mrs. McCabe in her therapy. Thus it was reasonable for the plaintiff not to infer the treatment was damaging to her.⁹⁶ Even if she was aware that the treatment was medically improper, the jury could have found that she had no reason to know of the causal connection between the malpractice and her condition, since she was already very ill when she started

tiff's mental condition "is among the many factors which can be weighed by the fact-finder in determining the time of discovery, insofar as that condition was caused by the defendant." *Id.* at 768.

The court emphasized the "narrowness" of its ruling on this issue, pointing out in dicta that "[i]t does not mean that a plaintiff may offer slow-wittedness, idiosyncratic weaknesses of reasoning or lack of legal sophistication to excuse a failure to discover. Thus we do not mean to suggest that a defendant can be deprived of the important protections provided by the statute of limitations [citations omitted], because he or she has the misfortune to harm a plaintiff who is not mentally capable of bringing the action within the statutory period. Rather, we mean to say that the statutory period does not begin to run if the fact-finder concludes that the plaintiff's failure of discovery, objectively determined, is brought about by the very nature of the defendant's conduct." *Id.* at 769. The court also suggested alternative conceptual approaches, such as "estoppel", which might be used to justify its decision. *Id.* at 769.

94. *Id.* at 770.

95. *Id.*

96. *Id.* at 770.

treatment.⁹⁷

Plaintiff was also advised by two psychiatrists at a drug detoxification program, to which she was admitted in 1972, that her sexual relationship with Dr. McCabe was wrong.⁹⁸ The defendant argued that the severity of her injuries when she was hospitalized and the advice from two outside psychiatrists should have started the statute of limitations running at least as early as 1972.⁹⁹ Again, the court found that a jury was not compelled to conclude she had reason to discover the causal connection in the absence of evidence that either of these doctors advised her that the defendant's therapy was psychiatrically improper or had damaged her.¹⁰⁰

The court considered three factors to be of special significance in its analysis. First, the plaintiff's impaired mental condition and extreme dependence, which resulted from the defendant's mishandling of the transference phenomenon, supported a jury inference "that she neither knew nor by objective standards could have known under those circumstances that the defendant's treatment of her was related to her psychological damages before 1974."¹⁰¹ Second, the defendant's reassurances that the sexual relationship and the drugs he was administering were proper therapy were relevant in determining what a reasonable plaintiff would have done.¹⁰² Finally, the continuing therapist-patient relationship during the time period when the defendant claimed the plaintiff should have known his improper treatment was causing her harm "could be taken into consideration in determining what investigation of the defendant's conduct the reasonably diligent plaintiff would have made and what knowledge the reasonably diligent plaintiff would have had."¹⁰³

In *Simmons v. United States*,¹⁰⁴ a federal court of appeals relied upon the reasoning of *Greenberg* to uphold the district court's finding that the plaintiff's cause of action did not accrue

97. *Id.*

98. *Id.* at 770-771.

99. *Id.* at 771.

100. *Id.* at 771.

101. *Id.* at 771-772.

102. *Id.* at 772.

103. *Id.*

104. *Simmons v. United States*, 805 F. 2d 1363 (9th Cir. 1986).

until she was advised by her subsequent treating psychiatrist that the defendant's improper handling of the transference phenomenon had caused the emotional and psychological damage she suffered.¹⁰⁵ Plaintiff's experts had testified that she was suffering from post-traumatic stress disorder caused by the unethical conduct of the defendant, and she had no idea her emotional condition had been caused by that conduct until advised by her subsequent psychiatrist. Until then, she had believed that what had occurred had happened because she was "a very bad person, a worthless person, a guilty person", all of which caused her great guilt and shame.¹⁰⁶ The court pointed out that transference, dependence, and the psychiatrist's assurance that the conduct is good for them, makes it very difficult for patients to believe the therapist caused their emotional damage; instead they blame themselves.¹⁰⁷ A delay in filing a legal claim may not be "unreasonable" under these circumstances.

Although one might applaud the analyses and the results of the *Greenberg* and *Simmons* cases, the discovery rule has serious limitations in evaluating whether a victim's claim against her therapist for sexual exploitation is timely filed. First, in jurisdictions with more restrictive interpretations of the rule (i.e. where only knowledge of the injury and not causation is required), plaintiffs may be unfairly barred from pursuing their claims.¹⁰⁸ Secondly, both courts and juries may reach different conclusions where all of the "significant" legal factors in *McCabe* are not present. Finally, even a generous interpretation of the discovery rule may not adequately protect the interests of patients who

105. *Id.* at 1366, 1367 ("Ms. Simmons did not know Mr. Kammers' conduct caused her emotional injury until another doctor so informed her in February 1983. It was not knowledge of his legal fault that she gained in 1983, but knowledge of the fact that his mishandling of her normal transference had caused her psychological damage.") *Id.* at 1367.

106. *Id.*

107. *Id.* at 1368.

108. *See, e.g., Seymour v. Lofgreen*, 209 Kan. 72, 495 P. 2d 969 (1972). Under the Kansas discovery rule, the statute of limitations begins to run when the "fact of injury becomes readily ascertainable." *Id.*, 209 Kan. at 77, 495 P.2d at 973. Plaintiff tried to avoid the harsh effects of this rule by claiming that her mental illness made her unable to ascertain the fact of her injury, but the court ruled that she was barred from making that argument because she did not assert "legal incapacity" as a cause for her delay. *Id.* Moreover, if she had alleged a legal disability, her action would have been barred by the one year tolling statute applicable to actions brought upon removal of a disability. *Id.*, 209 Kan. at 78, 495 P.2d at 974.

are advised by another professional that their sexual relationship is inappropriate and harmful, but who are unable to appreciate or act on that advice because of their dependency and continuing relationship with the offending therapist.

By way of illustration, consider the case of Marcia Decker, who claimed her therapist, Gerald Fink, improperly manipulated the analysis to engage in sexual relations with her during each and every visit to his office from 1971 until the end of the summer of 1975.¹⁰⁹ Ms. Decker filed suit against Dr. Fink in March, 1977, well within the applicable three-year statute of limitations if the period did not begin to run until the termination of their relationship. Under Maryland law, however, the "continuous treatment" rule is subsumed by the discovery rule; i.e., if the patient learns or reasonably should have learned of her injury during the course of treatment, the statute of limitations begins to run from the time of actual or constructive knowledge.¹¹⁰

The trial judge, ruling on a motion for directed verdict at the close of plaintiff's evidence, found that Ms. Decker should have known of the alleged malpractice in May of 1973, when she consulted another psychiatrist who told her the sexual relationship was inappropriate and not beneficial treatment, and she should terminate the relationship.¹¹¹ The consulting therapist had testified Ms. Decker was capable of understanding his advice; however, she testified she was in a state of confusion and anxiety caused by her emotional and psychological dependence on Dr. Fink during this period of time.¹¹²

109. *Decker v. Fink*, 47 Md. App. 202, 422 A. 2d 389 (1980). There was testimony that the regular treatment was terminated at the end of 1971, but the sexual relationship continued during plaintiff's regular visits to the same office where therapy had taken place. The court did not make any distinction between the formal therapy and the continuing sexual relationship in its analysis. *Id.*, 47 Md.App. at 205, 422 A.2d at 391.

110. *Id.*, 47 Md.App. at 393, 422 A.2d at 210.

111. *Id.*, 47 Md.App. at 394, 422 A.2d at 212. A subsequent Maryland case has called into question the standard of review applied by the court in deciding the *Fink* case. *O'Hara v. Kovens*, 305 Md. 280, 295-297, 503 A. 2d 1313, 1320-1321 (1986). In upholding the trial judge's grant of a directed verdict to the defendant, the Court of Special Appeals had applied a clearly erroneous standard to the fact-finding made by the trial judge rather than by resolving all conflicts in the evidence in favor of the plaintiff. *Id.* The substantive legal standards applied in the *Fink* case, however, were not challenged by the subsequent decision and are still valid Maryland law.

112. *Decker v. Fink*, 47 Md. App. 202, 205, 422 A.2d 389, 391 (1980).

In the *Fink* opinion, there was no analysis of the pressure exerted by the plaintiff's continuing relationship with her therapist, and its possible effects on her ability to psychologically understand or act upon the consulting therapist's advice. The court's interpretation of the discovery rule rendered Dr. Fink's continuing misconduct, which might be viewed as a reason to estop him from asserting a statute of limitations defense during the time the sexual relationship continued, legally irrelevant.

In *Greenberg*, the court pointed out that the statute of limitations was particularly inappropriate for a determination as a matter of law in sexual exploitation cases, "where the central factual inquiries concern the reasonableness of plaintiff's ignorance and of her diligence under all the circumstances, and where the injury and cause thereof are subtler and more complicated than in the normal malpractice case."¹¹³ This author sub-

113. *Greenberg v. McCabe*, 453 F. Supp. 765, 772 (E.D. Pa. 1978), *affirmed* 594 F.2d 854 (3d Cir. 1979), *cert. denied* 444 U.S. 840. The factors which led to a favorable result in the *Greenberg* case were not based upon pure "discovery rule" considerations. The court's analysis incorporated three distinct exceptions to the general statute of limitations rule: incapacity or diminished capacity, the continuous treatment rule, and estoppel based on fraudulent concealment. As a comparison of the *Greenberg* and *Fink* cases will illustrate, these exceptions are not applied uniformly by courts in different jurisdictions, and cannot be depended upon to protect victims of psychiatric sexual exploitation.

In the *Fink* case, the court rejected plaintiff's argument that her "impaired judgment" (caused by her emotional and psychological dependence on the defendant) should toll the statute. 47 Md.App. at 209, 422 A.2d at 392. One of the psychiatrists who treated plaintiff in 1973 testified that "she was not psychotic, not hallucinating, but could make decisions". *Id.*, 47 Md.App. at 208-209, 422 A.2d at 393. Based upon that testimony, the court found that the evidence did not support a claim of "impaired judgment". By contrast, in *Greenberg*, the court considered the plaintiff's impaired mental condition and extreme dependence upon the defendant to be an important factor in its discovery rule decision. 453 F. Supp. at 772.

Likewise, in *Greenberg*, despite the fact that Pennsylvania does not have a "continuous treatment rule" tolling the statute of limitations until the end of treatment by the defendant, the court considered the ongoing therapeutic relationship to be an important factor in determining the reasonableness of the plaintiff's state of knowledge. 453 F. Supp. at 772. By contrast, in *Fink*, the court held that once the plaintiff had been advised of the impropriety of the defendant's conduct, there was no legal excuse for her failure to file an action against him, notwithstanding their continued relationship. 47 Md.App. at 212, 422 A.2d at 393-395.

Finally, in *Greenberg*, the court considered the therapist's reassurances that the sexual relationship and the drugs he was administering were proper therapy to be significant in determining the reasonableness of plaintiff's efforts to discover her injury. 453 F. Supp. at 772. By contrast, in *Fink* the court summarily dismissed the possibility that its statutory exception where a party is kept in ignorance of a cause of action by the fraud of an adverse party might be applicable. 47 Md.App. at 209, 422 A.2d at 393.

A therapist's reassurances could arguably form the basis for a claim of "fraudulent

mits that the same factors make it extremely difficult to evaluate these cases in terms of traditional "discovery rule" analysis. Victims of psychiatric sexual exploitation would be better protected by a statute of limitations which incorporates the relevant clinical considerations (such as dependency, transference and the power imbalance inherent in the therapeutic relationship) unique to this particular class of plaintiffs.

B. A PROPOSED LEGISLATIVE REMEDY

The states which have created statutory rights of action for psychiatric sexual exploitation have not adequately addressed the statute of limitations problem.¹¹⁴ The most liberal approach is in Minnesota, where the usual two year statute for medical malpractice cases was enlarged to five years "after the cause of action arises" for sexual exploitation cases.¹¹⁵ This five year rule may be expected to protect a number of potential plaintiffs, but it incorporates all the limitations of the discovery rule discussed in Section IIIA, *supra*, and therefore does not provide adequate protection. Instead, a standard should be set which incorporates the relevant legal and clinical factors and offers all victims a reasonable opportunity to pursue their claims.

At a minimum, this writer recommends that the statute of limitations should not begin to run until *after* the patient's relationship with the therapist has ended. Given the power imbalance, patients should not be expected to psychologically appreciate or act upon the therapist's inappropriate conduct during the

concealment" which, in some jurisdictions, tolls the statute of limitations until the plaintiff learns or should have learned of facts sufficient to give knowledge of the concealment. *See, e.g.*, 61 AM. JUR. 2D, *Physicians, Surgeons & Other Healers*, §322 (1981); MASS. GEN. LAWS ANN. ch. 260, §12 (West 1959); *Flotech, Inc. v. Dupont*, 814 F.2d 775 (1st Cir. 1987). Obviously, victims of psychiatric sexual abuse have knowledge of the underlying facts (e.g. that the sexual conduct has occurred), but often do not have knowledge that this conduct was harmful to them until many years later. Arguably, they do not have knowledge of their therapists' "concealment" of the wrong until such time as they are able to understand the causal connection between the therapist's breach of duty and their injuries. Moreover, there is no question that during the course of the therapeutic relationship, a therapist has a fiduciary duty to disclose that a sexual relationship may be harmful to his patients. Many experts in this field agree that this fiduciary duty continues indefinitely even after the formal therapeutic relationship has ended. *See supra* note 71 and accompanying text.

114. *See* note 48, *supra*.

115. MINN. STAT. ANN. §148A.06 (West 1989).

ongoing relationship, even if they are advised of its dangers.

Once the relationship has ended, plaintiffs should be given a reasonable number of years within which to bring their claims. During this period, the statute should be stayed until the patient has received an "informed diagnosis," i.e., has been advised by a subsequent therapist of the impropriety and the harm which it caused. If the subsequent therapist (or expert testimony) establishes the patient was psychologically incapable of understanding or acting upon the informed diagnosis, the statute should be stayed until the patient reaches the necessary level of understanding.

Opponents may argue that this rule would subject therapists to perpetual liability for their sexual offenses. Indeed, in cases where the psychological damage is severe, the patient may be hospitalized, resist further treatment, or be unable to understand the therapist's role in causing her injuries for a substantial period of time. In setting policies and standards for the limitation of actions, legislatures have to balance potential defendants' needs for finality with potential plaintiffs' legitimate interests in seeking redress for their grievances. When the potential defendant has created the very conditions which cause the plaintiff to delay in filing her claim, the balance should weigh in favor of the plaintiff. In this writer's view, the proposed standard would place the responsibility for the victim's delay where it belongs — on the offending therapist who misled her, betrayed her trust, and rendered her unable to understand the implications of his actions.

IV. CONCLUSION

Therapist-patient sexual exploitation is a significant social problem. The consequences to victims, who are primarily women, are devastating. Civil litigation is the only avenue of redress which can provide monetary damages to compensate victims for their injuries, and to pay the expenses of future treatment. Successful civil actions are difficult, despite the fact that most courts which have viewed the problem consider therapist's sexual relationships with patients to be malpractice. There is often a statute of limitations problem, because the nature of the therapeutic relationship makes it difficult for patients to recog-

nize that their therapists have injured them. If the case is permitted to progress, it is common for the therapist to deny that there was a sexual relationship, or, alternatively, to claim that it was a mutual relationship between two consenting adults.

In either case, plaintiffs face problems of proof. Since there are seldom any witnesses, it is difficult to prove that the conduct occurred. Likewise, unless force was used, it is hard for the plaintiff to deny that she consented to the sex. Plaintiffs often feel re-victimized by the litigation process, which usually involves probing questions about their sexual and psychological histories. Civil "rape-shield" laws, like the one enacted in Minnesota, can help to protect plaintiffs from inappropriate questioning about their private sex lives.

The courts sometimes have difficulty in applying traditional common law theories to sexual exploitation cases. Since the conduct does have intentional aspects, some courts consider "consent" to be a possible defense, even if the case is characterized as a simple negligence or malpractice claim. This article contends that the consent defense is inappropriate unless the plaintiff proceeds on an intentional tort theory. Further, for clinical reasons, it is virtually impossible for a plaintiff to give truly "informed consent" to her therapist's sexual advances.

The underlying issue of real concern in these cases is the extent of a therapist's duty to a patient outside of the confines of the therapy setting, or to a former patient whose therapy has been terminated. For the most part, clinicians and courts are in agreement that a therapist has a duty to refrain from sexual relations with a present patient, even if the sex takes place outside of the therapeutic setting. Former patients pose more of a dilemma. Some clinicians believe that sex with a former patient may be appropriate after a period of time, especially if it is to pursue a serious relationship. Others believe that a therapist's duty to refrain from sex with a former patient can never be abrogated.

Until the clinicians reach some consensus on this issue, a therapist's duty to his former patient will have to be determined on a case by case basis by the trier of fact. If a plaintiff presents evidence that dependency, transference or the power imbalance

was still operating when the sex took place, this author recommends that the burden should shift to the therapist to establish that he did not know (or have reason to know) that his sexual conduct exploited the patient's trust.

Courts also have trouble with the statute of limitations issue in sexual exploitation cases. Most courts try to fit the facts into the typical discovery rule analysis, which requires only that the plaintiff be on notice of the fact that she was injured and, in some jurisdiction, their causal relationship to the defendant's conduct. This standard does not adequately take into account the psychological mechanisms of transference, dependency and the power imbalance between therapist and patient. Because of these psychological factors, a potential plaintiff may be unable to understand the harmfulness of an ongoing relationship with her therapist, even in the face of explicit advice from another professional. This article recommends legislation which would stay the statute of limitations until after the potential plaintiff's relationship with her therapist has ended, and she has received an informed diagnosis from a subsequent therapist. Since the therapist's misuse of the therapeutic process is responsible for the plaintiff's delay in filing, he should be estopped from using that delay as a defense to liability.

As two of the pioneer clinicians and researchers in this field have pointed out, filing a complaint

can be an important, positive, and healing experience for patients who have been sexually involved with their therapists. It can be a constructive assertion of one's rights, helping to counteract feelings of passive victimization. . . . It can be means by which a consumer holds accountable the professional for his or her violation of professional standards. . . . It can be an act of courage and self-affirmation, a refusal to be intimidated into paralysis by the explicit and implicit threats of the exploitive therapists.¹¹⁶

Legislative reform is the most effective means to ensure that our legal system takes into account the special clinical and legal considerations presented by these cases.

116. Pope & Bouhoutsos, *supra* note 2 at 110.