

When Colleagues Go Astray...

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One of the saddest aspects of a long career as a psychiatric psychotherapist is the experience of working with colleagues who have seriously betrayed the ethical code of our profession. Mostly sexual violations, these are inevitably distressing situations that gravely harm patients, ruin careers, and bring about personal tragedy to the wayward colleague and his or her family. When we encounter these situations, either through doing damage control with the victims or by trying to help the colleague deal with what he or she has done, we ourselves must come to grips with a sea of conflicting feelings in order to offer the best we can do as professionals. Each situation presents its own unique set of circumstances and challenges.

Dealing with our own feelings about what has happened

Understandably, our first reaction to hearing about the situation is a feeling of shock and revulsion. We have been intensively indoctrinated with the dictum of *primum non nocere* or “first, do no harm.” A patient has been hurt by the boundary violation, and so has the ethical tradition of our profession. Our colleague has betrayed what we stand for and undermined the fundamental trust that is essential to the patient’s full engagement in treatment, especially psychotherapy. Ethical violations also damage the public image of psychiatry, medicine, and other mental health professions. As we learn more about what has happened, our feelings may progress to indignation and anger. If we learn that the perpetrator is a habitual offender, we want to condemn and ostracize him or her.

But we are also likely to be aware of the truth uttered by early colonist John Bradford, as he watched prisoners marched to their execution, that “But for the grace of God, there goes John Bradford.” We are well aware that prominent, experienced leaders in psychiatry and other mental health professions, even professional association presidents or chairs of ethics committees, have fallen to disgrace in the wake of ethical violations. The private setting of psychotherapy and the encounter of deep-seated, intense emotional forces place a heavy burden on our adherence to ethi-

cal constraints. Thus we approach our task with some measure of humility, along with anxiety about our own vulnerability.

We also wonder about the role the patient has played in the dismal events. I resist using the word “blame” in regard to the patient’s part, because no matter what the patient has done, it was the therapist’s responsibility to maintain ethical boundaries. Patients bring powerful forces with them into therapy, and sometimes they act them out. It is our task to assist the patient in containing them and mastering them through understanding and managing them in a healthier manner, but a boundary violation is a failure on the part of the therapist.

These negative feelings are countered by compassion. We feel for the patient whose opportunity for the benefits of therapy has turned into a traumatic situation that will make future therapy much more difficult. There is much work to do, if the patient has not been too hurt to accept it. We also may feel for the colleague, especially if the colleague is a friend or respected member of our professional community. We wonder how this could have happened. We suspect that shame, anguish, and despair rule the day. We know that the colleague’s family relations and livelihood are in grave peril. We sense that the administration of justice and the grave matter of protecting other patients must be tempered by mercy along with concern for rehabilitation and preserving safe access to the talents and experience of a highly trained professional, if at all possible.

These are the natural feelings of any responsible professional in response to such a situation. In addition, we must recognize the possibility that these events may evoke true counter-transference within us. Our own histories of damaging childhood experiences with parents, siblings, close relatives, teachers, clergy, doctors, youth leaders, or others in positions of trust, along with problematic issues in our current life, may spring to mind consciously or influence us outside of our awareness. We may be alerted to such counter-

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transference reactions if we begin to feel uncommon anxiety, excitement, over-solicitude, rage, or other emotions as we work with our patient, whether the patient happens to be perpetrator or victim. We as therapists must work these things out privately and be watchful that such reactions do not lead to seductive, rejecting, vindictive, or other kinds of hurtful boundary crossings of our own.

When a colleague comes to us in crisis

Initially, it is likely that the colleague is suffering from shame, intense anxiety and/or depression. After all, one's world is crumbling. Unless the colleague is still in a state of denial and self-justification or has the defective superego of a repetitive offender, he or she is wracked by remorse and guilt. Grave realities must be dealt with: licensing board proceedings, professional society ethics investigations, malpractice suits, the reactions of spouses and families, or potential financial ruin. Insomnia, anorexia, stress-related illness, suicidal thoughts or behavior—all threaten the errant therapist turned patient.

Thus the first task is to deal with the crisis. Frequent therapy sessions and perhaps medication may be necessary to control the acute symptoms of stress and emotional intensity. One must be on the lookout for evidence of suicidal or other violent inclinations. It is a challenge to foster hope and an expectation that one will come through the crisis to rebuild self-esteem, the opportunity to work, and a way of life. Life must go on after the sanctions, penalties, financial damages, and effects on personal relationships have run their course. On the therapist's part, concern for the colleague as person must push the temptation to be judgmental or pessimistic into the background.

Once they are engaged in psychotherapy and coming to grips with the realistic consequences of the boundary violation, I have found that errant therapists fervently want to understand what went so grievously wrong. To take up this task has a healing quality, as they are intensely motivated in a way they may not have experienced in previous therapeutic encounters. Intensive psychotherapy may become a bridge back to professional competence and safe practice, not to mention restoring personal relationships.

Indeed, work with therapist-patients has taught me that transgressions usually occur at a time of extraordinary confluence of long-submerged, unresolved personal issues with contemporary conditions that destabilize defenses and compromise formations. Childhood abuse

involving occurrences such as seduction, abandonment, submission to severely dominating parents, and undermining of self-worth seems to be a common past experience of these therapists, perhaps compounded by having been the victims of therapeutic boundary violations themselves. Psychotherapy trainees sexually abused by their supervisors are reportedly more likely to commit sexual abuse of patients in the future.¹ One therapist went into a deeply dissociated state in the course of an ongoing affair with a patient; therapeutic work with that therapist-patient then brought out a past almost hypnotic experience of seduction in an induced dissociated state.

Extraordinary current stressors that I have seen contribute to aberrant behavior have included marital crises, major illnesses that threaten life or sexual function, narcissistic injuries, losses, or changes in longstanding problematic relationships. Prostate cancer has been a major offender in some situations.

An angry woman with borderline personality disorder brought an esteemed senior colleague before his association ethics committee for a sexual boundary violation that had occurred decades before. He meekly confessed and accepted expulsion without protest. He sought treatment for profound depression, got some relief from antidepressant medication, but seemed to attain the most benefit by entering into psychoanalysis to understand what had happened. There were many current and past manifestations of a marked reaction formation defending against assertiveness and rage that originated in his relationship with a highly accomplished, haughty, and belittling father. His passive trait led to many situations of exploitation by needful patients and people with whom he had business dealings. At the time of his sole sexual affair with a patient, which she had initiated by manipulating him into making a home visit for a simulated emergency, he was struggling with feelings about the terminal illness of a sibling who had dominated and abused him, and correspondingly feeling distant from his dominating wife. Working through these issues allowed him to bring current situations with patients under control and gradually to retire from a burdensome practice with a more stable self-esteem.

These are not facile explanations that can be used to rationalize or justify unequivocally reprehensible behavior. Rather, they are hard-won insights that can become pathways to deeper self-knowledge and

strengthening of realistic, appropriate self-control. They may also help those therapists who can return to professional practice be more aware of dangerous situations, avoid certain patients to whom they might feel vulnerable, and be sensitive to similar issues within future clients or patients.

When patients reveal a violation by a previous therapist

Some patients who have been abused by a former therapist arrive at our doorstep with great fear, hurt, anger, indignation, and/or a desire to retaliate. Others are consumed by guilt, blaming themselves for allowing abuse to happen or even for unwittingly encouraging a sexual relationship. They may be very hard on themselves for overlooking early signs of undue familiarity that led up to a more explicit sexual overture, and they may be in denial of their own needs for attention and affection that made them susceptible to a therapist's advances. In time they may recognize that transference was under way with the errant colleague that led to a re-enactment of childhood seduction or abuse. However, in other cases, there may be no indication that the patient participated in any way in bringing about the debacle in the previous therapy. Regardless of any of these factors, blaming the patient is inappropriate; it was the errant therapist's responsibility to maintain professional boundaries in the face of whatever the patient brought to the relationship, so that a valid psychotherapeutic process could take place.

Now the patient has the double task of rebuilding trust in a professional therapist and using the experience to gain relief, insight, mastery, and constructive change. The tasks of the new therapist are also compounded beyond the usual challenge of developing a therapeutic process, to encompass the undoing of the damage from the previous relationship and the new therapist's own reactions to the colleague's transgressions.

Sometimes the therapist may wish to determine the truth of what actually did happen, in addition to learning about the patient's experiential record of it. The accounts may differ, but neither one can be dismissed. It may or may not be possible to get independent verification of the events, and efforts to do so may disrupt the primary task of working with the patient's subjective record of the events and the associations they evoke, so it becomes a matter of judgment. As in many respects with these delicate situations, obtaining confidential consultation may be wise.

To report or not to report

Referred by a family friend, Mrs. A came to Dr. Z in a state of shock and disillusionment several months after leaving treatment with Dr. M. Mrs. A, a highly successful professional woman in her mid-50s, had seen Dr. M for 4 years with considerable benefit for her problems of depression, lack of warm and supportive relationships, and unremitting guilt over the death of a child many years before. However, as she was leaving a session, he had suddenly embraced her and kissed her passionately on the mouth, and she had fled. It was with great trepidation that she came to see Dr. Z. She blamed herself for not seeing this coming, as Dr. M had recently begun to put his arm on her shoulder as he ushered her to the door at the end of sessions (the slippery slope).

For several months she would not even divulge the identity of Dr. M, and she only did so finally on the condition that Dr. Z would not take any action against Dr. M based on the information. She showed Dr. Z a very contrite and apologetic letter that Dr. M had written, in which he asserted that he had never done such a thing during his long career and explained that at that time he was extremely sleep-deprived because of caring for his severely ill wife. (A cautionary note to all of us: it is dangerous to try to work with patients when we are not up to it.)

Although he felt duty-bound to honor his patient's wishes that he not act on this information, Dr. Z was troubled that Dr. M—a well-known and esteemed colleague—was in major difficulty and could be a danger to other patients. He obtained Mrs. A's permission to talk confidentially with Dr. M, who expressed great remorse and concern. Dr. M informed Dr. Z that he had entered therapy to deal with what had happened. Dr. Z was reassured but worried that he might have had an additional obligation to get independent verification that Dr. M was in therapy, or even to report him to the colleague assistance committee or the ethics committee of his professional society or the state licensing board.

There is no good answer to Dr. Z's dilemma, since the principle of *primum non nocere* applies to both alternatives—balancing the welfare of the individual patient against that of other patients Dr. M might conceivably abuse. Reporting Dr. M against Mrs. A's wishes would be a further betrayal, and it could involve Mrs. A in the difficult process of filing a complaint or giving evidence, which would have compounded the

traumatic situation. Dr. Z felt that the needs of his patient had to come first. In retrospect, Dr. Z thought that the best course of action might have been to request the patient's permission to ask the colleague assistance committee to meet with Dr. M without involving the patient in any way, so that they could make their own judgment about the extent of the problem, the remedial measures being taken, and any further course of action. Again, confidential consultation about the dilemma would have been a good idea.

These situations remind us that none of us can be sure that we are immune to these dangers. We cannot

take refuge in a lofty sense of moral superiority. We need to do our best to know ourselves, understand the challenges,² be vigilant, act responsibly, and be compassionate towards our patients as well as our colleagues when they go astray.

References

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