SEXUAL MISCONDUCT AND WELLNESS

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BACKGROUND

A great many professional wellness programs do not deal with professionals who have had sex with clients or who have a sexual impulse control disorder. Having evolved from programs which focused on substance abuse or alcoholism, while there were addictive issues in many of the patterns seen, the monitoring was a problem for one thing. You can't smell sex on the breath or find it in the bloodstream.

Many programs refer such assessments out and do not directly treat such conditions. What is even more complicated is the fact that the range of problems shown by those who have sex with clients is far greater than in the typical populations served. In addition, the reality of such situations is that often there are issues about training around boundaries and such which are simply not part of the situation with addictions.

Some of the assessment challenges are the same. Certainly psychologists often lacked expertise in evaluating drug abuse or alcoholism, and the same is true for sexual contact with clients or sexual impulse control disorders. Furthermore, when called upon to assess a colleague, there is a risk of falling victim to one of several general errors:

(1) Believing that we as a treating therapist can make the assessment;
(2) Responding to requests from our client or their employer to do so;
(3) As an employer feeling that a simple contact with the employee's therapist can answer the question adequately
(4) That as someone in the "helping business" we understand the subject's job duties sufficiently to be able to assess without studying the personel file and job-related background data.

It is my contention that the issue of **fitness for duty or fitness to return to work** **is in fact a function few clinicians are prepared for. It is typically something familiar to industrial & organizational psychologists, as well as some forensic psychologists who have learned this framework. My key point will be that to do this work you need to either be operating as an independent assessor or you need to do more than just a simple analysis.**

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WHAT'S DIFFERENT ABOUT PSYCHOLOGISTS?

While not completely different from other service occupations or professional jobs, the psychologist may be in trouble for poor management of professional boundaries. While not completely different from the need for any professional to maintain boundaries, this goes beyond keeping within the job role or avoiding sexual harassment. This includes a much more subtle range of offenses which can cause someone to get into trouble and to require an evaluation.

On the other hand, a psychologist may be under review by a Licensure Board or College because of having been found to have a sexual impulse control disorder which expressed itself outside of the professional setting. Furthermore, the professional work of the psychologist involves situations in which phenomena like transference and countertransference can help potentiate sexual behavior which is inappropriate, but where there does not appear to be a sexual impulse control disorder.

PSYCHOLOGISTS WHO OFFEND SEXUALLY OR WHO HAVE DIFFICULTY MAINTAINING PROFESSIONAL BOUNDARIES

The failure to maintain professional boundaries or having sexual contact with a client can occur for a great variety of reasons, including:

(1) **Inadequately Trained:** This may reflect a general lack of training relative to boundaries or a specific lack of training in specific areas of boundaries;

(2) **Poorly Trained for the Particular Role or Job, or who lacked good supervision at their worksite or who failed to use the supervision that was available to them:** The inexperienced practitioner allows boundaries to break down.

(3) **Professionals who lack awareness of transference/countertransference in general, or in a given situation:** Some are not aware of their areas of vulnerability and lose their boundaries with certain clients. Some clients (e.g. those with Borderline Personality Disorder) represent challenges to a wide range of workers.

(4) **Professionals who have excessive need for client approval:** Professionals who are insecure and who will do anything to gain client approval have great difficulty setting limits. This may prove to be characterological and not subject to easy remedy.

(5) **Emotionally Needy & Dependent:** There are a number of problems associated with low self esteem and high dependency needs, which lead workers to be highly needy of client acceptance, and who seek to meet their needs through their clients. Within this category is Gabbard's "**Lovesick"** practitioner. This may not be treatable and can be characterological.

(6) **Professionals who are naive and lacking in good social judgment:** Some appear to lack the "social intelligence" necessary to be a professional, or do not wish to be in the professional role and would like to function more like a friend. They readily slip into boundary-less situations. Several have been encountered where this is likely

Asperger's Disorder, but it can involve lesser forms of social naïveté.

(7) Practitioners with organic impairment: Although uncommon, some professionals are impaired due to brain injury or through disorders such as Alzheimers may show very bad judgment and get themselves into boundary-less situations.

(8) Practitioners with impaired judgment secondary to addiction or alcoholism: Substance abusers and alcoholics who begin using their drug of abuse can become impaired and have a decline in judgment. With or without intoxication they may engage in sexual contact with clients.

(9) Psychopathology: Beyond the psychopathology inherent in some of the previous points, it may turn out that the psychologist has any of the following problems:

Schizophrenia or Severe Borderline Condition: Troubled thinking or a lack of impulse control based on an underlying thinking disorder.

Mood Disorders: Bipolar disorders can lead to dysfunction due to manic or depressive episodes. Grandiosity, paranoid symptoms, etc. can all undermine the professional role. Other depressive illnesses can impair judgment. Co-morbidity with drug and alcohol abuse is quite common and can undermine rehabilitation.

Anxiety Disorders: These can disrupt thinking and also undermine client confidence when they are obvious.

Predators with Psychopathology -- Sociopaths or Severe Narcissistic Personality Disorders: Self centered and exploitive by nature, these workers seek to manipulate to get their needs met. This is not subject to psychotherapeutic remedy for the most part.

Impulse Control Disorder: This can be a sexual impulse control disorder or a more general problem, often combined with an addictive problem. Again, some of these practitioners seem genuinely concerned and "want help," but many of them are difficult to treat.

(11) Situationally Needy or Impaired – a temporarily "Wounded Healer": Due to depression, a life crisis, or other more transitory problems, a worker becomes situationally needy and crosses boundaries.

(12) The therapist or worker as a superhero: Practitioners who are driven to be "perfect" or do everything for clients, regardless of risks. This is an easy role to slip into when trying to make up for what you believed was poor care in the past. Some with this style are actually very difficult to change, but because they are so well-intended they tend to get leeway.

(13) The practitioner who surrenders to the client: Similar to Gabbard's concept of "masochistic surrender," the practitioner who has a history of being dominated in relationships and feeling frustrated about it, who allows a client to manipulate and

dominate and then who is consumed by resentment about this fact.

In most cases there are multiple determinants. The key is to determine what the pattern is, if any, and why it occurred. As critical as analysis of the problems in performance are, it is just as critical to examine strengths and what the subject of the assessment does particularly well. In the end there will always be a question of (1) job role; (2) supervision; (3) additional training; etc. as well as any sort of treatment for psychological problems.

REHABILITATION OF PSYCHOLOGISTS IMPAIRED OR UNDER DISCIPLINARY ORDER

MISUSES OF REHABILITATION

While it might seem reasonable to presume that ***rehabilitation*** involves **an attempt to alleviate conditions which led to the original misconduct so that the likelihood of a repeat offense is greatly lessened or eliminated, the term is often used to mean other things.** It has been noted that: ***Rehabilitation as it is sometimes now practiced serves more as a minor form of punishment, perhaps to expiate the guilt of the offending therapist and, maybe even more, of the sanctioning committee or court***. (Brodsky, 1986, p. 164) We use it to mean a planned attempt to return a professional to previous levels of functioning and competence and to lessen or eliminate the likelihood of misconduct, boundary crossings, or substandard work.

ONE MODEL OF ASSESSMENT

Figure 1 (at end of paper), an overview of the assessment process, provides a diagram of the framework and methodology utilized. The overall approach used is **a rule-out approach--the assessor attempts to rule out serious pathologies**. **The assessment involves a parallel assessment of both professional history and functioning and personal history and functioning.** Both psychological testing and interviewing are done, but collateral interviews and personnel data are also very important.

The **unique feature of this approach is the emphasis on attempting to gain detailed background data through an interview of third parties. In such assessments one can obtain information, usually over the phone, from colleagues or complainants.** It is our belief that an interview of the complainant greatly enhances our ability to understand the situation for at least three reasons:

(l) It is less likely that one can be deceived about what happened;

(2) Even when the professional is trying to tell the truth, defensiveness may lead to denial or minimization;

(3) Even with a very cooperative subject the person being evaluated only knows part of the story of what happened--each person stores the information differently.

Much like the situation with visual perception where one needs two eyes to see in three dimensions, and where the discrepancy between the view granted by each of ones eyes creates the three dimensional view, having information from both parties provides a much richer picture.

Other approaches for the professional who has engaged in sexual misconduct include the **cognitive behavioral approach** (Abel, Osborn, & Warberg, 1995), **psychodynamic approaches** (Claman, 1987; Gabbard, 1994; Strean, 1993), and **sexual addiction approach** (Irons & Schneider, 1999) to name just a few. Each pays some attention to the dynamics of the professional relationship and assumes multiple determinants in the typical case. Each presumes that public safety is a key issue, and each involves an initial diagnostic decision, a treatment plan, and an eventual evaluation after treatment is concluded to assess whether it was successful.

Each involves the use of supervision and the development of a re-entry plan with possible practice limitations. However, **all stress the importance of clearly defining the supervision**. It is critical that its goals and requirements be spelled out in detail, and that case consultation (voluntary sharing of clinical material, often termed "supervision") be differentiated from true supervision wherein the supervisor is legally responsible for the practice oversight.

In recent years some employers and licensure boards have taken to requiring "ethics consultation" which involves regular meetings, often monthly, with an "ethics consultant." It is unclear what this is expected to accomplish in that in most misconduct cases there was no lack of understanding of professional ethical standards. We have seen this required of professionals who teach ethics or have served on ethics committees, and in situations where ***knowledge of ethics*** was in no way lacking. That is, in situations where the practitioner was completely clear at to what was being violated. "Boundaries training" has also been added to rehabilitation plans (Abraham, 1995), but again this is often not clearly connected to why the misconduct occurred. **Even referrals for ethics coursework, meetings with an ethics consultant, or boundaries "training or coaching" should have their justification in the findings of an independent assessment**. **There is no less rationale needed for such a referral than for a referral for therapy.**

TREATING PSYCHOLOGISTS & OTHER PROFESSIONALS

It is beyond the scope of this presentation to discuss the treatment of psychologists and other professionals. Geller, Norcross, & Orlinsky (2004) have produced a fine volume on this topic and there are many books and tapes concerning the treatment of impaired professionals, although few which deal with psychologists (Schwebel, Skorina, Schoener, 1994).

OUTCOMES & PRACTICE RE-ENTRY

Note that the proposal of a rehabilitation plan does not mean that it is fully carried out or that the professional ever returns to practice. Outcomes include:

(l) Professional refuses the evaluation once he/she sees what it entails;

(2) Professional begins the evaluation but does not complete it;

(3) Professional is evaluated but has a problem not subject to "cure";

(4) Professional is evaluated, but we cannot explain the behavior, and therefore can't design rehabilitation (in such situations it is legitimate to send them for therapy in hopes of having the situation become clearer, but when more is learned an assessment is still needed);

(5) Professional agrees to rehabilitation, but then goes back and tries to get the requirements changed by the licensure board, training program, or employer;

(6) Professional begins the rehabilitation program but drops out within the first 6 months;

(7) Professional becomes disenchanted with the field during rehabilitation and asks for vocational counseling into another field;

(8) Professional makes all of the progress they are likely to make, but are not sufficiently changed to be a "safe practitioner;"

(9) Either the "old problems" or newly identified ones are still there--rehabilitation is not successful.

It is important to make an overall assessment of the success of the rehabilitation effort. **If there has been professional misconduct or the behavior presents dangers for consumers,** the evaluator must put themselves on the line as regards future risks to consumers. When one is doing the re-evaluation for field re-entry one should be prepared to answer at least **two key questions:**

(l) To a reasonable degree of psychological certainty, have the goals set for the rehabilitation been attained?

(2) Would you have any qualms whatsoever of having your daughter (or wife? or son?) see this man (or woman) for private counseling?

If you can't answer these questions with a sense of personal conviction, then the job isn't done. If this practitioner is not trustworthy enough to work with your friends and family, he/she shouldn't be rendering services to others' families. If rehabilitation is deemed successful, then the planning for practice re-entry can begin. This is usually done during the later stages of rehabilitation.

ASSESSMENT OF ABILITY TO RETURN TO WORK

It is critical to note that treating therapists often lack the most critical things they need to know in order to be able to opine concerning readiness to return to work and fitness to work:

(1) What are the precise job duties and work challenges for the client if he/she is to return to work?

(2) What is their history on the job? What have been their strengths and weaknesses and what precisely are their performance issues?

(3) What if anything has changed in the workplace since they have been out of work?

(4) As a practical matter, what is possible in terms of alternations in the work situation:

a. Any alterations in their work duties or work load?
b. Any changes in their job description, temporary or longer term?
c. Any alternative roles they might play?
d. Any alterations in hours, which staff they would work along side?
e. Any other accommodations which are possible?

It is key to know what might be accommodations in the workplace which might facilitate their return. So, the evaluator **starts with the personnel file and an understanding of the person's track record, and ends up an understanding of what might follow. Possible *reasonable accommodations* as specified under the the ADA need to be known in order to develop a plan.**

A Plan for Return to work needs to specify the manner in which the return to work will be designed so as to maximize successful re-entry into the workplace. So, all of the factors noted above about work load, supervision, accommodations, etc. need to be considered.

WHAT ABOUT STUDENTS & TRAINEES?

We evaluate students and trainees with boundary problems in the same fashion as practicing professionals in the same field. However, the issue is normally whether the student can return to the classroom or to an internship. Student impairment is related to the maintenance of boundary issues (Lamb, 1999; Schoener, 1999) and the American Psychological Association Advisory Committee on the Impaired Psychologist has repeatedly made this point (Schwebel, Skorina, & Schoener, 1988, 1994). Forrest, Elman, Gizara, & Vacha-Hasse (1999) have provided a discussion of this issue which is followed by commentaries from others. The longstanding practice of simply sending students for psychotherapy, or disciplining them and providing them with tighter supervision, is not adequate.

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