# "Therapist-Patient Sex Syndrome": The Perils of Nomenclature for the Forensic Psychiatrist

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**The escalating problem of sexual misconduct has heightened clinicians' awareness of the consequences of therapist-patient sexual relations. One consciousness-raising device, the definition of "therapist-patient sex syndrome," may pose more problems than remedies in the forensic, rather than clinical context. The author reviews the conceptual, diagnostic, and teleological dimensions of this addition to diagnostic nomenclature.**

Bernard Diamond, M.D. was a model forensic clinician. The quality I most admired and appreciated in his work was a kind of sensible hardheadedness about our work. This tribute attempts to employ such hardheadedness in analyzing a complex topic.

The thesis of this essay is that the commonly used term, "therapist-patient sex syndrome" (1)—while serving some role in raising clinical consciousness about the effects of sexual misconduct—is fundamentally flawed in both nosologic and forensic terms; and hence should be replaced by more neutral and less prejudicial terms such as "Disorders of extreme stress NOS," (DSM-IV field trials, B. Van der Kolk, personal communication).

The term, "therapist-patient sex syndrome," was created by Pope and Bouhoutsos[1] to refer to a list of symptoms allegedly manifested by patients whose therapists had involved them in sexual misconduct. This list is given in Table 1.

## Background

Scholars of current trends in psychiatry including forensic psychiatry have noted a growing interest in victims and the dynamics of victimization, the response to trauma, and recovery. However, nomenclature in this area poses some difficulties for the forensic practitioner.

The classic example of this is, of course, posttraumatic stress disorder.

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While I have no quarrel with this diagnosis or its validity, it is important to remind ourselves, as others[2] have indicated, that this ostensibly descriptive diagnosis, couched and defined in the operational conceptual framework of DSM-III and DSM-III-R, differs from other official diagnoses in that it contains latent assumptions of causation that are clinically innocent but forensically problematic, as follows.

The therapist in the clinical setting has no difficulty with accepting a patient's drawing a causal connection between a particular perceived trauma and its aftereffects; this is yet one more dynamic element meriting exploration along with all other data. In the usual clinical context, one simply accepts patients' descriptions uncritically, at least at first, in the service of empathy and the alliance, since to question or challenge the patient's perceptions may feel to the patient unempathic or oppositional.

However, in the forensic context, such empathy must be conjoined with objectivity. The necessary credulousness of all good treaters must perforce be replaced by the necessary skepticism of all good forensic clinicians. That same causal link, postulated by the patient and accepted at face value in treatment, may represent the crux upon which a piece of litigation turns and may require hard substantiation (the objectivity). Thus, it becomes extremely significant whether a particular trauma and a patient's condition of distress (or disorder) are *indeed* cause and effect, since hard reality in the form of monetary damages may well hinge upon the answer. In sum, given the perhaps overenthusiastic modern attribution of many phenomena today to traumatic origins and the likelihood of hindsight contaminations, we must be vigilant about possibly specious "post-hoc-ergo-propter-hoc" traumatic stress disorder (PHEPHTSD).

**Table 1**
**Symptoms of Therapist—Patient Sex Syndrome[1]**

1. Ambivalence
2. Guilt
3. Feelings of isolation
4. Emptiness
5. Cognitive dysfunction
6. Identity disturbance
7. Inability to trust
8. Sexual confusion
9. Mood lability
10. Suppressed rage
11. Increased suicidal risk

A special case of the foregoing is "rape-trauma syndrome."[3] Here the common problem for the forensic professional is the plaintiff's attorney's reasoning: "If the patient exhibits symptomatology of rape-trauma syndrome, an actual rape must indeed have occurred." The syndrome is assumed to constitute evidence of the real-life event's occurrence." When this occurs, the diagnosis is being used, not as a clinically validated description of the patient's present state, but as a statement about causation, extended far beyond any diagnostic claim to the realm of ostensible empirical proof—a function diagnosis was never intended to serve.

To put this in other words: while purporting to be a statement about a current clinical condition, the diagnosis, "rape-trauma syndrome," itself appears to validate both the existence of a past histor-

ical fact (without external or other corroborating evidence) and the causal linkage of that fact with the present symptomatology (causation and potential damages).

## Thesis

With the above as background, we consider now a special variant of the foregoing, which is the subject of this discourse, namely, "therapist-patient sex syndrome," described by Pope and Bouhoutsos[1] in their important and valuable book, *Sexual Intimacy Between Therapist and Patients.* As with rape-trauma syndrome, this term is obviously in danger of being taken inappropriately as proof of an external act in reality. According to that text, therapist-patient sex syndrome includes the following clinical symptoms seen in Table 1.

Clinicians who work in the field would agree that patients who have been sexually involved with therapists and have experienced resulting trauma may manifest these and many other symptoms as well. Sexual misconduct is almost universally recognized as often damaging to the mental health of patients. Yet this particular grouping of these nonspecific symptoms (most of which might also fit well with diagnoses of schizophrenia or major depression), combined with epidemiological considerations described below, raises serious questions as to whether compiling this listing under the rubric of "therapist-patient sex syndrome" serves a constructive purpose or, instead, a misleading and hence destructive one.

To place this discussion in perspective, three separate realms of data need to be introduced. First, a significant number of patients involved in sexual misconduct have previously been involved in incest or sexual abuse in earlier years, especially childhood.[4] Second, Herman et al.[5] point out that a significant fraction of patients later diagnosed as suffering from borderline personality disorder have been previously sexually abused themselves (those authors suggest that 68% have been sexually abused and 75% physically abused); the authors indeed speculate about a possible causal role of this previous abuse in the symptomatology of the borderline syndrome itself.

Third, I have elsewhere suggested[4] that a significant percentage (in some samples ranging as high as 90%) of patients involved in sexual misconduct with therapists manifest the borderline syndrome. Indeed, some of the dynamic basis for this phenomenon can be found precisely in the earlier data, namely, that a history of previous sexual abuse may well predispose individuals to being vulnerable to susceptible to sexual advances from authority figures for a number of dynamic reasons elsewhere described.[6-8]

Simultaneous consideration of these separate findings imply that one could define a kind of comorbidity among patients previously sexually abused, patients with borderline personality disorder, and patients involved in therapists' sexual misconduct. A Venn diagram of this comorbidity would consist of three overlapping circles whose centers form a triangle (Fig. 1). This interlinkage would be supported by much of the cur-

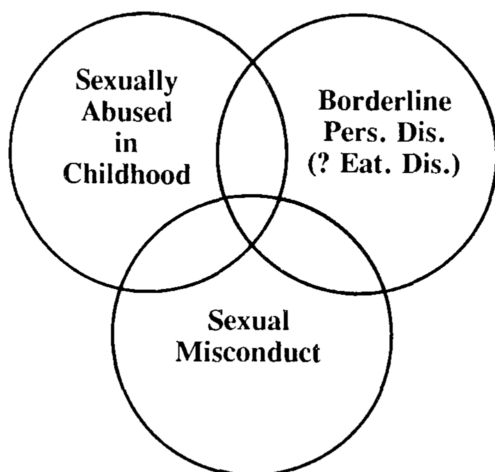


Figure 1. Venn diagram of comorbidity among patients previously sexually abused, patients with borderline personality disorders, and patients involved in therapists' misconduct.

rent literature. Once one grasps this point, it becomes clear that "therapist-patient sex syndrome" may not be indicative of a history of actual contemporary abuse by a therapist, as plaintiff's attorneys have claimed in litigation, but rather of the above comorbidity.

To extend this exploration, consider first the following: seven of the symptoms—feelings of isolation, emptiness, identity disturbance, sexual confusion, mood lability, suppressed rage, and increased suicidal risk—are part of the DSM-III-R criteria[9] for borderline personality disorder in the first place. Most clinicians working with borderline patients would in addition describe these patients as commonly manifesting the remaining criteria on the Pope-Bouhoutsos list: 1) ambivalence about seeking treatment, captured regarding schizophrenia by Burnham et al.[10] (and later regarding borderlines by Buie and Adler[11]) as the "need/fear dilemma": pervasive feelings of guilt, worthlessness, and low self-esteem; and cognitive dysfunction, extending even to the point of significant distortions in the form of micropsychoses of the physical reality of the therapist's persona, body image, or objective behavior. The *reductio ad absurdum* occurs when we conclude from the foregoing summary analysis that, in order to be diagnosed as a borderline patient in the first place, the patient must manifest a symptom picture of "therapist-patient sex syndrome," whether or not they have *ever* been in therapy before!

The heuristic implications of this correlation masquerading as causation are predictable, but the analysis is necessarily complex. If, indeed, borderline patients represent a population with a high prevalence of a history of sexual abuse, then indeed it is possible, as Herman et al.[5] suggest, that the borderline symptomatology is actually shaped by this earlier sexual abuse: that is, childhood sexual abuse produces, among other sequelae, both borderline syndrome and so-called "therapist-patient sex syndrome." It is further possible that *current* sexual misconduct could present to subsequent evaluators a picture consistent with borderline personality disorder in a case where the patient had not shown such traits before; here, the effects of later-life sexual misconduct produce a borderline-like picture. As elsewhere suggested,[4,6-8] moreover, current sexual misconduct itself may dynamically repeat earlier abuse in accordance with the concepts of the repetition compulsion, "sitting duck" vulnerability,[6] and other relevant dynamic issues.

If, as either cause or result of the above correlations, borderline patients themselves represent a significant fraction of the patients involved in sexual misconduct, as empirical evidence suggests they do, then so-called "therapist-patient sex syndrome" may fail completely to discriminate among the above permutations. Such a discrimination would be essential for forensic purposes.

This conceptual muddiness is particularly dangerous in the real forensic world from three aspects. First, the issue of present damages becomes harder to assess because of previous abuse. Second, the issue of comorbidity weakens for the plaintiff the significance as a noxious event of actual sexual misconduct. Third, borderline patients also represent the overwhelming majority of that smaller fraction of cases involving false or specious accusations of sexual misconduct, as elsewhere described.[4] Thus serious miscarriages of justice could result from the following hypothetical scenario:

> A borderline patient falsely accuses the therapist of sexual misconduct and presents, as evidence for this claim, her manifestations of "patient-therapist sex syndrome" well-documented by the subsequent treater. If the syndrome is taken inappropriately as pseudo-objective evidence of a factual event, then an innocent clinician may be falsely blamed.

The argument has been advanced that this label serves the clinical purpose of heightening subsequent treaters' awareness of both the damages of misconduct and possible signs of its occurrence; such clinical consciousness raising would then promote improved case-finding and treatment. Considering the nonspecificity of this symptom list, I believe this argument falls before the previous analysis.

One caveat to the forensic examiner may here be in order. Patients who have genuinely been injured by sexual misconduct are often distrustful of professionals subsequently encountered in evaluation or treatment. The forensic evaluator's need for objectivity and even skepticism must be tempered for humanitarian reasons with sensitivity to the traumatized patient's tendency to experience the objective position as unempathic, rapport-destroying, and even traumatic as perceived disbelief (L. Strasburger, personal communication). The remedy for this unfortunate outcome, beyond customary clarification of agency and extended informed consent, may require attention to support, preparation, and education through such interventions as: "You might find this question a bit confrontational but bear with me"; "There are some things I need to ask you that will probably be brought up one way or another, though I recognize they are uncomfortable for you"; and the like. Repeated reminders of the examinee's freedom to refuse to answer, take breaks, have water or coffee and the like are often empowering and useful.

I recommend that the nomenclature of an explicit syndrome, "therapist-patient sex syndrome," be eschewed, since in forensic terms no phenomenologic description can be adduced as causal evidence for the occurrence of objective external events. Our approach to therapists, victims of misconduct and the assessment process will thus be rendered

more credible, valid, and authentic—an outcome of benefit to all concerned.

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