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Boundary Training 106

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How Misconduct Occurs

[T]he chiropractic adjustment requires the D.C. to palpate, measure, touch and often provide ongoing supportive and/or maintenance care to the same patient over many years. This can result in a greater potential for relationships, regardless of how honorable, to be misconstrued.¹

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The Slippery Slope

Sexual misconduct can begin with a very minor violation of boundaries—a first step on “the slippery slope,” as Linda Bowers puts it in her article about boundary issues in the caregiver/patient relationship.² Few healthcare professionals have bad intentions. Boundary violations that constitute sexual misconduct may begin slowly, with seemingly harmless deviations from standard procedures. A provider may slightly depart from the rules incrementally until the sum of “minor deviations” have added up to something far from harmless.

An Example of a Predatory Doctor and the Slippery Slope

NOTE: This is an example from a consultation we were involved in. The example details the inappropriate actions of two healthcare providers with the same patient, but years apart. The providers’ actions led to patient harm, and eventually to a licensing board complaint. Names have been changed.
Here are the circumstances:

The patient, Maureen, was at one of the lowest points in her life. She was in her twenties and recently engaged. Before their marriage, her fiancé was killed in a tragic accident. She was so distraught that she sought care from a psychiatrist (Dr. A).

Dr. A became the lifeline Maureen needed. He understood and cared for her and seemed to know exactly what she needed—love, attention, and understanding.

In a short time, Dr. A influenced her to push others away, including family and friends. He prescribed drugs. Maureen could not remember what they were, but she reported that the medications kept her “foggy” and unable to think clearly.

Dr. A and Maureen began having sexual relations.

The counseling and sexual activity continued for over a year.

It took quite a while for Maureen to realize what was happening to her. In time, her trust for this doctor faded, and she could see him for what he really was. It took everything she had to get herself out of the relationship.

Over the ensuing years, Maureen had difficulty trusting healthcare providers. When she developed chronic neck and back pain, trusted friends referred her to a chiropractor (Dr. B) in her city who was considered kind, sensitive and competent. Maureen felt safe with Dr. B. Dr. B and Maureen increasingly engaged in conversation during visits.

Apparently, Dr. B was going through a difficult time in his life and Maureen, being a sympathetic listener, understood him and cared about her provider’s difficulties. At some point, Dr. B suggested that Maureen be the last patient of the day, so that they could talk at length during this visit, he asked for her phone number so they could continue the conversations. After suggesting they meet at the office on a day when there were no other patients, Dr. B began grabbing and kissing Maureen. The feelings she had while this was happening, reminded Maureen of the relationship with her psychiatrist and she pushed Dr. B away.

Discussion

Dr. A was quite skilled at separating Maureen from all who cared about her. As a result, he was the only one she trusted. Maureen believed Dr. A was the only one who truly cared about her and loved her. Then, when he had her complete confidence (helped by the drugs he had prescribed), Dr. A enticed Maureen into a sexual relationship. Dr. A demonstrated the characteristics of a very skillful predator. A predatory individual generally has a deliberate plan of action to achieve their goals. It is likely this psychiatrist attempted this predatory behavior with other patients. Even though Dr. A’s deliberate actions are not an example of the slippery slope per se, steps were taken to little by little gain the trust of the patient and to separate the patient from others.

Dr. B appears to have been naïve, rather than predatory. This provider was apparently unaware of the minor deviations he was taking until the relationship had developed too far.

Minor violations often set the stage for the further rationalizing of one’s behavior—that is, for kidding oneself. What can a healthcare practitioner do to avoid inadvertently
becoming involved in such a situation? Awareness of the breakdown of professionalism is one of the major keys to avoidance.

**An Example of a Doctor Avoiding the Slippery Slope**

Here we provide an example of a psychiatrist who was tempted to act on a patient’s vulnerability, who was not only able to stop himself, but helped his client heal. This experience was told to me by Dr. Peter Rutter, a psychiatrist and author.

Dr. Rutter was going through a difficult time in his life, a common contributing factor to breakdowns in professionalism, and was feeling lonely. According to Dr. Rutter, one of his established patients who was receiving therapy for relationship problems ‘offered herself’ to him in a non-verbal manner. He couldn’t readily explain this body language, but it caught his attention. In a flash, he recognized what she was doing that evening and most likely what she had been doing to prevent her from being in a healthy relationship. He surmised that she would notice on what someone needed from her, and then proceed to become available to that person. It was clear to him that she did not consider herself. She was so wounded that she likely only considered the other person. Continuing like this in her life, would likely never result in her having a relationship that would be good for her.

Dr. Rutter told his patient what he had observed from her behavior. He explained that he suspected that this is what she would frequently do. He then told her that by repeating this pattern with prospective partners, she would put herself in a situation in which she would be taken advantage of and used until the other person grew tired of her.

He offered to her that they could utilize this new insight gained on this evening to help her to heal and to change her behavior. They now had very important new information with which to help her to find a person to be in a relationship with that would be good for both of them.

Dr. Rutter demonstrated a very high level of practice. When Dr. Rutter told me about this experience, I felt tremendous respect for his ability to put aside what he wanted at that moment and to concern himself with what was going to be life changing for his patient.

**Assignment**

Please answer the following questions.

1. What experiences you have had where you have either betrayed a patient’s trust or were able to put the patient first?
2. What have you learned from these experiences?
3. Do you now feel you are able to always put your patients first? If not, why?
4. If you discovered that you most likely cannot always put your patients first, what steps might you take to protect your patients?

**THE BREAKDOWN OF PROFESSIONALISM**
“How do we understand members putting themselves on this slippery slope? While there is no justification for their conduct, contributing factors may be that members are ill-informed about the standards of practice and/or heedless of their own needs and the feelings that lead them to violate boundaries.”

There are many ways in which professional boundaries can fail. The following are only a few of many possible examples. When a practitioner begins to act in any of these ways, it is time for him or her to step away from that slippery slope.

- **Getting Too Personal.** Excessive self-disclosure on the part of the healthcare provider is a reversal of the practitioner role—the client begins to care for the caregiver. It creates an emotional intimacy that may lead to physical intimacies. As we discussed in the second of the examples of the ‘slippery slope’ above, talking about oneself and revealing personal information is a part of the breakdown of professionalism. “In fact, excessive self-disclosure is the single most common precursor to professional-client sex in the thousands of cases we have seen. In particular, the disclosure of current problems, especially in a significant relationship, is predictive of trouble.”

- **Making Special Financial Arrangements.** When the payment method breaks down, it’s an indication that the caregiver is already in a mild form of boundary violation. And when monetary compensation is not being provided, some professionals may begin to expect less appropriate substitutes.

- **Changing the Rules.** Changing office policies, or your behavior regarding office policies, sets a dangerous precedent. Once the line those policies represent has been crossed—or redrawn—where does that process end?

- **Prolonging Treatment.** Spending extra time during office visits or continuing treatment for longer than the condition warrants is a sign that a provider’s attitude toward that client is less than professional.

- **Neglecting Recordkeeping.** This may indicate an awareness, conscious or unconscious, that there is something to hide. “There was a time when many organizations were advised by counsel to keep sparse records...[But] the notion that one can retrospectively concoct a favorable version of events is quite misguided. Physicians, psychologists, social workers, clergy, and those who oversee their work do not make effective liars.”

### TWO FLAWED MODELS OF MISCONDUCT

Let’s look at two of the most commonly held beliefs about responsibility for sexual misconduct. People generally believe that either the caregiver is at fault or the client is at fault. These are two very simplistic ways of considering who is at fault in cases of sexual misconduct. It’s black and white thinking. Either the doctor is to blame or the client.
The Rotten Apple Model
If you believe there are some bad practitioners, and that they need to be disciplined, then your beliefs fall into the “Rotten Apple” model of sexual misconduct. In the Rotten Apple model view, there are a few caregivers who should not be practicing. These caregivers may look normal but they can fool us, and they cause all the problems.

Here are some flaws with this model:
- It finds no need for action beyond getting rid of the rotten apples. If providers are either good or bad, then there is no reason to bother with training.
- It doesn’t categorize lesser degrees of sexual misconduct as a problem—only behavior that is obviously inappropriate and may only take the most serious offenses seriously.
- With this belief system, practitioners can feel very safe, believing they could not possibly become involved in such a situation, because they’re not “sick.”

The Seductor/Seductress Model
If you believe the client (either male or female) is to blame, then you might think the fault lies within the client. This is like believing that women who were raped were asking for it. This is the “Seductor/Seductress Model,” although usually it’s a woman who is blamed. This belief system goes back a few thousand years—to Adam and Eve! There are problems with this model, too.

Flaws with the Seductor/Seductress Model:
- The emphasis is to protect the providers from their seductive clients.
- By focusing on the client, we lose sight of the actions of the caregiver, ignoring their potentially naive, abusive and/or damaging behavior.
- With this belief system, we may further hurt the very people who have already experienced what they deem to be inappropriate behavior.
- This approach has, for many years, very effectively silenced other victims with valid complaints. Having seen others treated as liars, who in their right mind would come forward?

The Rotten Apple and the Seductor/Seductress models both have flaws—neither fully explains who is responsible and neither can really solve the problem of sexual misconduct. We need to look deeper to gain a better understanding.

CULTURAL CONTRIBUTORS TO MISCONDUCT

The Rotten Apple model and the Seductor/Seductress model did not arise independently, but sprang from our culture’s beliefs and attitudes. There are several cultural contributors that play a role in the incidence of sexual misconduct by increasing patient or provider vulnerability.

A Belief in Entitlement
First, there is the belief in sexual entitlement. It goes something like this: “I’m entitled to sexual relations with anyone who inspires sexual feelings in me, with anyone to whom
I’m attracted, and with anyone who accepts some item or service from me.” The pervasive belief system of sexual entitlement, in which sex becomes a right or a commodity, can play a major role in sexual misconduct. The patient might feel grateful or indebted to the caregiver, and might see sex or sexually charged activities as a means of expressing that gratitude or discharging that debt. As a result, the patient may offer sexual favors or may accept unwelcome advances. The practitioner might rationalize that, having provided valuable, high-status services, and perhaps even the miracle of restored health, they are entitled to more than just money. If both the provider and the client are thinking this way, a volatile and potentially explosive situation is created.

A Lack of Education/Knowledge
Misconduct may arise from a lack of proper boundary training. When even healthcare professionals are unsure of where they should draw the line, it is not surprising that clients also are relatively unaware of what is appropriate behavior.

Patients have at times left their common sense at the door of the provider’s office. Likewise, our society teaches that caregivers always act in the best interest of their clients—but it does not always teach practitioners how to recognize what the “best interest of their clients” is or how to appropriately attain it.

A Deference to Power
A third consideration is the power of the provider’s role. Healthcare professionals are looked up to because of their high occupational prestige, but some patients come to a caregiver’s office as penitents or petitioners. This creates at least a temporary willingness on the patient’s part to go along with whatever the practitioner says or does, without stopping to consider the consequences. This phenomenon also exists in other relationships where the distribution of power is unequal, as between employers and employees, or as between men and women: “If women are more likely to conform to other people’s ideas in social situations (a tendency noted in some research), it may be due to their typically inferior social status.”8 The usual training in politeness and the natural tendency to accede to the wishes of a higher-status individual can serve a person well in many situations, but in a situation involving coercion or abuse, these tendencies may betray the patient.

Ironically, two additional factors that may influence someone to cooperate when a caregiver behaves inappropriately are a history of abuse and a fear of violence.

A History of Abuse
Within the United States about one in ten children have been sexually abused before they reach the age of eighteen. (https://www.d2l.org/)9 And having been abused, an individual may be more likely to submit to further abuse, in a situation where such behavior is expected. If the abuse took place in a situation where protesting or fighting back didn’t help, then the patient may have learned not to protest or fight back. Such individuals may still feel utterly helpless to control their own fate. This “learned helplessness,” a phenomenon observed even in animal studies, generally plays a role in keeping children with abusive parents, altar boys with abusive priests, women with abusive husbands, and clients with abusive practitioners. Those who have survived abuse may feel their only value, especially to a person perceived as more powerful, is as a sexual object.
A Fear of Violence

We would like to report on an interesting statistic about workplace harassment. “A new survey found that one in three women between the ages of 18-34 has been sexually harassed at work.” Alanna Vagianos; HuffPost; “1 In 3 Women Has Been Sexually Harassed At Work, According To Survey”; 02/19/2015.

Certain people can be more frightened of potential violence against them than others can possibly know. Any behavior that evokes this latent fear can make them vulnerable; and out of fear, they may submit to treatment they would never permit voluntarily. And because our culture sees power as sexy, the assailant may fail to realize that his victim was not seduced but simply intimidated.

A fear of violence, a history of violence and/or abuse, a lack of certainty about what behavior is inappropriate in the healthcare relationship, and our culture’s ideas about sex and sexuality all contribute to the problem of vulnerability. The stress of illness or injury, the very thing that brings people to the caregiver, dramatically increases that vulnerability. Some are so vulnerable that they can be taken advantage of very easily.

WHO COMMITS SEXUAL MISCONDUCT?

“All health professionals have been the subject of sexual misconduct made to licensing boards. In our experience, all practitioners have a bit of risk, especially when they are going through challenging times in their lives. Psychiatrists are simply a more frequently surveyed group of healthcare practitioners. There is no reason to believe that they commit misconduct any more frequently than their counterparts.

The discrepancy between the incidence of improper behavior reported by clients and that reported by practitioners indicates a high level of denial or naiveté on the part of the offenders. This conclusion is supported by another finding—many practitioners who report they have engaged in sexual misconduct decline to describe their behavior as exploitative or harmful. Interestingly, rather than admitting fault, offenders often attempt to justify their behavior with one or more of the following rationales:

1. **It was a therapeutic technique.**
   • One doctor said his “therapeutic” sexual relationship with a bipolar patient was consensual and helped to “treat her emotional illness and … her self-esteem.”
   • A Virginia doctor accused of kissing patients said it was a mind-body technique in his cardiology practice. “Over the years, I have developed a sensation of what people seem to need,” he told the medical board.
• A California doctor accused of molesting a dozen women during exams gave a detective several reasons why he kissed the breast of one massage patient. Among them: She was bipolar. And she thought she was a lesbian.”

“Doctors & Sex Abuse” – an investigation; Atlanta Journal-Constitution; 2016; Danny Robbins, et al. 12

2. **Misunderstood.** They may assert that their actions were appropriate and misunderstood. If a provider’s actions are “misunderstood” in the same way by many, however, then the provider is the one who has been doing the misunderstanding.

3. **She was too tempting.** “A Florida doctor told one of the six women he was accused of violating, “I’m sorry, you are just so irresistible”. 13 Ibid.

4. **Needs.** Some offenders try to justify their behavior based on their own needs and desires. But these have no place in the healthcare relationship.

5. **Love.** Another common justification for inappropriate or abusive behavior is love, with offenders characterizing themselves as having been in love with the client when the incident occurred. Finding someone attractive is not an unusual phenomenon; in fact, it probably happens to the average healthcare professional on a daily or weekly basis. It is how a physician deals with this attraction that determines the potential course toward, or away from, misconduct.

**Types of Offenders**

John C. Gonsiorek and Gary R. Schoener describe the following categories in their “Tentative Typology of Professional Offenders.”14

- **Psychotics.** These are seriously disturbed professionals - “a diverse group categorized together for convenience. They have in common impaired reality testing and significant functional impairment. They demonstrate great variability in their understanding of the effects of behavior upon victims and in their ability to feel remorse. In terms of dealing with the legal system...their behavior is also unpredictable.”15 A practitioner who is psychotic may believe he or she has a special connection with God, that his semen is curative, or that he or she has special powers.

- **“Classic” Sex Offenders.** This group includes “chronic, repetitive pedophiles and also physically aggressive sex offenders regardless of the age of the victim...The focus of the pedophile or the aggressive nature of the inappropriate behavior is so distinctive that they are separately classified even though there may be other dynamics operating.”16

- **Impulsive Character Disorders.** “Their problem behaviors are not limited to boundary violations but may include insurance fraud, sexual harassment of staff or trainees, poorly controlled sexual behavior in their personal lives, tax fraud, and a wide variety of inappropriate or criminal activity. They do not plan and are not cunning, do not cover their tracks, and are easily caught once investigated...They rarely have a true appreciation of the effects of their behavior on victims.”17

- **Sociopathic/Narcissistic Character Disorders.** Though also lacking impulse and behavior controls, these offenders generally are “cool, calculating, and detached and
often carefully select clients who are vulnerable and/or lacking in credibility should they complain. They may be respected professionally for their skills. They are cunning enough to maintain appropriate boundaries in some situations, particularly ones in which they have public exposure…and are adept at outmaneuvering others.”

**Medically Disabled.** These are professionals with good past records “who, because of a medical condition [most commonly, neurological problems or bipolar mood disorder], engage in inappropriate behavior with clients.” For those who have bipolar illness (also known as manic-depression), good control often can be achieved with medication. If medically disabled providers are taking medications and receiving regular therapy, they may be able to safely practice.

**Masochistic/Self-Defeating.** “A peculiar mix of both neurotic and character disordered features…On the surface, they often appear to be overworking therapists like the more severely neurotic/socially isolated type.” Except that, “because of their internal conflicts about setting limits…with borderline personality or similarly disturbed patients, their otherwise reasonable clinical practice deteriorates. They become seriously impaired and boundary-less, at times, with behavior involving romantic and sexual contact. It is typical in this group to find other examples of masochistic and self-defeating behavior, for example, not collecting fees, not taking adequate care of themselves…generally being long-suffering and self-defeating.”

**Severely Neurotic and/or Socially Isolated.** “Their problems are long-standing and more significant. They often have ongoing depression, feelings of inadequacy, low self-esteem, and social isolation. Work tends to be the center of their lives and most of their personal needs are met in the work setting. Their inappropriate romantic or sexual involvement with clients…is repetitive in the sense that every few years, or even every decade or so, the situation recurs. Inappropriate boundaries develop as in the healthy/neurotic group, but rooted in long-standing problems.” There may be a role reversal, in which the patient starts helping the provider with his or her problems—a relationship that may easily become sexual. “They may rationalize that, because they truly love a client, the behavior is not inappropriate; because they were vulnerable or open, they had equalized the relationship; and so on. They may vacillate between self-revelation, remorse, defensiveness, and self-justification.”

“Simply stated, such therapists need to get a life and keep a life outside of work—but they rarely do…They are often regarded among other professionals as particularly giving, skilled, dedicated, and hardworking individuals…However, the same factors that predispose them to this dedicated behavior also predispose them to periodic, repetitive, severe boundary violations with a small number of their clients.”

**Naïve.** These practitioner may be unaware of personal or professional boundaries. “Some…may simply not know (or may have such simplistic understandings that they might as well not know) about sexual impropriety with patients.” They may “not literally believe” it is permissible to have sex with a patient. But typically, they are naïve about ethical gray areas that, once transgressed, often eventuate in increasingly inappropriate and boundary-less behavior that may result in sexual misconduct. They are naïve about
the trajectory of their behavior and start down the ‘slippery slope.’ Generally, these people can practice once they gain an understanding of their role.

- Normal and/or Mildly Neurotic. “These individuals potentially constitute all healthcare professionals and clergy.” Under severe emotional stress people become vulnerable and impulsive. In such a state, it is possible for a very sudden, intense emotional connection to occur.

The typical scenario “is a reasonably well-trained, responsible professional who, at a bad spot in his or her life, is socially isolated, depressed, and lacking in adequate support…[meets] a client who fits his or her counter-transference like lock and key. The professional begins a slow and gradual process of developing a romantic attachment to the client, often by inappropriate self-disclosure, moving to social interaction, and sometimes…proceeding to romantic and sexual interaction. Such individuals literally fall in love with their patients…Almost without exception, these perpetrators have one and only one victim.” “It is our impression that the number of these perpetrators is not small. It is one of the most common groups that we have assessed [at the Walk-In Counseling Center].” Individuals in this group need to be educated concerning setting appropriate boundaries, and then they should be free to practice. This is a good thing because otherwise there would be no healthcare providers for anyone to see!

Unfortunately, the responsibility to file a complaint or stop seeing the offending provider rests with the client. In later courses in this series, we will offer some ways for practitioners to discern patients’ attitudes toward the caregiver’s behavior prior to licensing board problems arising.

WHO IS AFFECTED BY SEXUAL MISCONDUCT?

| Sexual abuse of all kinds represents a gross failure in the empathic concern one person has for the subjective experience of the other. | Judith V. Jordan, “The Movement of Mutuality and Power,” 1991 |

Many rationalize that their intimacies with clients were beneficial or neutral experiences for them. They may justify the episode either based on their own needs and concerns or by citing the supposed benefit to the patient.

- 1 in 5 girls and 1 in 20 boys is a victim of child sexual abuse;
- Self-report studies show that 20% of adult females and 5-10% of adult males recall a childhood sexual assault or sexual abuse incident.

National Center for Victims Of Crime website; 2017
However, it should be noted that “psychiatrists who later treated such patients reported that the sexual contact was harmful to the patients.” And the Ontario College of Physicians and Surgeons sponsored one of the largest studies to date of the problem of non-psychiatric sexual misconduct. The study concluded that these violations of trust in the provider/patient relationship were “devastating” for the patient, for the patient’s family, for the public’s trust in the healthcare professions and for society as a whole.

Effects on Healthcare Providers

- **Loss of Reputation.** The caregiver’s professional and personal reputations may be negatively affected if accusations become public.

- **Loss of Income.** The provider’s practice is likely to suffer as news or rumors about a sexual offense drive away patients and further damaged if court appearances conflict with office hours.

- **Loss of Relationships.** The practitioner’s relationships with others are likely to be hurt, whether by the content of the accusations or by the stress of legal proceedings. Divorce and other break-ups could follow.

- **Loss of Assets.** Because many malpractice insurance policies do not cover incidents of misconduct, the caregiver may lose large amounts of money to attorneys’ fees, even if no judgment is entered against him or her.

- **Loss of Livelihood.** The practitioner’s license might be suspended or revoked.

- **Loss of Freedom.** The provider might face imprisonment.

Effects on Colleagues

Other healthcare providers in the area could also suffer loss of reputation and income, especially if media coverage is involved.

Effects on Professions

In a high-profile case, the profession of the accused provider, along with related professions, are likely to lose both trust and prestige.

Effects on Patients/Victims

The marks that sexual misconduct leaves on its victims are numerous. The following are a few of the most common repercussions:

- **Loss of Identity.** Having been treated as an object, a victim may feel that he or she is nothing more than an object.

- **Loss of Self-Esteem.** The victim may feel used, unclean, good only for sex, unworthy of normal courtesy and a healthy relationship.

- **Depression.** The victim may suffer from mild to severe clinical depression and may even become suicidal.
➢ *Post-Traumatic Stress Disorder.* The victim may suffer physical and emotional exhaustion and may be so profoundly affected that he or she has trouble functioning; housekeeping, finances, and relationships all may suffer.

➢ *Guilt/Self-Blame.* The victim may feel he or she was somehow at fault. Such feelings, often encouraged by the perpetrator, are a major contributor to depression.

➢ *Isolation.* The victim may feel cut off from all sources of support— especially if he or she is keeping the abuser’s secret.

➢ *Loss of Boundaries.* The victim may have difficulty reestablishing the boundaries that have been violated. This lack of firm boundaries makes him or her even more vulnerable to subsequent sexual misconduct or abuse.

➢ *Loss of Healthcare.* Once the relationship with the abuser ceases to be entirely professional, the care the victim receives is likely to suffer. Later, a lingering distrust of practitioners may pose a continuing barrier to appropriate care.

**COMMON FEARS AND MISCONCEPTIONS**

I urge women and men to appreciate the deep but differing fears the [phrase] “sexual harassment” engenders in the other. Men should try to understand women’s abiding fear of male violence and their reluctance to offend by stating that something makes them uncomfortable. This, I think, is what lies behind the familiar refrain that some men ‘just don’t get it.’ But women, for their part, should try to understand men’s fears of being falsely accused, of having a woman they felt protective toward turn on them and destroy them.

Deborah Tannen, “Talking from 9 to 5,” 1994

Just as sexual harassment generates fears in both men and women in the workplace, so sexual misconduct engenders fear as well. Some of these fears are based on facts, while others are not. Here are some of the most common fears and misconceptions:

**Providers’ Fears**

➢ *The “Fatal Attraction.”* A common fear is that an angry, rebuffed patient will stalk or torment the caregiver. A perhaps less improbable scenario is that the practitioner will be haunted by an angry abuse survivor who feels that he or she was denied justice.

➢ *The Temptress.* Many healthcare providers fear an irresistible client who will somehow lure him or her into wrongdoing. But anyone who has so little control of his or her sexual impulses that this is a realistic possibility should not be working in a healthcare profession.

➢ *False Complaints.* Many providers fear they will be falsely accused, but very few false complaints are filed. Through the late 1970s, there were very few complaints of any kind,
and those that were filed received short shrift. In the last two decades, the social cost of filing a complaint against a practitioner has decreased, while the likelihood that such a complaint will be taken seriously has increased. This has been followed by an increase in complaints, as had previously been seen with rape and sexual harassment cases; at some point—as has already been seen with rape cases—these improvements in the complaint process are likely to bring an increase in false complaints.

**False Censure or Conviction.** While not impossible, this is highly unlikely, at least in the current regulatory atmosphere. In an analysis including hundreds of cases involving physicians, clergy, and psychotherapists who had been censured or convicted for sexual misconduct, found not a single instance in which the decision was not fully supported by the facts.32

**An Innocent Mistake or Misunderstanding.** For caregivers who lack training in touch, sexuality and boundary issues—that is, for most practitioners—this is a serious risk. They may unknowingly violate laws and boundaries by acting in ways that are improper or unsafe.

**Client/Patient Fears**

**The Vengeful Perpetrator.** Clients fear that, if they complain, their abuser will come after them. While this has been known to happen, it is far from likely, although the practitioner and his or her legal team may attack the patient’s reputation.

**Disbelief.** Victims fear they will not be believed or that their complaints will not be taken seriously.

**Blaming the Victim.** They fear that even if they hated and objected to what happened, even if they struggled to prevent it, they may be accused of “asking for it.”

**Self-Blame.** Some victims of sexual misconduct are afraid that—having consented to what happened, or having failed to object strenuously enough to prevent it—they might be to blame. Like victims of other forms of sexual abuse, they are likely to suffer from feelings of shame and self-loathing.

**Inaction.** Clients fear that filing a complaint will do no good; that even if they complain and are believed, no action will be taken. Sadly, they have often been proven correct.

**Case Study 3 – “Bad Medicine”**

Probably the most common fears among victims of sexual misconduct are that they will not be believed, or that, even if they are believed, the perpetrator will not be punished. This nightmare came true for psychiatric patient Barbara Noel, whose book *You Must Be Dreaming* chronicles her own real-life experience with sexual misconduct.

For seventeen years, Noel had been seeing an internationally renowned psychiatrist—Jules Masserman, a former president of the American Psychiatric Association—who drugged her at many sessions with sodium amytal, an addictive and dangerous barbiturate. He told her that these “amytal interviews” were necessary to permit them to
explore issues that her conscious mind was not ready to address. Finally, during one of these “interviews,” she came to a little early. She awoke to discover that her psychiatrist was having sexual intercourse with her. “After Dr. Masserman blinked the light on and off I’d usually lie there for another half hour, but not this time. Not when I knew what he had done to me. Not when the repulsive stench of his body odor and the after-shave lotion wafted up from my own shoulders and made me feel like gagging.” The odors were familiar; for years, she had thought they were a side effect of the drug. Now she knew better.

After leaving her psychiatrist’s office, she went straight to the office of another doctor in the same building. After she decided that she wanted to report the rape, she was referred to a hospital for examination. There, she was questioned by a male police officer who ridiculed her story and tried to get her to say that she had imagined the whole experience:

“Now, wouldn’t it be better to assume you might have been dreaming all this?” “No,” she said, “I was not dreaming.”
“You’re saying that you couldn’t have been dreaming this?” “I was not dreaming this,” she said.
“But you could have been, couldn’t you, ma’am?” “Yes, I suppose I could have been, but I wasn’t.”
“I felt like shouting at him,” she said later. “Did he think a woman would go to the hospital—get herself wheeled in to be poked and prodded and disbelieved and totally humiliated, with people asking insulting and irrelevant questions…and not even allowed to pee—just to have a little fun with these guys or waste their time?”

After this initial experience, it took years—and lawsuits from four other women, who also had been patients of Jules Masserman—before Barbara Noel saw any results. In 1987, Masserman consented to give up his license to practice medicine or prescribe drugs in Illinois. In 1991, he was suspended for five years from the American Psychiatric Association and from the Illinois Psychiatric Society. But, as of 1992, when Noel’s book was published, he continued to serve on the American Psychiatric Association’s Board of Trustees.

Caring for the Abused Individual

Sexual abuse is an all-too-common phenomenon. The greatest of care must be exercised, because anyone who comes to you may be a survivor of rape, violence, or abuse. Remember the First Law of Medicine: “First, do no harm.”

Those with a history of sexual abuse need to be treated with particular sensitivity and care since: (1) they have been traumatized, and (2) they are more vulnerable to future abuse.
Anyone previously abused needs to be treated with particular sensitivity and care, not only because they have been traumatized but also because, having once been abused, they have become more vulnerable to further abuse. “When a person has been abused and violated by caretakers…all relationships become infused with distorted sexual and aggressive elements.”\(^1\) Someone who has suffered abuse may have been left with a feeling of utter helplessness that makes it impossible to resist coercion, may have been led to believe that he or she is worthless except as a sexual plaything, or may have learned to think of sex as a currency with which to purchase affection and approval.

Whether they know it or not, anyone caring for a significant number of people is going to have among them those who have been sexually abused. Since abuse survivors rarely identify themselves, however, it is difficult, if not impossible, to identify which patients have a history of abuse.

**A SURVIVOR’S TALE**

At a conference on sexual abuse that I attended in Toronto, in Ontario, Canada, I heard a speaker who talked about his own experience of sexual abuse.

_He is a Cree Indian, from northern Canada. When he was a child, it was common for the government to remove Indian children from their families when they were about six years old. And this is what happened to him: He was sent to a Catholic residential school._

_Naturally, there were priests there. These priests went around to each child’s bed after the lights went out and proceeded to masturbate the children nightly. Imagine the terror. You’re six years old. Away from your family. It’s dark. And the priest is on you. What scars would that leave? And what would your experience be like in a doctor’s office after that?_

_Will we know which of our clients have been abused, sexually or otherwise? How do we administer appropriate care for such individuals? They need special care._\(^2\)

Because so many people have been abused, all office procedures, behavior, and communication should take these large numbers of potential abuse survivors into account. And because statistics indicate that the overwhelming majority of those who abuse children are men, the care of abuse survivors is particularly problematic for male practitioners. The former victims generally will be the most vulnerable and the most anxious or fearful in the presence of those who most resemble their former abusers.\(^3\)

**SIGNS AND SYMPTOMS OF ABUSE**

People who have been abused, sexually or otherwise, may suffer from post-traumatic
stress disorder, which combines both psychological and physiological symptoms. These symptoms could include anxiety, fears, extreme startle responses, and intense reactions to stimuli associated with the traumatic event. Abuse survivors also may have sleep disorders or suffer from depression.

These symptoms are so common that they are of only limited usefulness in identifying abuse survivors. If confronted with such symptoms, however, it is helpful to be aware that abuse may be their cause. Clients exhibiting such behavior need special care, whatever the cause of their condition.

**STAGES OF RECOVERY**

| Three stages of recovery from sexual abuse include: safety, reconstruction and reconnection. |
|---|---|

Three stages are commonly described in the recovery from sexual abuse: safety, reconstruction and reconnection. But it should be noted that abuse survivors do not necessarily recover in a neat, linear manner. There often is much moving back and forth from one stage of recovery to another. Sadly, for many, the process may never be complete.

- **Safety.** The traumatized individual starts to regain control of his/her life and needs, such as nutrition, sleeping, and exercise. In addition, the person must have a safe place to live.

- **Reconstruction.** Once the victim feels safe, memories of the traumatic experience begin to resurface at any time or place. The tragic event(s) are replayed and reconstructed in the survivor’s mind. These are sometimes prompted by outside circumstances (touch, smells, situations, etc.) that jolt the memory, but often the victim isn’t consciously aware of what triggered the thought.

- **Reconnection.** The former victim begins to rebuild his or her life and regain the ability to trust others.

**DISCUSSION:** It is important to note that these stages of healing do not necessarily take place in a linear fashion – meaning, stage two immediately follows stage one, and then progresses to stage three. It is not that simple. Anything can bring the person back to the first stage. It is believed that bodywork should ideally happen when an individual is in the third stage of healing – reconnection.
GUIDELINES FOR THE PRACTITIONER

Potential Pitfalls
When you know that someone has been abused, there are several very important points to keep in mind:

➢ Don’t Fall into the “Rescuer” Trap. Do not try to take on the entire burden of their healing by yourself. The rescuer fantasy of believing you, and you alone, have the power and the gift to save someone can be very attractive and also quite dangerous. A perceived need for rescue and a practitioner’s perceived ability to provide it have been the basis for the rationalization of all kinds of boundary infractions, including sexual misconduct. Such “white knight” aspirations are among the most narcissistic and dangerous of traps. Abused individuals need many people on their side, possibly a therapist as part of the team.

➢ Don’t Get in Over Your Head. Caring for an individual who has not yet reached the third stage of recovery can present problems that most practitioners are unprepared to handle. If a patient tells us about their past, with their permission, we might consider contacting their therapist and having a discussion of the individual’s readiness for body work. Generally, this is not something the average practitioner should get involved with.

➢ Don’t Work Without a Network of Help. When caring for a severely traumatized person, especially in the early stages of recovery, be certain they have a safety net—a psychotherapist and a network of friends—so that you do not become the sole source of support.

➢ Don’t Get Victimized Yourself. Previously abused individuals may feel that their only value is as a sex object; some may encourage, request, or even demand a sexual relationship. Be prepared to deal with this possibility. It can be like juggling with fire to care for such people and should not be attempted without adequate training and support.

Proper Preparation
If you wish to care for people whom you know have been sexually abused, study the field of sexual abuse—read the literature, take the classes, and learn from the experts. This and previous sections that deal with this topic are only very general guidelines.

➢ Consider Entering Psychotherapy. Working with a therapist or counselor can be helpful in: (1) exploring your own attitudes toward power and sexuality, (2) teaching you about the therapy experience your abused patients are likely to be going through, and (3) helping you to cope with the stresses and challenges that will probably arise.

➢ Consult the Patient’s Psychotherapist. If someone is in counseling or psychotherapy and also needs intensive care from you, let them know that you would like to discuss their case with the psychotherapist. If it is agreeable, get a written authorization from your client and then speak with the psychotherapist. Ask relevant questions, such as: Is he/she ready for bodywork? Are there specific guidelines that should be offered in caring for this individual? What sorts of problems are most likely to arise with physical care? Is
there any area of the body that should be avoided?

➢ Stay in Touch. Ask the psychotherapist whether the lines of communication between you can be kept open. Ask to be informed of any new issues that arise during the counseling that might be relevant to the care that you provide.

Treating the Abuse Survivor
After getting the go-ahead from the psychotherapist to work with your client, you’ll still need to abide by some very basic rules:

➢ Set Goals Together. Involve them in any decision that will affect their care. This will help to prevent misunderstandings and may help to restore their sense of autonomy and control. Some goals may be long-term and others short-term. For example, you may spend time discussing what parts of the body are okay to touch as well as when and under what circumstances the treatment should take place – perhaps with others in the room or a door left open.

➢ Empower the Individual. Educate them about their rights and power; encourage them to exercise those rights. Explain to the individual that they will determine how, where and when they will be touched and that the full treatment may not happen right away. It would also be beneficial to inform your patient that they aren’t alone and that other people with their background also required a bit of time to receive a standard treatment.

➢ Build Emotional Safety. Show respect, compassion and non-judgment for their experience. Never do anything without consent. Some people may ask you to take pictures down from the walls of your office if they contain any nudity. Be ready to comply with such requests.

➢ Be Prepared for Flashbacks. Memories and emotions may be triggered as the client is touched. Like scent, touch is a powerful trigger for memory.

➢ Be Deliberate. Remain aware of the pace of touch, and be meticulous about obtaining consent for every procedure, for every touch. Keep things sedate and predictable; avoid surprises.
REFERENCES FOR HOW MISCONDUCT OCCURS

3. The Slippery Slope to Sexual Misconduct: Be Informed, Be Aware; Practice Notes; Ontario, Canada Perspective: Fall, 2016; PAMELA BLAKE, MSW
7. The following section is adapted from the transcript of the keynote address by Dr. Angelica Redleaf, “Beneath the Surface: A Deeper Look at Sexual Misconduct,” that was delivered at the 62nd Annual Congress of the Federation of Chiropractic Licensing Boards in Portland, Ore., on May 11, 1995 (Warwick, R.I.: Association for Chiropractic Excellence, Inc., 1995).
12. Ibid
26. Even those insurers who do not provide sexual misconduct coverage may be named in misconduct suits against their malpractice-insurance clients, and may therefore be saddled with substantial attorney’s fees. Several insurance companies, therefore, have decided to educate their policyholders about misconduct, in hopes of minimizing the number of such problems that will arise in the future. One example is the handbook by Michael J. Stahl and Stephen M. Foreman, entitled Sexual Misconduct: Ethical, Clinical and Legal Ramifications for the Chiropractic Profession (Des Moines, Iowa: NCMIC Insurance Co., 1997).
27. National Center For Victims Of Crime website; 2017
29. Also helpful was the work of Gartrell, Milliken, Goodson, Thiemann, and Lo, in “Physician-Patient Sexual Contact: Prevalence and Problems,” 18-28.
31. Barbara Noel, with Kathryn Watterson, You Must be Dreaming (New York: Poseidon Press, 1992), 120.
Noel, with Watterson, You Must be Dreaming, 126.

REFERENCES FOR CARING FOR THE ABUSED INDIVIDUAL