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PATIENT-THERAPIST SEX: CRIMINALIZATION AND ITS DISCONTENTS

*Patricia M.L. Illingworth, Ph.D.*

In the most widely referred to study of sexual involvement between patient and therapist, it was estimated that seven to ten percent of male and one to three percent of female therapists have had sexual intercourse with one or more of their patients.¹

Most of the patients who have had sex with their therapists are female.² Sexual relations between doctor and patient are unethical under the Hippocratic oath. Sex between patient and therapist is held unethical by a number of professional associations, including the American Psychiatric Association³ and the American Psychological Association.⁴ This Article examines sexual relations between patient and therapist.⁵ For the most

¹ See Nanette Gartrell et al., Psychiatrist-Patient Sexual Contact: Results of a National Survey, I: Prevalence 143 AM. J. PSYCHIATRY 1126, 1128 (1986); see also Judith Lewis Herman et al., Psychiatrist-Patient Sexual Contact: Results of a National Survey, II: Psychiatrists' Attitudes 144 AM. J. PSYCHIATRY 164 (1987).

² Gartrell et al., supra note 1, at 1128 (88% of patients who had sex with their therapists were female).


⁴ AMERICAN PSYCHOLOGICAL ASSOCIATION: ETHICAL PRINCIPLES OF PSYCHOLOGISTS 6(A) (1980).

⁵ The primary reason for focusing the discussion on patient-therapist sex as opposed to doctor-patient sex is that the former raises questions having to do with the phenomenon of transference—which is thought by many to undermine patient consent.
part, it excludes the most egregious cases of patient-therapist sex in which
the therapist administers drugs to the patient or misrepresents sex with
the therapist as part of the treatment.

Patients harmed by sexual relationships with their therapists have
sought recourse through administrative remedies such as license revoca-
tion, and in the courts through civil malpractice claims and criminal pros-
secution. This Article focuses on malpractice claims and criminal statutes
that specifically target sex between patient and therapist. In particular, I
am concerned with the question of whether or not patient-therapist sex
should be criminalized. For the purposes of this discussion, I assume that
patient-therapist sex should continue to be classified as malpractice. I ar-
gue against criminalization, and show that the two main arguments in
support of criminalization are based on a false and paternalistic picture of
patients and the relationship between patient and therapist.

I. Legal Responses

A. Civil Actions

Although some patients who have had sex with their therapists have
sued under a breach of contract theory, most actions in connection with
sex between patient and therapist are brought as malpractice actions.
Malpractice requires (1) evidence of a recognized standard in the medical
community and (2) evidence that the physician has negligently departed
from that standard. Additionally, as in any negligence suit, the plaintiff
must show that she has (3) suffered an injury and that (4) the negligent
behavior was the proximate cause of her injury. Patients can sue for
compensatory damages for emotional harm and punitive damages for un-
professional conduct.

Once a psychiatrist-patient relationship has been

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6. I shall not discuss administrative remedies because the main controversy is be-
tween civil and criminal remedies. Administrative remedies such as license revocation
generally have been ineffective. In the United States, therapists whose licenses were re-
voked because of sexual misconduct are able, nonetheless, to practice therapy without a
license. Recently, however, Massachusetts passed a bill making it possible to bar a psychi-
atrist from continuing to practice as a psychotherapist, if he or she lost a medical license
9. See W. PROSSER & W. KEETON, PROSSER AND KEETON ON THE LAW OF TORTS 30,
established, the doctor is under a duty of care to the patient.\footnote{J. Smith, Medical Malpractice: Psychiatric Care §§ 2.01-05 (1986).}

The prohibition against patient-therapist sexual relations has been held to apply not only to the patient, but also to people related to the patient, such as the patient's spouse.\footnote{See Richard H. v. Larry D., 243 Cal. Rptr. 807, 810 (1988) (allowing plaintiff's action against psychiatrist for sexual relations the psychiatrist had with plaintiff's wife).} The ban on patient-therapist sex has also been held to extend beyond the termination of individual therapy.\footnote{See Noto v. St. Vincent's Hospital and Medical Ctr., 537 N.Y.S.2d 446, 448 (Sup. Ct. 1988), aff'd, 559 N.Y.S.2d 510 (App. Div. 1990); see generally Paul S. Appelbaum & Linda Jorgenson, Psychotherapist-Patient Sexual Contact After Termination of Treatment: An Analysis and A Proposal, 148 Am. J. Psychiatry 1466 (1991).} Therapists, as opposed to obstetricians and gynecologists, are uniquely held accountable in malpractice actions for sex with a patient because of a psychiatrist's mishandling of the transference.\footnote{Alan A. Stone, Law, Psychiatry and Morality 199 (1984).} Roughly, transference can be defined as "the set of expectations, beliefs, and emotional responses that the patient brings into the doctor-patient relationship."\footnote{H. Kaplan & Benjamin J. Sadock, Synopsis of Psychiatry 2-3 (6th ed. 1991).} "Transference" is a technical term which refers to "the patient's feelings and behavior toward the analyst that are based on infantile wishes the patient has toward parents or parental figures."\footnote{Id. at 573.} These beliefs and feelings, which are often about the therapist, are not based on real facts about the therapist, but on "persistent experiences the patient has had with other important authority figures throughout life."\footnote{Id. at 3.}

Many courts have held that mishandling transference constitutes gross negligence or malpractice.\footnote{Simmons v. United States, 805 F.2d 1363, 1365-66 (9th Cir. 1986).} For example, in Zipkin v. Freeman,\footnote{436 S.W.2d 753 (Mo. 1968).} the Supreme Court of Missouri held that therapist Dr. Freeman mishandled the transference of his patient, Mrs. Zipkin.\footnote{See id. at 761.} Mrs. Zipkin began treatment with Dr. Freeman, a psychiatrist, to relieve persistent diarrhea and headaches.\footnote{Id. at 755.} Although these symptoms subsided after about two months, Dr. Freeman told Mrs. Zipkin that the symptoms would return if she did not continue treatment.\footnote{Id. at 756-57.} Mrs. Zipkin continued her treatment with Dr. Freeman and experienced a withdrawal from her husband and
family, and a feeling that she thought of as love for Dr. Freeman. In addition to engaging in sexual relations with Dr. Freedman, she participated in skating parties, nude swimming parties, and overnight trips with him. Eventually, Mrs. Zipkin left her husband and moved into an apartment located above Dr. Freeman's office.

In Roy v. Hartogs, Dr. Hartogs, a psychiatrist, engaged in sexual relations with Ms. Roy after telling her it was part of her treatment. The court held that the psychiatrist-patient relationship imposed a fiduciary relationship on the doctor. The jury awarded Ms. Roy money damages because of Dr. Hartogs' "failure to treat the plaintiff with professionally acceptable procedures." These cases are typical of both the nature of malpractice claims brought by patients and of the treatment courts give those claims. Courts tend to treat the mishandling of the transference as behavior in violation of professional standards.

2. Insurance and the Ability of Patients to Recover

The psychiatric and psychology communities have conducted extensive research documenting the harm to patients who have had sexual relations with their therapists. The harms experienced range from an impaired ability to trust others to an increased risk of suicide. There is, then, potential for large damage awards which insurance companies have attempted to sidestep.

Establishing that patient-therapist sex constitutes a mishandling of the transference is important if plaintiffs are to recover damages from insurance companies. Responsibility for abstaining from sexual relations with a patient must be within the scope of a therapist's professional skills. If
the therapist’s behavior is not considered a negligent departure from those skills, the efforts of insurance companies to deny coverage of patient-therapist sex based on the theory that sexual relations are outside of professional services would be increasingly successful. For example, in *St. Paul Fire and Marine Insurance Co. v. Mitchell*, the plaintiff’s insurance company tried to refuse coverage because it drew a distinction between medical malpractice and intentional sexual assault. For the most part, courts have upheld the plaintiff’s right to compensation. If, however, insurance companies are successful in refusing coverage, patients are often unsuccessful in collecting damages from the doctor.

B. Criminal Actions

1. Rape

Some physicians have been charged and convicted under criminal rape statutes. This occurred in a situation where patients were drugged as a means of facilitating sex. In another case, a therapist administered electroconvulsive shock treatments on his patients and injections of hypnotic drugs before having sex with them. The defendant was charged, convicted, and imprisoned for rape. But rape statutes cover only the most egregious cases. Rape statutes do not cover many cases of sex between patient and therapist because “rape” is narrowly defined, and the statutes closely scrutinize victim consent.

2. Statutes That Specifically Target Patient-Therapist Sex

California, Colorado, Florida, Maine, Minnesota, North Dakota, and Wisconsin enacted criminal statutes specifically targeted to proscribe patient-therapist sex, and impose penalties such as fines and imprisonment for such conduct. Wisconsin’s statute is typical of those that criminalize

34. 296 S.E.2d 126 (Ga. Ct. App. 1982).
35. See id.
36. LeBoeuf, supra note 33, at 107.
37. Id. at 107 n.115.
40. Id.
42. See CAL. BUS. & PROF. CODE § 729 (Deering Supp. 1995); COLO. REV. STAT. § 18-3-405.5 (1994); 1990 Fla. Laws ch. 70; ME. REV. STAT. ANN. tit. 17-A, § 253 (West 1994);
patient-therapist sex. Consider the following:

(2) Sexual contact prohibited. Any person who is or who holds himself or herself out to be a therapist and who intentionally has sexual contact with a patient or client during any ongoing therapist-patient or therapist-client relationship, regardless of whether it occurs during any treatment, consultation, interview or examination, is guilty of a Class D felony. Consent is not an issue in an action under this subsection.

Under these statutes, “therapists” include physicians, psychologists, social workers, marriage and family therapists, professional counselors, nurses, chemical dependency counselors, members of the clergy, and any other people, licensed or not, who are either administering psychotherapy or who claim to be administering psychotherapy. It follows from the statutory definition of “therapist” that the prohibition on patient-therapist sex does not apply to all nurses, psychologists, etc. who counsel patients, but only to those involved in psychotherapy. Given this, the definition of “psychotherapy” is critical for determining the scope of the statute. One would expect the definition of “psychotherapy” to narrow the scope of the provision by specifying the kind of therapy at issue. Instead, the following expansive definition of “psychotherapy” is offered, “(6) ‘Psychotherapy’ means the use of learning, conditioning methods and emotional reactions in a professional relationship to assist persons to modify feelings, attitudes and behaviors which are intellectually, socially or emotionally maladjustive or ineffectual.”

Two features of this definition should be highlighted. First, the practice of psychotherapy is not tied to any particular field, such as psychoanalysis. Instead, under this definition, something will qualify as “psychotherapy” if it is used in a particular way—that is, if it is used to help people modify their feelings, attitudes, and behavior. Second, it seems clear from this definition of “psychotherapy” that the patients or clients the statute targets are not necessarily those who are seriously debilitated by emotional problems. This broad definition of “psychotherapy” treats as psychotherapy any activity directed at modifying behavior and feelings, conducted by a person who makes use of some kind of learning to change those feelings. In other words, this statute includes within its scope ther-

44. Id.
45. Id. § 455.01(6) (West 1990).
apy that does not use transference. It also protects a wide range of patients—from those with severe mental health problems to those seeking insight-oriented therapy for the purpose of acquiring self-knowledge.

In the Wisconsin statute, the definition of “sexual contact” includes “any intentional touching by the complainant or defendant, either directly or through clothing by the use of any body part or object, of the complainant’s or defendant’s intimate parts.” The definition seems overly broad because it encompasses behavior ranging from the explicitly sexual, such as sexual intercourse, to a touching of intimate parts, which may merely be incidental to an intentional touching, such as a therapist brushing his arm against the patient’s breast as he opens the door.

In Wisconsin, then, any person is guilty of a crime who performs or claims to be performing a care-taking activity that uses learning, conditioning, and emotional reaction methods in a professional relationship to help people change their behavior and intentionally touches the intimate parts of their patients during this relationship. For example, a psychiatrist with an ongoing patient-therapist relationship in which the psychiatrist sees the patient in his office for twice-weekly therapy to resolve panic attacks would be guilty of a crime in Wisconsin if he had sexual relations with his patient. This is a straightforward case. The psychiatrist is having sexual contact with someone with whom he is administering psychotherapy. Consider another scenario: A well-trained therapist who counsels people, in groups of 200, on how to quit smoking and who has sex with one of his clients during the course of treatment would also be guilty of a crime in Wisconsin. Because the statute deems consent irrelevant, the fact that the client consents here would be irrelevant.

If the second scenario falls under the statute, then the statute is overly broad. One court, although not a Wisconsin court, stated that “[t]hese statutes are meant to protect vulnerable persons and allow them to reposit trust in those who can help them. The legislature has recognized the emotional devastation that can result when a psychotherapist takes advantage of a patient.” If the goal of these statutes is to protect the emotionally vulnerable from emotional devastation, then at the very least, the scenario in which the therapist treats 200 people at one time should fall outside the statute’s scope. The therapist’s treatment qualifies as psychotherapy as it is broadly defined by the statute, yet there is no reason to

46. See supra notes 16, 17 and accompanying text.
believe that the person seeking smoking cessation is either particularly vulnerable (except to the temptations of cigarette smoke) or likely to experience emotional devastation because of a sexual encounter with the therapist.

There does not seem to be anything about the person quitting smoking that makes him or her vulnerable. Moreover, on the basis of the definition of "psychotherapy" that serves to define who is governed by the statute, there is nothing about a therapist that would give a therapist the "power" to make vulnerable someone like the person who wants to stop smoking. The definition of "psychotherapy" used in the Wisconsin statute mentions the use of "emotional reactions" as one of the characteristics of psychotherapy. This may be intended to cover transference and phenomena that resemble it. However, the concept of an "emotional reaction" is much broader than the technical concept of "transference." Even if the concept of "transference" could explain why patients could not consent to a sexual relationship with their therapists, it would not follow that "emotional reaction" would render the patient similarly incapable.

If anything can be safely inferred from this statute, it is that those who promulgated it believed that patient consent either was irrelevant or absent in a sufficiently high number of cases that it was not worth taking into account. The promulgators assumed that the concatenation of patient, therapist, and intimate touching is enough for a crime.

II. EXPLANATIONS AND RATIONALIZATIONS

A. The Inability of Patients to Consent

Many of those who support patient-therapist sex as a basis for malpractice and those who support the criminalization of patient-therapist sex believe that patients who have sex with their doctors are unable to consent to it. The following is a summary of this position:

[the] patient who becomes involved in such a relationship (in the vast majority of cases, the patients are women involved with male therapists) is likely to have a significantly impaired ability to decide whether to have sexual contact with the therapist. This impairment may result from two causes: the underlying distress that brought the patient into treatment, which may continue to cloud the patient's judgment, and the transference toward the therapist that develops.\textsuperscript{49}

\textsuperscript{49} Appelbaum & Jorgenson, supra note 13, at 1469.
Paul S. Appelbaum and Linda Jorgenson claim that a patient’s decision to engage in sexual relations with her therapist is sufficiently undermined by one of these two factors so as to call into question her capacity to consent. The following are three arguments that have been marshalled on behalf of the claim that patients cannot consent to have sexual relations with their therapists.

1. The Patient’s Illness as an Obstacle to Consent

Appelbaum and Jorgenson claimed that the patient’s impaired ability to consent to sex with her therapist is a result of the “underlying distress that brought the patient into” therapy in the first place. The idea seems to be there is something about the patient’s mental health that makes it impossible for her to give consent to have sex with her therapist. I assume that this impairment to the patient’s ability to make decisions about her sexual life exists only with respect to sexual activity with her therapist; that is, her decisions to have sex with other people are not impaired—at least not sufficiently impaired to be prohibited in all cases. Moreover, her decisions about matters, other than sex with her therapist, are not similarly undermined, even when they concern her therapist.

For example, the recent Guidelines of the Massachusetts Psychiatric Society articulate an unqualified ban on sexual contact between patient and therapist. They also contain a provision permitting patients to donate large amounts of money to organizations with which their therapists are affiliated—although the Guidelines include the caveat that this not be done without consultation with another physician. Under these Guidelines, it is only the patient’s decision to have sex with her therapist that the patient is considered unable to make. Decisions to donate large sums of money to the therapist’s favorite institution can be checked to ensure that they are not coerced.

Apparently the patient’s judgment is potentially astute enough that she is able to decide to enter into protracted and expensive therapy, to donate large sums of money, and to make other major decisions which affect

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50. Id.
51. The authors specify that the impaired judgment is with respect to sex with therapists; they do not specify whether there is additional impairment either regarding sex with other people or regarding other areas, such as finances. See id.
52. COMMONWEALTH OF MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE, POLICY 94-001 GENERAL GUIDELINES RELATED TO THE MAINTENANCE OF BOUNDARIES IN THE PRACTICE OF PSYCHOTHERAPY BY PHYSICIANS (ADULT PATIENTS) 1994.
53. Id.
her life and which can benefit the therapist. At the same time, however, she is thought to suffer from an illness which undermines her capacity to consent to have sex with her therapist. There is no evidence that patients who have had sex with their therapists share common qualities. "The female victims varied widely in occupation, socioeconomic status, and level of functioning." Given the wide variation in the level of functioning which patients present, it is difficult to see how one could make any kind of generalization about the impaired decisionmaking of patients based simply on the fact that they are in therapy, unless of course, one subscribed to a biased view of the population who turn to therapists. Even if there were an illness that targeted the consent-to-sex-with-your-therapist capacity, it is unlikely that it is sufficiently widespread to justify stating that a substantial number of patients lack the capacity to consent.

Alternatively, if the assumption is that patients in therapy are more likely to have compromised decisionmaking abilities than those outside of therapy, then the assumption is probably false. One interesting study, although dated, showed that psychiatric symptoms are so prevalent among community members (most of whom have never been psychiatric patients) that such symptoms are more normal than not. Eighty-one percent of 1,660 adults in the sample were found to have psychiatric symptoms; 23% were found to be incapacitated, and a mere 19% were considered well.

Patients who seek the assistance of a therapist may in fact have an enhanced ability to make decisions. They may be more acutely aware of their own weaknesses and unconscious motivations than people who have never participated in psychotherapy. They may reflect more carefully on their decisions and be more autonomous. Psychotherapy and psychoanalysis are, after all, informed by the values of self-knowledge and authenticity. Moreover, if patients in psychotherapy were impaired decisionmakers at the onset of therapy, there is no reason to believe that this impairment would continue for any substantial period after therapy commenced.

To assume that patients have an impaired ability to decide whether to

55. LAURENCE R. TANCREDI ET AL., LEGAL ISSUES IN PSYCHIATRIC CARE 28 (1975).
56. Id.
58. See William W. Meissner, The Concept of Therapeutic Alliance, 40 J. AM. PSYCHO-
have sex with their therapists because they are patients seeking mental health treatment is to fall prey to a prejudicial view about patients in therapy and to contribute to the stigmatization of people who seek therapy. Furthermore, if psychotherapy is associated with social stigma, people may be reluctant to seek the help of a therapist. Insofar as psychotherapy helps people live healthier, happier, and more productive lives, there are important public policy reasons for not discouraging people from seeking therapy.

2. Transference as an Obstacle to Consent

The second reason that has been advanced for questioning the patient's capacity to consent to have sex with her therapist relates to the phenomenon of transference. Transference is invoked in order to show that patients cannot consent to have sex with their therapists, at least, not in the requisite way.

In *L.L. v. Medical Protective Co.*, the court stated:

[A] sexual relationship between therapist and patient cannot be viewed separately from the therapeutic relationship that has developed between them. The transference phenomenon makes it impossible that the patient will have the same emotional response to sexual contact with the therapist that he or she would have to sexual contact with other persons.

A patient in transference “unconsciously attributes to the psychiatrist or analyst those feelings which he may have repressed towards his own parents . . . . It is through the creation, experiencing and resolution of these feelings that [the patient] becomes well.” Although transference may consist of both negative and positive feelings toward the therapist, the transference at issue in patient-therapist sex is positive transference.

Positive transference occurs when the patient begins to see her therapist as an exceptional person and falls “in love” with him. Freud distin-
guished transference love by the fact that it takes place in the context of an analysis and can provide both the analyst and patient with much needed data about the patient's psychic life. Furthermore, because transference feelings are not founded on the real relationship between therapist and patient, but rather on the feelings that the patient imputes to the therapist from her early childhood, it is possible to infer something about the nature of these early childhoods. Roughly, the idea is that the love that the patient claims to have for the therapist is not really for the therapist, but it is instead an emotion based on experiences with other significant people in the patient's life.

Although the term "transference" is a technical term used to designate phenomena that happen to a patient in the context of therapy, it does not follow from this that transference does not occur in other contexts. Alan Stone, for example, notes that transference enters into many relationships, such as student-teacher, lawyer-client, and physician-patient. Arguably, one of the reasons transference occurs so consistently and so readily in the therapist-patient context is precisely that it happens very often in any case. By gaining insight into the transference in the therapeutic context, the patient can increase her "capacity for gratifying relationships based on mature and realistic expectations, rather than on irrational, childhood-derived fantasies."

If transference is present in everyday situations, then it is probably present in situations where people consent to sexual activity. People frequently consent to sexual activity with others on the basis of fantasies about the other person, instead of on strictly reality-based considerations. Consensual sex occurs for a variety of reasons, from those having to do with the way the others look, dress, and smell, to considerations concerning their skills as a conversationalist. In view of the panoply of reasons thought legitimate for consent to sex, it would be difficult to argue that consent to have sex ought to be transference free.

Finally, it is worth remembering that "transference" is a concept specific to a particular paradigm of human nature, namely, the psychoanalytic one. Although that picture of human nature has captured the

68. STONE, supra note 14, at 196; see also JEFFERSON SINGER & JEROME SINGER, TRANSFERENCE IN PSYCHOTHERAPY AND DAILY LIFE: IMPLICATIONS OF CURRENT MEMORY AND SOCIAL COGNITION IN THE INTERFACE OF PSYCHOANALYSIS AND PSYCHIATRY 516 (1992).
69. KAPLAN & SADOCK, supra note 15, at 573.
Twentieth Century imagination, it is nonetheless one paradigm among others. Attempts to take the dramatic step of calling into question a patient’s ability to consent to sex on the basis of it are highly problematic. Furthermore, given the ubiquitous nature of transference, allowing consent to be undermined by transference in one context may ultimately undermine consent in cases outside the therapy context.

3. Power-Dependency Relations

There is yet a third reason that has been advanced in support of the view that patients cannot consent to have sexual relations with their therapists. Phyllis Coleman has argued that there can be no legally effective consent to sex in what she calls power-dependency relationships. The power-dependency relationships with which Coleman is concerned are parent-child, psychotherapist-patient, physician-patient, clergy-penitent, attorney-client, and employer-employee. Coleman favors liability for any sexual contact in these relationships on the grounds that consent is suspect. Coleman provides two reasons for questioning the validity of consent in these cases. First, the dependent person’s desire for sex with the powerful person is rooted in the power relationship instead of the inherent qualities of the powerful person. Second, the consent may be a product of implicit or explicit threats.

Although some of Coleman’s analysis is similar to what we have considered in the first two sections, she provides something we have not seen thus far. Namely, Coleman articulates a substantive view of “consent-to-sex.” For example, by implication, Coleman tells us that the source of a sexual desire should be the person himself and not some fantasies projected onto that person. As background to her theory, Coleman develops the following view.

When two people are approximately equal in power ... agreement to a sexual relationship ... represents a decision that antic-

73. Id.
74. Id. at 97.
75. Id.
ipated benefits outweigh potential injury . . . Arguably this [consent to sex] is a rational decision, similar to a commercial cost-benefit analysis, where the cost—distress over a failed love relationship is neither so high as to discourage such voluntary relationships nor so problematic as to require legal protection for either party. When there is no significant power imbalance between them, competent adults should be free to choose their sexual partners and to assume the risk of potential injury.76

Thus, the background against which Coleman evaluates consent is the paradigm of the rational consumer undertaking a cost-benefit analysis before making a major purchase.

It is not entirely clear from Coleman’s discussion whether she believes she is describing the way people in fact consent to have sex in non-power-dependency relationships, or an ideal to which she believes everyone ought to aspire. As to the former, her view is obviously false, and as to the latter, it is not universally shared. Many people, if not most, engage in sexual relations for reasons other than those connected with cost-benefit analysis. Needless to say, it would have been far easier to slow the spread of HIV/AIDS were sexual decisions made in the way that Coleman suggests.77 A great deal of sexual activity takes place while people are intoxicated or under the influence of drugs.78

Coleman’s view is important because it highlights what may be an unspoken, normative value. Namely, decisions to have sex should be autonomous in the full-blown sense of the word, and people should not have sex for impulsive or lustful reasons. The main problem with this view is that by dictating people’s sexuality, it undermines the very values of autonomy and liberty upon which it is founded.

On the basis of my analysis, there are no good reasons to believe that patients are, in general, unable to consent to have sex with their therapists. Thus, the argument that patient-therapist sex should be criminalized because it is non-consensual sex (rape) fails.

76. Id. at 97 n.13. See also Phyllis Coleman, Sex Between Psychiatrist and Former Patient: A Proposal for a "No Harm, No Foul" Rule, 41 Okla. L. Rev. 1 (1988).
B. The Therapist as a Fiduciary

1. Patient-Therapist Relationship as a Fiduciary Relationship

Suppose, as I have suggested, that it is difficult to justify the assumption that patients are unable to consent to have sex with their therapists on the basis of transference and the conditions that bring people to seek therapy. The criminalization of patient-therapist sex has also been justified on the basis of the idea that the relationship between the patient and therapist is a fiduciary one. Alan Stone takes that view when he says “one can assume that the psychotherapist has a fiduciary relationship to the patient . . . . Violations of fiduciary obligations can be made a crime, not necessarily rape, and they are also relevant to claims of malpractice.”

The court in Roy v. Hartogs held that the relationship between patient and therapist is a fiduciary one and treated it akin to the relationship between a guardian and his ward. Similarly, Linda Jorgenson, Rebecca Randles, and Larry Strassburger believe that a fiduciary relationship exists between therapist and patient, and that the emotionally vulnerable patient comes to the therapist whose expertise she relies on to reduce her suffering.

2. Fiduciaries Scrutinized: Power and Deference

A fiduciary “relationship arises whenever confidence is reposed on one side, and domination and influence result on the other.” Attorney-client, guardian-ward, and executor-heir are examples of fiduciary relationships. Psychiatrists have recently been added to the community of fiduciaries. A fiduciary has “[a] duty to act for someone else’s benefit, while subordinating [his] personal interests to that of the other person.”

In an extensive analysis of the idea of a “fiduciary,” Tamar Frankel identifies two features which characterize fiduciary relationships. First,
the fiduciary serves as a substitute for the entrustor,\textsuperscript{88} who places his trust in the fiduciary.\textsuperscript{89} Furthermore, both parties in the relationship, as well as the courts, view the fiduciary as acting as a substitute for the entrustor.\textsuperscript{90} This is probably more true of the paradigmatic fiduciary relationships. For example, when the guardian of an incompetent ward makes decisions in the stead of her ward, she is a substitute decisionmaker. An attorney who represents his client in court, and a stock broker who makes investment decisions for his client, are also examples of substitute decisionmakers. Moreover, where possible, attorney-client, broker-client, and guardian-ward understand the fiduciary as a substitute decisionmaker.

The second feature Frankel identifies as characterizing fiduciary relationships is a delegation of power from either the entrustor or a third party to the fiduciary “for the sole purpose of enabling the fiduciary to act effectively.”\textsuperscript{91} Frankel gives the example of a client transferring his securities\textsuperscript{92} to his broker and appointing the broker a holder of the securities. Similarly, a guardian may hold funds for her ward. Where the power that is delegated to the fiduciary is minor, the act delegating it is likewise minor.\textsuperscript{93}

3. Problems with Viewing the Patient-Therapist Relationship as a Fiduciary Relationship

It is clear how traditional fiduciary relationships fit Frankel's framework. Moreover, the framework provides some insight into the power relations underlying fiduciary relationships. But this conceptual model of fiduciary relations cannot easily be applied to the relationship between patient and therapist, especially with respect to either insight-oriented psychotherapy or psychoanalysis. Because these therapeutic approaches are informed by the value of individual autonomy, they are at odds with the dependency values that inform fiduciary relationships. To frame the relationship between patient and therapist as a fiduciary relationship in which patients defer to the authority of therapists does not so much set aside the question of patient consent as it does build the failure of consent into the relationship.

\begin{itemize}
\item \textsuperscript{88} Id.
\item \textsuperscript{89} Id. at 800.
\item \textsuperscript{90} Id. at 808.
\item \textsuperscript{91} Id. at 809.
\item \textsuperscript{92} Id.
\item \textsuperscript{93} Id. at 809 n.49.
\end{itemize}
In MacDonald v. Clinger, the court held that psychiatrists are fiduciaries with respect to confidential information in situations where psychiatrists disclose confidential information to a patient's spouse. To fit this into Frankel's framework, we would have to say both that there was a delegation of power to the psychiatrist, and that the fiduciary is, in some sense, a substitute actor for the patient. However, there is no sense in which the psychiatrist serves a substitution role. Ironically, the court's reaffirmation in MacDonald of the doctor's duty not to disclose confidential information, although grounded in the idea of a fiduciary relationship, indicates that the doctor is not to act as a substitute.

Consider the following scenario: When a physician takes it upon herself to disclose private information she is acting as a substitute for the patient. She is doing what some people might say the patient ought to be doing. For example, if a therapist, upon hearing from her patient that he is HIV positive and that he, nonetheless, plans to have sex with his spouse, discloses that information to the spouse, the therapist arguably is acting as a substitute for the patient.

After Tarasoff v. Regents of University of California, psychiatrists have a duty to warn third parties when there is a danger to them. There is, however, also a wide recognition of the right of the patient to control the disclosure of confidential information as they see fit. Underlying the duty of confidentiality, then, is a recognition that patients have a privacy right to control information about themselves and that psychiatrists do not have the legal right to contravene this except in limited cases. Although the MacDonald court found that therapists were fiduciaries with respect to confidential information, it is not clear what "fiduciary" amounts to here, since the duty to maintain confidences is a duty to refrain from exercising power with respect to those confidences and to refrain from acting as a substitute for the patient. Under Tarasoff, psychiatrists have a duty to warn when the patient poses a danger to third persons; under statutes, psychiatrists can commit patients when they are a

95. Id. at 805.
96. 529 P.2d 553, 561 (Cal. 1974).
97. Id. at 555.
98. Id. at 560-61.
99. Id. at 561.
100. Thomas G. Gutheil & Glen O. Gabbard, The Concept of Boundaries in Clinical Practice: Theoretical and Risk-Management Dimensions, 150 AM. J. PSYCHIATRY 188 (1993). The psychiatric concept of a "boundary crossing" shows how highly structured therapy is and the extent to which therapists avoid acting as substitutes for their patients.
danger to themselves or others. In these cases, psychiatrists could be said to act as a substitute for the patient. These, however, are extraordinary circumstances and are not indicative of the relationship between patient and therapist.

Now consider the second feature of fiduciary relationships as applied to psychiatrists: the delegation of power to the psychiatrist. It would probably be argued that in conveying private information to the psychiatrist, the patient is delegating power. Frankel defines “power” as “an ability to make changes that affect the entrustor.” An investor, for example, may allow his broker to choose his investments. In this way, the broker undertakes an activity that affects the investor—ultimately, he makes or loses money for the client. A guardian makes decisions concerning the care or property of a ward who, either because of minority or incapacity, cannot act on his own.

A similar analysis can be drawn with patients who, for instance, seek the help of a surgeon. A patient who is unconscious and about to have surgery has delegated power to the doctor in a way that affects the entrustor-patient. But psychiatrists and their non-medical colleagues have a different role from that of other physicians. Kaplan and Sadock, authors of a standard text in psychiatry, explain the difference:

In many respects the role of the psychiatrist is different from that of a nonpsychiatric physician, and yet many patients expect the same from the psychiatrist as they do from other physicians. If they expect a doctor to take action, give advice, and prescribe medication to cure an illness, they may well expect this same interaction with a psychiatrist and be disappointed or angry if it does not occur.

Thus, psychiatrists are unlike non-psychiatric physicians because they do not tell patients what to do (take action on their behalf) nor, do they give advice to patients. That is, psychiatrists do not perform the kinds of activities which tend to establish a fiduciary relationship (activities in which the patient delegates authority) in the medical field. In view of this, the analysis that is easily applied to some non-psychiatric physicians, and other fiduciaries, is not as easily applied to psychiatrists and those

101. Tarasoff, 529 P.2d at 561.
102. Frankel, supra note 84, at 809.
103. BLACK'S LAW DICTIONARY 707 (6th ed. 1990) (definition of "guardianship").
104. KAPLAN & SADOCK, supra note 15, at 3.
105. Supportive therapy during a crisis is an exception to this general rule of thumb. Id. at 575.
nonpsychiatric therapists who practice psychoanalysis, psychoanalytically informed therapy, and other insight-oriented therapies.

The trend is toward understanding the relationship between patient and therapist as an alliance in which patient and therapist work together. In psychoanalysis and its derivatives, patients are active participants who disclose private thoughts, feelings, and beliefs; and who are responsible for contributing to the understanding of the material they introduce for discussion during their analysis. Moreover, there is variation in how much individual patients participate depending on at what stage the therapy is. Consider the following:

The patient moves from a position of looking to the analyst for guidance or interpretive input to one of taking greater activity and responsibility for uncovering, sorting out, and integrating his own psychic experience and analytic productions. The respective roles of analyst [therapist] and patient shift so that they gradually come to occupy a middle ground in which both contribute, share, and collaboratively process analytic material, and so gain deepening understanding ...

The relationship between patient and analyst is a dynamic one. During the initial stages of the relationship, the patient may perceive the psychiatrist as an authority to whom he looks for psychological insight. As the relationship develops, however, patient and psychiatrist move toward an equal footing. The values inherent in psychoanalysis and psychoanalytic psychotherapy simply do not fit the paternalism that characterizes the fiduciary.

The analogy drawn by the court in Roy v. Hartogs, and underscored by Alan Stone in Law, Psychiatry, and Morality, namely, that the relationship between therapist and patient is a fiduciary one, akin to the rela-

106. Meissner, supra note 57, at 1059.
107. Id. at 1076.
108. Id. at 1078.
109. I intend the term “paternalism” in the way it has come to be known through the tradition of John S. Mill; namely, interfering with a person’s freedom of action for her own sake. The idea underlying the fiduciary model of acting for another person for their sake is paternalistic in this sense.
110. This view of psychoanalysis and psychoanalytically informed therapies is not peculiar to Meissner. Consider the following: “I find it useful to define ... the principal method of psychoanalysis, as a joint venture in which the patient attempts to express whatever comes to mind, ... and the analyst, guided by his own associations and formulations, contributes only with the goal of enhancing the expression of the patient’s free associations.” ANTON O. KRIS, FREE ASSOCIATIONS 3 (1982).
112. STONE, supra note 14, at 199.
tionship between a guardian and ward, misconstrues the nature of the relationship. Patients do not “entrust their body and mind” to a psychiatrist113 as a bailor entrusts goods to a bailee. Stone realizes that the court in Hartogs misunderstood the therapist-patient relationship when he suggests that there has been an idealization of the therapist’s authority and that the analogy to the guardian-ward relationship “does not capture the subtleties of transference.”114 Nonetheless, Stone explains that the fiduciary model is a way for the court “to say that the psychotherapist has a duty not to become sexually involved with a patient, even if she maturely consents.”115 According to Stone, psychotherapists are ascribed this duty because they have the professional responsibility for “managing the transference and countertransference.”

For Stone, then, the advantages of the fiduciary model are: (1) it can explain the duty of therapists to refrain from having sex with their patients (even those who maturely consent); (2) it can extend the scope of the duty to refrain from having sex with patients from therapists who are responsible for managing the transference to all therapists; and, (3) it can explain both civil and criminal law.117 Stone points out that some psychologists, like behavior therapists (methods of treatment include aversion therapy, relaxation training, etc.) and biological psychiatrists (treatment with psychopharmacology), deal with patients impersonally,118 and have no more responsibility for managing transference than does the pilot of a Boeing 747 with respect to his passengers.

The fiduciary model does not succeed (1) because it appears to build the idea of a compromised decisionmaker into the relationship itself, and (2) it is not really an advantage at all once you unravel the mystique of transference. If transference is not the “bugaboo” it has been made out to be, then the reason for extending responsibility for it to other therapists disappears. Explaining the relevance of civil and criminal law is not really an advantage if criminal sanctions are wrongly imposed. But the real problem with applying the fiduciary model to the relationship between patient and therapist is that it rests on a fictionalized and troubling version of psychotherapy.

113. Hartogs, 366 N.Y.S.2d at 301.
114. Stone, supra note 14, at 199.
115. Id.
116. Id.
117. See id.
118. Id.
C. Disadvantages of the Fiction of the Therapist as Fiduciary

Although legal fictions are common, they normally serve a beneficial end having to do with the advancement of justice. Here, however, we have a fictionalized version of the world of patient and therapist. We are asked to accept the view that psychotherapy is a process in which patients hand over mind and body to their therapists. Patients, most of whom are women, have transferred control and self-determination to therapists, most of whom are men. As the court recognized in Roy v. Hartogs, "[c]onsent obtained under such circumstances is no consent, and should stand for naught." The advantages of this fiction are that all therapists, not merely those who endorse some model of transference, can be held legally responsible for patient-therapist sex, and that fiduciary duties can generate obligations covered by civil and criminal law. I have already explained why these advantages are problematic. I now want to explain why the fiction itself is troubling.

1. Sexism

There are significant disadvantages to construing the relationship between patient and therapist as a fiduciary one. First, most of the patients who seek therapy are women and most of the patients who have sex with their therapists are women. To characterize the relationship between patient and therapist as a fiduciary relationship similar to the relationship between guardian and ward treats women as if they are children—unable to consent. When a court discusses a patient handing over mind and body to her therapist, it is difficult not to be reminded of Blackstone’s characterization of the relationship between husband and wife. "By marriage the husband and wife are one person in the law: that is, the very being or legal existence of the woman is suspended during marriage, or at least is incorporated and consolidated into that of the husband: under whose wing, protection and cover, she performs everything." A patient turning over mind and body to her therapist is, for all intents and purposes, equivalent to a woman suspending her existence during marriage. As this passage from Blackstone shows, this view of women was deeply embedded in the law and in society. Just how deeply embed-
ded is the view of a woman as one with her husband in marriage is borne out by the automatic inclination to view the patient-therapist relationship as it has been viewed by the courts—despite very clear evidence that much of psychotherapy involves a great deal of patient self-determination.\textsuperscript{124} Hence, one major disadvantage to the framing of the relationship between patient and therapist in the terms of a fiduciary relationship is that it burdens women patients with a prejudicial stereotype.\textsuperscript{125}

2. \textit{Biomedical Ethics}

Casting the therapist as a fiduciary may also be in conflict with well-accepted principles of biomedical ethics. The recent history of biomedical ethics is founded on a principle of respect for patient autonomy.\textsuperscript{126} This liberal principle has also found expression in the case law concerning matters such as informed consent and the right to refuse treatment.\textsuperscript{127} The case law shows, at least, an appreciation of patient autonomy and privacy rights. Construing the relationship between patient and therapist as a fiduciary one, in which patients defer to the authority of their doctors, is a throwback to a time when paternalistic medical practices were the norm. This is not so today and the trend has been toward ever-increasing autonomy.

3. \textit{Stigmatizing Patients Seeking Therapy}

Portraying the relationship between patient and therapist as one in which the patient makes the therapist a substitute decisionmaker presents the risk of placing patients in an unfounded stereotype in which they are not viewed as self-determining and consequently stigmatized. The fiduciary model of the relationship between therapist and patient may equate all patients with the most disabled psychiatric patients who are subject to involuntary commitment. Because most patients who seek the help of a therapist do not fall into this category, it is a mistake to base the law on this picture.

\textsuperscript{124} See, \textit{e.g.}, \textsc{Jay Katz}, \textsc{The Silent World of Doctor and Patient} 121 (1984) (using the framework of psychoanalysis to articulate a model for the doctor-patient relationship which will foster patient self-determination).

\textsuperscript{125} See \textit{Pusey v. Pusey}, 728 P.2d 117 (Utah 1986) (overruling maternal preference in child custody cases). The trend toward gender neutrality in the law is an example of the determination of the courts to move away from sexism.

\textsuperscript{126} See \textsc{James F. Childress} \& \textsc{John C. Fletcher}, \textsc{Respect for Autonomy}, \textit{Hastings Ctr. Rep.}, May-June 1994, at 34.

\textsuperscript{127} See \textit{Cobbs v. Gran}, 8 Cal. 3d 229, 243 (1972) (discussing duty of doctors to disclose for patient consent).
It might be argued that although there are disadvantages to the fiduciary model, the model is nonetheless an important device. It is not intended to give an actual description of the relationship between patient and therapist, and it permits us to understand why patient consent is irrelevant. But I have identified the disadvantages of the fiduciary fiction in order to underscore the point that the costs of this device are too high. I have shown that the arguments marshalled to undermine patient consent are weak. There is no reason to think that a patient's illness will lead to an impaired ability to consent, and either that transference per se impairs consent or power-dependency relationships undermine consent. I also have shown that although casting the patient-therapist relationship as a fiduciary one can justify the prohibition on sex between patient and therapist and can explain why a patient's consent is irrelevant, it does so at a high price.

In *Patient-Therapist Sexual Relations*, Thomas Gutheil tries to save the fiduciary model by combining it with the concept of "undue influence." He introduces the latter into the debate because he believes that it "does not imply that the patient is impaired or incapable of consenting." Unfortunately, "undue influence" is defined as "[p]ersuasion, pressure, or influence . . . that so overpowers the dominated party's free will or judgment that he or she cannot act intelligently." Although I appreciate the effort to liberate the fiduciary model in this way, I do not think that the concept of "undue influence" is sufficiently free of paternalistic implications to meet the challenge Dr. Gutheil has set for it.

**D. Implications of the Assumption that Patients can Consent**

**1. Prohibition on Patient-Therapist Sex Maintained**

Assume, for the sake of argument, that patients can consent to have sex with their therapists. Would it follow that it is thereby permissible for them to do so—or that the law is saddled with condoning this interaction? I do not think so. In *Bunce v. Parkside Lodge of Columbus*, the court held that although consent would be a valid defense to the criminal charge of sexual assault or rape, it is not a defense to a malpractice claim based on sexual contact.
Maintenance of a malpractice claim does not rely upon the question of whether Bunce validly consented to the sexual contact but instead upon the possible breach of a duty owed her by Brown... although consent would be a valid defense to a criminal charge of sexual assault or rape, consent is not a defense to a malpractice claim based on sexual contact. Malpractice involves the breach of a professional duty; where the duty itself is to refrain from sexual contact, consent would not excuse the breach.\textsuperscript{133}

The following reasoning may underlie this holding. If the therapist is under a duty to refrain from engaging in non-consensual sex with others (as is everyone) and under a duty to refrain from engaging in consensual sex with patients (a duty unique to therapists and some other professionals), then consent is irrelevant as to whether or not that duty has been breached. The \textit{Bunce} court does not elaborate on what the grounding of this duty is, but instead refers to the \textit{Hartogs} discussion of the fiduciary model and breach of trust.\textsuperscript{134} I have argued that this is the wrong foundation on which to ground the duty of a therapist not to have sexual relations with his patients.

2. \textit{Two Proposals for Consideration}

I suggest two alternative explanations for the therapist’s duty to refrain from having sex with his patients. First, the therapist’s duty to refrain from engaging in sexual activity with a patient (both consensual and non-consensual) can be founded on the professionally honed skill of objectivity. Psychoanalysts, for example, are required to undergo a personal psychoanalysis in part to facilitate objectivity and neutrality toward the patient.\textsuperscript{135} The importance of objectivity explains why an analyst should not analyze his or her friends.\textsuperscript{136} Surely, one can assume that sexual relations with a patient would undermine the therapist’s objectivity, and in turn, his professional performance. Thus, I suggest that the therapist’s duty to refrain from having sex with his patients, even when it is consensual, can be derived from the professional duty to remain objective.

The skill of remaining objective, like that of managing the transference, is a professional skill, departures from which could qualify as negligence. Unlike the skill of managing the transference, however, objectivity is a

\textsuperscript{133} \textit{Id.} at 1111.

\textsuperscript{134} \textit{Id.}

\textsuperscript{135} \textit{KAPLAN} \& \textit{SADOCK}, supra note 15, at 572.

\textsuperscript{136} \textit{Id.} at 574.
skill expected of all therapists and justifies holding all therapists liable for malpractice when the duty to remain objective is breached. This duty to remain objective also explains why therapists should avoid acting in self-interest. If acting in self-interest is a possibility for therapists, then they risk a conflict of interest which would undermine their objectivity. Finally, objectivity, and its more normative correlate, impartiality, can explain the prohibition on sex in professional relationships in general (such as attorney-client, doctor-patient, and student-teacher).

A second possible grounding for the prohibition on patient-therapist sex is the professional duty of therapists to manage the countertransference. Countertransference is the therapist's counterpart to transference. "Countertransference may . . . encompass disproportionately positive, idealizing, or even eroticized reactions." To ground the therapist's duty to refrain from having sex with a patient on the duty to manage the countertransference avoids the disadvantage of being saddled with the highly paternalistic implications inherent in the view that therapists are responsible for managing the patient's transference, and it more accurately reflects the wrong at issue here. The fact is that it is not the patient's desires, feelings, etc. that have to be managed, but the therapist's countertransference and behavior.

III. Ethical Considerations

A. To Criminalize or Not to Criminalize

I have considered the two main arguments in support of criminalization. First there is the argument that because patients cannot consent, sex between patient and therapist is more like rape than consensual sex. Hence, it ought to be criminalized. I argued that there was no reason to accept the view that, in general, patients cannot consent to have sex with their therapists. Then, I looked at the second argument that patient-therapist sex should be criminalized because the relationship between patient and therapist is a fiduciary one and violations to fiduciary relationships have, in some cases, been criminalized (as with insider trading). I argued against understanding the relationship between patient and therapist as a fiduciary relationship. In this way, I have shown that criminalization is not justified even on the basis of the criteria of those who support it. This

137. Stone, supra note 14, at 144.
is not to say that I accept either analysis as a correct one of the criteria for criminalization.

The question of whether or not to criminalize conduct is a moral one. The answer to that question will depend on what moral principles we select. Jules Coleman and Jeffrie Murphy argue against what they call the “absurdly simpleminded” idea that particular conduct is so “bad” that we pass a criminal law against it. Moreover, the idea that we criminalize conduct which, as a society, we want to deter, is also problematic. Presumably, we want to deter all kinds of behavior, that we would not consider criminalizing. For example, most people are not willing to criminalize jay walking and high-fat diets. Coleman and Murphy suggest that conduct be criminalized when (1) the private means of protecting rights is inadequate, and (2) the private means of protection will work only with the help of criminal sanctions. Let us consider these as applied to patient-therapist sex.

It is not clear what right is being protected in the case of patient-therapist sex. Assume, however, that there is a right to professional services and that patient-therapist sex violates that right. There is no good reason to think that malpractice would not be enough to protect this right. Malpractice suits carry with them a negative stigma that would have the effect of discouraging therapists from having sex with patients. Potential repeat offenders would be discouraged by higher insurance rates which might ultimately make it too costly for them to practice. Malpractice law should be adequate to protect the right, compensate patients who have been harmed, and discourage the activity. Malpractice could also be combined with administrative remedies that allow for license revocation, and buttressed with laws that prevent people from practicing therapy without a license.

Given this combination of measures, it should not be necessary to invoke criminal sanctions as a way of supporting the private remedy of malpractice. Moreover, it is worth asking if the cost of using the criminal law as a way to support private remedies is not too high. At some point, especially with respect to celebrities and other well-off members of society (like doctors), it will just be too costly for them to have their day in

139. The question of what should be criminalized is different from the question of when do we criminalize. Clearly all kinds of factors would determine when conduct deserves to be criminalized, including the agenda of special interests groups.
140. See JEFFRIE MURPHY & JULIES COLEMAN, PHILOSOPHY OF LAW: AN INTRODUCTION TO JURISPRUDENCE 117 (1990).
141. Id. at 116.
court and exercise their right to a trial. If the threat of criminal sanctions means more to those who have more to lose, then they—although innocent—may be forced to settle and forfeit their right to a trial.

2. Mill's Harm Principle as a Restriction on Criminalization

Freedom and liberty are considered to be a good worth pursuing in our society. One way to pursue them is to limit the occasions on which the state can interfere with individual liberty. John Stuart Mill's "harm principle" is the criterion used by a liberal state to distinguish occasions when it is considered morally right to interfere with people's freedom to act as they please.¹⁴² That principle provides that the only time you can interfere with a person's freedom of action is when the action to be interfered with harms another person and they have not consented to the harm.¹⁴³ Actions which harm only the person who performs them are considered to be outside of the reach of the criminal law.¹⁴⁴

Following this tradition, paternalists are those who believe that it is permissible to interfere with a person's freedom of action, even when the action harms only the person who performs it, provided that the interference is for that person's own good.¹⁴⁵ Soft paternalists tread a middle ground and claim that it is permissible for the state to interfere with a person's self-regarding actions (actions which effect only the person who performs them) when those actions are not performed autonomously.¹⁴⁶

The criminalization of patient-therapist sex would seem to violate the harm principle and the importance it places on freedom and the right of individuals to act as they wish. The liberty of at least two people is interfered with, that of the therapist and that of the patient. Laws which criminalize patient-therapist sex are worrisome from a liberal perspective because they interfere with the actions to which adults have freely consented and which harm no one other than those who have consented.

The issue of consent is important on a liberal picture of the "good" because a person who consents to an activity which is harmful to himself or herself is thereby prevented from turning to the criminal law for protection. This same idea is captured in the legal maxim volenti non fit injuria which can be translated as "to one who consents no harm is

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¹⁴². JOEL FEINBERG, HARMLESS WRONGDOING ix (1988).
¹⁴³. Id.
¹⁴⁴. Id.
¹⁴⁵. JOEL FEINBERG, HARM TO SELF 12 (1986).
¹⁴⁶. Id.
Joel Feinberg suggests that we understand the *volenti* maxim as not concerned with harms, but with wrongs and injustices. On this interpretation, the maxim means that to one who freely consents to a thing no wrong is done, no matter how harmful the consequences may be. At the heart of this principle is the right of individuals to perform foolish and potentially harmful actions without interference. Such a principle is necessary in order to protect a sphere of liberty with respect to actions and behavior which are self-regarding (effect only the person performing the action) but harmful to the person who performs the action and to which the agent consents. At issue here is the right to enter into apparently destructive arrangements with other people.

One way to look at patient-therapist sex, at least when a patient consents to have sex with her therapist, is as a situation in which the patient consents to the risk of being harmed by engaging in a sexual relationship with her therapist. That is, we could look at the relationship as one in which there is a high probability of harm but one in which there has been consent on the part of the party who is harmed. Were we to look at cases in which there was consent by the patient, through the eyes of Mill's harm principle, combined with the *volenti* maxim, we would be barred from holding the therapist criminally responsible for the harm to the patient. If I am right and there is no generalized grounds for questioning the ability of patients in therapy to consent, then Mill's harm principle speaks strongly against the criminalization of patient-therapist sex. Of course, the harm principle is silent with respect to tort law and contract law. I have suggested that the question of whether patient-therapist sex should be criminalized is a moral question to be answered using moral principles. On the basis of the two principles that I considered, it is clear that patient-therapist sex ought not to be criminalized.