

ORIGINAL RESEARCH

Boundary Violations and Personality Traits among Psychiatrists

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Objective: To demonstrate that sexual abuse of patients by psychiatrists can be due to a variety of contributors, which may include therapists' psychopathic and narcissistic personality styles.

Method: Data from a prospective cohort of residents training in psychiatry were examined to evaluate the personality traits of 2 psychiatrists subsequently convicted of boundary violations.

Results: The 2 psychiatrists who lost their licenses were identifiable at the beginning of their residency training as individuals with significant character pathology.

Conclusions: For some psychiatrists, repetitive sexual abuse of patients represents one aspect of an ongoing pattern of exploitative relationships. The professional and ethical implications of these findings as they relate to early identification for those at risk are considered.

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Key Words: boundary issues, predictors of abuse, therapist character pathology

Surveys examining the frequency of sexual contact between psychiatrists and their patients indicate that 6% to 10% of those surveyed admitted to having engaged in such contact (1,2). Those psychiatrists who engage in sexual contact with their patients are more likely to be men who work in private practice and who have undergone personal psychotherapy or psychoanalysis (1). The recent literature on this subject has examined means of preventing these boundary violations, the assessment and treatment of victims, and the relevant medicolegal aspects (3–5). More than a third of the state legislatures in the United States have now passed laws declaring therapist–patient sexual intimacy to be illegal, thus establishing with absolute clarity the violation of the standard

of care (6). Given these circumstances, an understanding of why psychiatrists might engage in these behaviours is essential. One obvious area to examine includes the psychological characteristics of psychiatrists who have sexually abused their patients (4,7).

Twemlow and Gabbard (8) describe 3 categories of such psychotherapists. The smallest group consists of psychotic individuals whose behaviour may be affected by delusional thoughts. Individuals in the second larger group display anti-social characteristics and have engaged in exploitative behaviour in many relationships. The third group, the largest, is comprised of neurotic or character-disordered individuals who are susceptible in the state of “lovesickness.” Typically, these are middle-aged men described as socially isolated and emotionally needy who invariably “fall in love” with women much younger than themselves. Dahlberg (9) reported that one-third of male psychotherapists who became erotically involved with their patients were in the midst of separation or divorce. There may be some overlap between the antisocial and “lovesick” categories, since not all or even most therapists display such boundary violations in the midst of periods of emotional needs. Indeed, 87% of therapists surveyed in a

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recent study acknowledged feeling sexual attraction to some of their patients (10).

Case reports of some clinicians who have been sexually exploitive are consistent with descriptions of the antisocial category. Averill and others (11) reported that male staff on inpatient units who became sexually involved with their inpatients were younger, tended to be exploitive in all their relationships, and were generally lacking in empathy and remorse. Brodsky (12) noted that practitioners who engaged in sexual activities with their patients were overconfident, maintained a dismissive attitude toward consultation from others, and manifested an exceptionally strong need to be admired. Stone (13) provided case reports of 2 younger psychiatrists who violated such boundaries based on their rationale of these patients' "special" needs. Stone (13) described one of the psychiatrists as antisocial and the second as borderline. Clearly, the second category of psychiatrists outlined by Twemlow and Gabbard (8) contains anecdotally a variety of antisocial, narcissistic, and borderline traits. The overlap between the antisocial and lovesick categories may be seen in the description of psychotherapists in the lovesick category as high-functioning on the surface, yet suffering from an underlying narcissistic disturbance. It is this disturbance, presumably, which make them vulnerable to the experience of the pathological state of lovesickness and permits them to deny or otherwise minimize ethical and legal prohibitions, ultimately "acting out" their feelings with a consequence of extreme destructiveness to their patients.

The present communication is part of a larger ongoing longitudinal study of psychiatrists over the course of their careers. We present the psychological profiles of 2 psychiatrists who, as part of this larger project, completed a battery of psychological tests during their residency training and who later were disciplined for repeated sexual involvement with their patients. While the sample size in this study is small, we believe that the findings warrant reporting as they raise important questions about early identification of clinicians who may be vulnerable to such behaviours.

Method

Subjects and Procedure

The participants were physicians solicited from residency programs from several different universities who were entering their first year of psychiatric training. All were within the first 3 months of their first year of their psychiatric residency. All potential participants were told that the study was a personal research project of the investigators and that the research was not connected with the departments of post-graduate education or psychiatry. All potential participants were also informed that to take part in the study they must 1) complete a battery of psychological tests to which they would not be given the results, 2) allow the investigators access to their personal files held by their department of

psychiatry, and 3) participate in follow-up interviews with the investigators after completion of their training. Those who agreed to participate signed an informed consent document that stipulated each of these 3 conditions.

There were 120 first-year psychiatric residents in the university programs from which the sample was drawn, all of whom were asked to participate. Ninety (75%) of the 120 agreed to participate and provided informed consent. Of these, 20 (22%) did not return all or some of the research protocol. Thus 70 subjects (58%) of the original sample completed the research protocol and returned it to the investigators during the first 6 months of the residency. A series of chi-square analyses indicated that the residents who participated in the study ($n = 70$) did not differ significantly from those who did not participate in the study ($n = 50$) in terms of age, gender, marital status, country of origin, or previous medical experience.

As part of a regular follow-up of the practice patterns of this sample of 70 psychiatrists, we conducted an interim review of their practice and career patterns between 13 and 17 years after completion of residency training. For this segment of the study, data were collected by a review of the membership catalogues of the Canadian and American medical and psychiatric associations and the provincial psychiatric associations. Data on boundary violations were obtained from reports of the provincial licencing bodies for physicians.

At the time of the follow-up, we were not able to trace 8 of the 70 psychiatry residents who had completed the research protocol. Of the remaining 62, 2 were deceased, and an additional 8 were not currently practising psychiatry. Of the 52 still practising psychiatry and whom we were able to contact, 40 were men and 12 were women. Of the 40 men, 2 had their licences revoked due to repeated sexual boundary violations with patients. Neither had exhibited a major affective disorder, paraphilia, or substance abuse at the time of the offences.

Measures

All participants completed a battery of psychological tests, which included the Eysenck Personality Inventory, the General Health Questionnaire, the Strong Vocational Interest Blank, and the Minnesota Multiphasic Personality Inventory (MMPI) (14). The MMPI was the only test in the battery that was designed specifically to measure psychopathology. The other tests measured normal dimensions of personality, general health, and vocational interests. As the focus of the present investigation was the relationship between boundary violations and psychopathology of the psychiatrists committing such actions, we report only the results from the MMPI. This psychological questionnaire is the most widely used measure of dysfunctional personality patterns and psychopathology. As well, personality self-ratings on the MMPI have been shown to be stable over a span of 30 years (15), a useful consideration in a longitudinal study such as ours.

The MMPI consists of 3 validity scales and 10 clinical scales. The validity scales—L, F, and K—were developed to assess test-taking attitudes that might invalidate the results of the clinical scales, although these scales are sometimes used to make clinical interpretations. The 10 clinical scales assess a wide spectrum of psychopathology and overall level of psychological functioning. These scales are Hypochondriasis (Hs), Depression (D), Hysteria (Hy), Psychopathic Deviancy (Pd), Masculinity–Femininity (Mf), Paranoia (Pa), Psychasthenia (Pt), Schizophrenia (Sc), Hypomania (Ma), and Social Introversion (Si).

Results

Figure 1 displays the MMPI profiles for the 2 psychiatrists who lost their licences compared with the 38 male psychiatrists who did not. Student's *t* test scores greater than 70 on most clinical scales are considered to be evidence of clinically significant levels of psychopathology.

Examination of Figure 1 reveals that the 2 psychiatrists who were disciplined scored approximately 10 points higher than did the remaining group on 3 scales: one validity scale—the K scale—and 2 clinical scales—Psychopathic Deviancy and Hypomania. For 2 of these scales, K and Psychopathic Deviancy, the *t* scores for those who lost their licences reached 70. In comparison, only 7 of the 38 remaining male psychiatrists (18%) scored higher than 70 on the K scale, while 9 of the 38 (24%) exceeded 70 on the Psychopathic Deviancy scale.

Both groups of psychiatric residents also produced *t* scores over 70 on the Masculinity–Femininity scale. This scale reflects stereotypic masculine and feminine interest patterns. Higher scores on the Masculinity–Femininity scale are typically not associated with psychopathology but rather are commonly found in university-educated men from higher socioeconomic strata who are intelligent and maintain a broad range of interests, including esthetic and artistic interests.

We also rank-ordered the K, Psychopathic Deviancy, and Hypomania scale scores for the entire sample to examine the relationship between the 2 psychiatrists who had their licences revoked relative to the psychiatrists who did not have their licences revoked. On the K scale, only 4 of the 38 practising psychiatrists (11%) scored higher than the 2 psychiatrists who had their licences revoked. On the Psychopathic Deviancy scale, 9 of the 38 (24%) scored higher than one of these psychiatrists, while only 3 of the 38 (8%) scored higher than the other who had his licence revoked. A similar pattern emerged for the Hypomania scale; 24% scored higher than one of the psychiatrists who had his licence revoked, while none in the group of 38 scored higher than the other psychiatrist who had his licence revoked.

The use of 2-point codes in the interpretation of MMPI profiles is commonly employed and enhances the accuracy of the diagnostic description (14), since single-scale eleva-

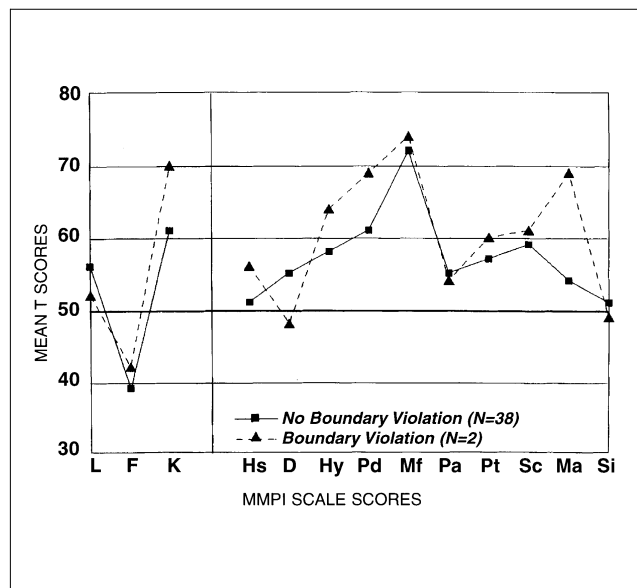


Figure 1. Median MMPI profiles of psychiatrists with and without boundary violations.

tions are more susceptible to spurious or artifactual influences. Two-point codes refer to the 2 highest clinical scores on the MMPI profile. The 2-point code most characteristic of the 2 psychiatrists who had their licences revoked is referred to as a 4/9 or 9/4 code type. This clinical profile was readily evident in only 4 of the 38 (11%) psychiatrists who did not have their licences revoked.

We also subjected the median profiles from these 2 groups to a modal profile analysis (16). This analysis classifies MMPI profiles into 1 of 3 broad prototypes of psychopathology—neurotic, psychotic, or sociopathic—according to a model of psychopathology using MMPI actuarial systems. For the psychiatrists without boundary violations, the median profile was not classifiable as either neurotic ($r = 0.07$, $P = ns$), psychotic ($r = -0.21$, $P = ns$), or sociopathic ($r = 0.12$, $P = ns$), indicating that the profile was unclassifiable and therefore normal. For the psychiatrists with boundary violations, the median profile was not classifiable as neurotic ($r = -0.05$, $P = ns$) or psychotic ($r = -0.26$, $P = ns$). The profile was, however, classifiable as sociopathic ($r = 0.55$, $P = 0.05$).

Discussion

The results of this study highlight some important issues regarding psychiatrists who become sexually involved with their patients and raise questions that require thoughtful debate. These data should not be considered prevalence figures, as they do not take into account participants who may have been involved in similar behaviours but have not been caught and/or disciplined. Rather, these data characterize personality traits of one group of physicians who become involved sexually with patients.

The results from the MMPI indicate substantial levels of psychopathology for the 2 psychiatrists who had their licences revoked. Both had clinically significant scale elevations on the Psychopathic Deviancy and Hypomania scales. They also produced an MMPI profile code type known as 4/9 or 9/4 and had an elevated K scale. The Psychopathic Deviancy scale was developed to measure antisocial tendencies or psychopathic behaviour. Individuals who score high on this scale typically have difficulty incorporating the values and standards of society and are likely to engage in lying, cheating, stealing, and sexual acting out (17). They also show poor judgement, take risks, and typically do not learn from past experiences. The Hypomania scale was developed to identify psychiatric patients manifesting hypomanic symptoms. Individuals with high scores on this scale are likely to be energetic and talkative, and prefer action to thought. They have great difficulty in inhibiting expression of impulses. It is not uncommon for these individuals to have an exaggerated appraisal of their own self-worth and self-importance (17).

Standard interpretative MMPI manuals invariably describe the most salient feature of the 4/9 code type as characterizing individuals who have a marked disregard for social standards and values. Such individuals typically have great difficulty with authorities and are also described as having poorly developed consciences and fluctuating ethical values. They are seen as selfish and self-indulgent and are not very successful in delaying the gratification of their impulses (17).

The K scale is one of the 3 "validity scales" on the MMPI that measure the extent to which one has attempted to deny psychopathology and/or to present oneself in a favourable light. Other characteristics associated with high K scores are a lack of both insight and self-understanding. An increased K scale score, when coupled with significant elevations on the clinical scales, as was the case with the 2 psychiatrists who had their licences revoked, implies character difficulties that are compounded by little or no awareness of such problems (17). While individuals with a university education typically score higher on this scale relative to less educated persons, the 2 psychiatrists who lost their licences scored higher than most (89%) of the remaining male respondents in this study. It is reasonable to assume, therefore, that these 2 psychiatrists differ from their cohorts, at least in this sample.

In summary, MMPI profiles of the 2 psychiatrists who had their licences revoked because of boundary violations revealed evidence of: 1) antisocial attitudes and behaviours, and 2) defensive cognitive-perceptual style, both characteristics that were generally absent in the study participants who did not have their licences revoked. Of consideration, these 2 individuals were not distinguished by other criteria; their assessments by interviewers and supervisors, as well as their academic examinations, were far above average or nearly excellent. This latter observation, which is consistent with that reported in the literature, may in part be a function of these individuals' need for admiration and their ability to

comply with the external expectations of a training program while presenting themselves in a favourable way in order to gain approval.

A major question arising from this study is whether the MMPI or other similar measures should be used predictively to help assess the suitability of applicants for a residency program in psychiatry. If so, what are the criteria and how are they to be interpreted? For example, to our knowledge, none of the remaining 38 psychiatrists in our sample has a history of problems with the licencing college, yet 11% of these individuals produced 2-point profiles that are consistent with a personality disorder similar to the 2 psychiatrists who did lose their licences, and 5% were classified according to Skinner and Jackson's modal profile analysis as sociopathic (16).

Putting aside for the moment the diagnostic accuracy of the MMPI, would it have been ethical to deny a residency in psychiatry to those applicants who produced sociopathic profiles in order to prevent the 2 individuals now known to have engaged in boundary violations from becoming psychiatrists (of whom only one would have been characterized as sociopathic by Skinner and Jackson's analysis)? Put differently, is the protection of the public and the preservation of the integrity of the practice of psychiatry reasonable grounds to "wrongly" deny 4 physicians access to their field of choice? If not, then what is an acceptable rate of false positives? Closely related to this question is the issue of whether the MMPI or any other measure could be used to identify people at risk for such behaviours. Such screening may not necessarily be for acceptance to residency programs, but rather for education or counselling. If so, how effective will such endeavours be with this population?

In addressing questions such as these, one must consider again the particular exigencies of a psychotherapeutic practice. For patients, the power differential, the disturbances that brought them to therapy initially, and the inevitable emergence of historically based, infantile feelings in the transference continue to create a context of extreme vulnerability. Not infrequently, patients entrapped by an unconscious reenactment of a role-reversal and highly attuned to the psychotherapist's needs and wishes become the caretakers of the therapist. The regressive state and the attendant guilty and shameful feelings evoked by the incestuous involvement make patients further susceptible to the psychological manipulations that exploitive therapists may use to strengthen the bondage.

Although transference elements are present in all relationships, there is no other situation so likely as the psychotherapy context to provoke powerful primitive feelings or, in its isolation from everyday reality, so likely to be permissive of the acting out of those very feelings and fantasies. In this context, it should be noted that the damage done by sexual abuse in a therapy relationship is in direct proportion to the

extent of the original psychopathology of the victim. The consequences for even highly functioning individuals are severe and comparable to other posttraumatic states such as rape response syndrome (6).

Additional considerations in the development of criterion-based acceptance to training programs include the evidence that 80% of incidents of sexual exploitations are attributable to repeat offenders, that offenders were more likely to have had a personal analysis or psychotherapy, and that attempts to rehabilitate repeat offenders have been largely unsuccessful.

As a consequence of the great concern about psychiatrists who become sexually involved with their patients, there has been effort recently focused on early education for prevention, especially in the area of psychotherapy supervision and in disclosure about abuse, and on an appropriate deterrent action by the profession when these violations do occur. For some psychiatrists, however, these behaviours represent aspects of ongoing patterns of relationships.

This study shows that psychiatrists who sexually abused their patients have significant character pathology. Use of personality screening instruments, such as the MMPI, might facilitate identifying those at risk—but with the possibility of misclassifying those who are not. For example, while the true positive rate for the 4/9 or 9/4 MMPI code type was 100%, the positive predictive value was only 33%. Because we had no information on psychiatrists who *did not* have a reported boundary violation and who actually did or did not commit a violation, however, we were unable to calculate the overall hit rate, sensitivity, specificity and negative predictive value—information that would prove helpful in determining whether or not to employ such screening. Nevertheless, if we work from the presumption that all those who committed a violation were reported to their provincial college over the 17-year period—a reasonable presumption, we believe, for the most egregious instances of boundary violation—and if we use the 4/9 or 9/4 code type, the following classification rates would apply: overall hit rate = 90%, sensitivity 100%, specificity 89%, positive predictive value 33%, negative predictive value 100%. These classification figures are established on a prevalence rate of 15% for the occurrence of a 4/9 or 9/4 MMPI code type, and a base rate of 5% for boundary violations, both derived from the present sample; different base rates could produce very different classification rates. Using this type of information may also prove valuable for specific counselling and education, although the benefits of counselling have not yet been demonstrated with psychiatrists with long-standing character pathology.

Boundary violations by psychiatrists are far too common. Partly, this reflects inadequacies in our education programs and in psychotherapy supervision. Even improved training programs, however, are intrinsically limited by the level of integrity and capacity for self-awareness of the trainees. Certain personality traits may be predictive of the propensity

for boundary violations, and given that the stakes are so high, perhaps an acceptance of restrictive criterion variables is warranted. We need more awareness of this on the part of educators and further research to define more accurately those at risk.

Clinical Implications

- This paper should increase awareness of the frequency of sexual boundary violations.
- It outlines therapist characteristics related to later sexual abuse.
- The study presents early identification factors for those individuals at risk.

Limitations

- This is not a study of prevalence.
- This study does not identify therapists who have abused, but who have not been reported to their provincial college.

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Résumé

Objectif : *Démontrer que l'abus sexuel des patients par les psychiatres peut découler de divers facteurs, pouvant comprendre des styles de personnalité psychopathiques et narcissiques chez les thérapeutes.*

Méthode : *On a examiné les données d'une cohorte prospective de résidents en psychiatrie pour évaluer les traits de personnalité de 2 psychiatres reconnus coupables d'avoir transgressé des interdits.*

Résultats : *Dès le début de leur formation de résidents, on pouvait identifier les 2 psychiatres qui ont perdu leur permis d'exercice parce qu'il s'agissait de personnes atteintes de pathologie caractérielle importante.*

Conclusions : *Pour certains psychiatres, l'abus sexuel répétitif des patients représente un aspect d'un modèle évolutif de relations axées sur l'exploitation. Les conséquences professionnelles et éthiques de ces constatations font l'objet d'une discussion.*