

SEX OUTSIDE OF THE THERAPY HOUR: * PRACTICAL AND CONSTITUTIONAL LIMITS ON THERAPIST SEXUAL MISCONDUCT REGULATIONS

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In many states, sexual misconduct regulations categorically prohibit various healthcare professionals from having sexual contact with current patients and with former patients for years after the end of therapy. In many instances, these categorical bans reach conduct that gives no cause for concern: fewer harms are risked by sex between an optician and a former client, for instance, than are risked by sex between a psychologist and a former patient. This Comment identifies precisely what are the harms we should worry about in these types of healthcare professions, and explains why these harms don't apply equally in all professions or cases. It then proposes a model code standard that addresses the identified harms while permitting harmless relationships.

The existence of a standard alternative to a categorical ban is important because the United States and many state constitutions recognize rights of sexual autonomy that are significantly burdened by categorical bans. This Comment argues that many current regulations are unconstitutional largely because the alternative would do just as well at preventing the harms risked by sexual relationships. This is extremely important for healthcare professionals who wish to engage in harmless relationships, however few and far between. States must provide more substantial justification for categorical bans that appear to negatively affect only a few unlucky citizens if those citizens are supported by constitutional rights.

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* From the autobiographical *Sex in The Therapy Hour: A Case of Professional Incest*. CAROLYN M. BATES & ANNETTE M. BRODSKY, *SEX IN THE THERAPY HOUR: A CASE OF PROFESSIONAL INCEST* (1989).

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INTRODUCTION

In nearly two dozen states, a psychologist risks losing his license to practice if he has sex with a former client within one, two, or even five years of the end of treatment.¹ Some of these states have extended similar restrictions to other

1. For one year, see, e.g., N.M. CODE R. § 16.22.2.9 (Weil 2006). For two years, see, e.g., ALA. ADMIN. CODE r. 750-X-5-.03(2)(b) (Supp. 2004); FLA. ADMIN. CODE ANN. r. 64B4-10.003 (1998); ILL. ADMIN. CODE tit. 68, § 1400.80 (2007); 868 IND. ADMIN. CODE 1.1-11-4.5 (2002); MD. CODE REGS. 10.36.05.07(C) (Supp. 2006); 49 PA. CODE § 41.83 (2005); UTAH ADMIN. CODE r. 156-61-502(9) (2008).

healthcare professionals. Social workers may not have sex with former clients within one year of treatment in Oklahoma,² within eighteen months of treatment in Montana,³ and for an undefined time period in Massachusetts⁴ and Minnesota.⁵ In Washington, massage therapists and opticians risk losing their licenses if they “solicit a date with” a former client within two years of treatment.⁶

This is a small sample of sexual misconduct regulations that categorically prohibit sexual contact between healthcare professionals and their former clients.⁷ As a result of one of these types of bans, a massage therapist in Minnesota recently lost her license after she dated, moved in with, and married a former client within the two-year period during which sexual contact is prohibited.⁸ A psychologist in Florida also lost his license for beginning to date (and then dating happily for six years) a former patient a year after treatment ended.⁹ Other cases like this rarely appear in the courts, but the mere existence of such regulations may prevent harmless romantic relationships or force the participants to keep their relationship secret.

Sensational news stories appear to provide good reasons to worry about sexual contact between healthcare professionals and their clients. For instance, Washington’s regulation of opticians may seem quite appropriate and necessary when, three months before the regulation passed, an optometrist touched a client’s breasts and then masturbated in front of her.¹⁰ But despite (and even in) situations like these, is a categorical prohibition on sexual relationships desirable? In this Comment, I explain when and why the

For five years, *see, e.g.*, MO. CODE REGS. ANN. tit. 20, § 2235-5.030(6)(C)(2) (2007); 18 VA. ADMIN. CODE § 115-20-130(D)(2) (2006).

2. OKLA. ADMIN. CODE § 675:20-1-4(d) (2006).

3. MONT. ADMIN. R. 24.219.2305(e) (2004).

4. 258 MASS. CODE REGS. 20.06 (2003).

5. MINN. R. 8740.0325(8) (2007).

6. The restriction is set out for all “health care provider[s]” in WASH. ADMIN. CODE 246-16-100 (2007). Opticians and massage operators are healthcare providers under *id.* at 246-16-020(2) and WASH. REV. CODE ANN. §§ 18-130-040(2)(a)(i), (2)(a)(v) (West Supp. 2009).

7. See *infra* Part I for more examples.

8. See *In re Fjellmann*, No. 11-0900-17165-2, 2006 WL 3147575 (Minn. Office of Admin. Hearings Sept. 11, 2006); MINN. STAT. § 146A.08(1)(d) (2006 & Supp. 2007).

9. See *Caddy v. State, Dep’t of Health, Bd. Of Psychology*, 764 So. 2d 625, 626–27 (Fla. Dist. Ct. App. 2000). The psychologist’s license was restored after the Florida Supreme Court ruled that the regulation unconstitutionally burdened his right to privacy. See discussion *infra* Part VI.

10. See Wash. State Dep’t of Health, News Release, Douglas County Optometrist Restricted for Charges of Sexual Misconduct (June 7, 2006), http://www.doh.wa.gov/Publicat/2006_news/06-084.htm. The news of the abuse was issued on June 7, 2006. *Id.* The regulation was filed on August 30, 2006, and passed on September 30, 2006. See WASH. ADMIN. CODE 246-16-100.

answer is no, by taking a novel look at what should motivate sexual misconduct regulations in all healthcare professions.¹¹

Part I provides a sample of current regulations. These regulations seem to appear most often in response to obvious misconduct like the Washington optician's.¹² But it's important to understand that sexual misconduct regulations don't need to address his sort of behavior. He violated sexual assault and indecent exposure statutes that prohibit nonconsensual sexual activity.¹³ So long as these statutes are enforced, sexual misconduct regulations should be primarily directed at behavior that, although consensual, still gives cause for concern for some other reason.

Part II examines in detail the harms risked by consensual sexual contact between a psychotherapist and a current patient in order to understand the concerns underlying sexual misconduct regulations. Most of these harms may be understood as derivative of one of two concerns. First, patients of psychotherapists often lack some capacity to appreciate the risks of sexual intimacies with their therapists and to make autonomous decisions regarding those risks. Second, psychotherapists who engage in sexual relationships with their patients risk creating a conflict of interest that impairs their judgment about the patient's treatment. These two concerns are legally significant because

11. Previous articles and comments on sexual misconduct regulations have had different explanations for sexual misconduct regulations and/or narrower scopes in applying those explanations. See, e.g., Phyllis Coleman, *Sex Between Psychiatrist and Former Patient: A Proposal for a "No Harm, No Foul" Rule*, 41 OKLA. L. REV. 1 (1988); Linda Jorgenson, Rebecca Randles & Larry Strasburger, *The Furor Over Psychotherapist-Patient Sexual Contact: New Solutions to an Old Problem*, 32 WM. & MARY L. REV. 645 (1991); Ronald J. Maurer, *Ohio Psychotherapist Civil Liability for Sexual Relations with Former Patients*, 26 U. TOL. L. REV. 547 (1995); Tanya J. Dobash, Note, *Physician-Patient Sexual Contact: The Battle Between the State and the Medical Profession*, 50 WASH. & LEE L. REV. 1725 (1993); Teresa K. Douglass, Comment, *Psychotherapist Sexual Misconduct: A Proposal for Legislative Change in Missouri*, 62 U. MO. KAN. CITY L. REV. 777 (1994); Matt J. O'Laughlin, Note, *Dr. Strangelove: Therapist-Client Dual Relationship Bans and Freedom of Association, or How I Learned to Stop Worrying and Love My Clients*, 69 U. MO. KAN. CITY L. REV. 697 (2001).

12. For instance, Washington's comprehensive regulations followed a series of news reports documenting the extent of sexual abuse by healthcare professionals. See, e.g., Michael J. Berens and Julia Sommerfeld, *License to Harm: Weak Regulation Fosters More Abuse*, SEATTLE TIMES, May 9, 2006, available at http://seattletimes.nwsourc.com/html/licensetoharm/2002947883_sexmed23.html. Ohio passed a law criminalizing sex between psychologists and their patients following similar news reporting. See David Milne, *Psychologists' Disciplinary Failure Leads to New Law in Ohio*, PSYCHIATRIC NEWS, Mar. 15, 2002, at 18.

13. Sexual assault statutes vary by state, but generally prohibit nonconsensual touching. Washington's law prohibits "Indecent liberties": "knowingly caus[ing] another person who is not his or her spouse to have sexual contact." WASH. REV. CODE ANN. § 9A.44.100 (West Supp. 2008). Indecent exposure statutes generally prohibit purposefully displaying one's genitals to someone who will be offended. See, e.g., WASH. REV. CODE ANN. § 9A.88.010 (West Supp. 2008) (prohibiting "intentionally mak[ing] any open and obscene exposure of his or her person or the person of another knowing that such conduct is likely to cause reasonable affront or alarm").

a psychotherapist's fiduciary duty obligates him to look out for a patient's best interests when she can not adequately do it for herself, and to ensure that his judgment about her treatment is always the most objective it can be.¹⁴

The remainder of the Comment provides a model code standard and then assesses, on both practical and constitutional grounds, when that standard should (and must) be preferred to a categorical ban. Part III proposes the standard. Part IV compares the standard to categorical bans in contexts where categorical bans currently exist. Parts V and VI then evaluate federal and state constitutional limitations, respectively, on sexual misconduct regulations.

Specifically, the federal Constitution requires significant tailoring of regulations that burden rights of sexual autonomy, intimate association, and marriage.¹⁵ Of particular interest, *Lawrence v. Texas*¹⁶ established that the Constitution "gives substantial protection to adult persons in deciding how to conduct their private lives in matters pertaining to sex."¹⁷ Sexual misconduct regulations in healthcare professions provide an excellent opportunity to explore the precise scope of this protection. Did Justice Kennedy's exclusion of sexual relations that are nonconsensual or abusive of an institution mean to apply to sex between a healthcare professional and client or former client? In Part V, I answer this question no. I also address the scope and application of the constitutional right to marry.

Additionally, many states have found constitutional rights to privacy encompassing a right to sexual autonomy that is greater than the right under *Lawrence*. In these states, regulations burdening a person's right to engage in private, consensual sex with another adult must be supported by a compelling state interest, and must have no less restrictive alternative. Using this level of review, the Florida Supreme Court in 2000 struck down a regulation that prohibited psychologist-patient sexual relationships for an indefinite time period after the termination of the professional relationship.¹⁸ Part VI explains the argument for invalidating Florida's regulation and applies it to other regulations that appear to equally burden constitutional rights.

14. See *infra* Part II. Throughout the Comment, I refer to the healthcare professional as a he and the patient as a she, for clarity and because most professionals violating sexual misconduct regulations are men and their patient-victims women.

15. See *Lawrence v. Texas*, 539 U.S. 558 (2003) (on the right to sexual autonomy); *Roberts v. U.S. Jaycees*, 468 U.S. 609 (1984) (on the right to intimate association); *Zablocki v. Redhail*, 434 U.S. 374 (1978) (on the right to marry); *Loving v. Virginia*, 388 U.S. 1 (1967) (on the right to marry); *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923) (on the right to marry).

16. 539 U.S. 558.

17. *Id.* at 572.

18. See *Caddy v. State, Dep't of Health, Bd. of Psychology*, 764 So. 2d 625 (Fla. Dist. Ct. App. 2000).

These constitutional arguments comprise a small portion of this Comment's space, but their substance is critical. Without constitutional support, many healthcare professionals who wish to engage in harmless sexual relationships will have little success challenging categorical prohibitions. A state can easily justify on practical grounds a sweeping ban if it only appears to negatively affect a few unlucky citizens. But if these few citizens have the federal or state constitutions behind them, the state must provide more substantial support for even limited overreaching.

I. A SAMPLE OF CURRENT REGULATIONS

A typical sexual misconduct regulation looks like this one from Alabama, which reflects the American Psychological Association's (APA) Code of Conduct:¹⁹

The Board shall . . . revoke any license to practice as a psychologist . . . whenever the Board finds . . . that the psychologist . . . has engaged in any of the following acts or offenses: . . .

(b) The licensee in interacting with a client or former client to whom the licensee has at anytime within the previous 24 months rendered any professional psychological services, shall not:

(i) engage in any verbal or physical behavior toward him/her which is sexually seductive, demeaning, or harassing; or

(ii) engage in sexual intercourse or other sexual intimacies with him/her . . .

(c) The prohibitions set out in (b) above shall not be limited to a period of twenty-four (24) months but shall continue indefinitely if the client is determined by the Board to be vulnerable, by reason of emotional or cognitive disorder, to exploitive influence by the licensee.²⁰

The rest of this section provides two sets of sample regulations from other professions. The first set includes regulations from psychotherapeutic

19. AM. PSYCHOLOGICAL ASS'N, ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT §§ 10.05, 10.08 (2002), available at <http://www.apa.org/ethics/code2002.html>. The American Psychological Association (APA) Code also forbids psychologists from "engag[ing] in sexual intimacies with individuals they know to be close relatives, guardians, or significant others of current clients/patients." *Id.* § 10.06. Other examples of proposed restrictions by national associations include the American Counseling Association, which has a ban of five years on relationships with former clients, AM. COUNSELING ASS'N, CODE OF ETHICS § A.5.b (2005), available at <http://www.counseling.org/Files/FD.ashx?guid=ab7c1272-71c4-46cf-848c-f98489937dda>, and the American Association for Marriage and Family Therapy, which has a two-year ban, AM. ASS'N FOR MARRIAGE AND FAMILY THERAPY, AAMFT CODE OF ETHICS § 1.5 (2001), available at http://www.aamft.org/resources/lrm_plan/Ethics/ethicscode2001.asp.

20. ALA. ADMIN. CODE r. 750-x-5-.03(1), (2)(b)-(c) (Supp. 2004).

professions: psychology, psychiatry, counseling, and social work. These professions primarily treat mental disorders. The second set of examples includes regulations from all other healthcare professions, including chiropractors, massage therapists, and opticians, among others. I describe this set generally as nonpsychotherapeutic professionals, since the primary therapeutic focus is not the patient's mental health.²¹

A. Regulations in Psychotherapeutic Professions

Psychologists in Virginia and Missouri may not have sexual contact with former clients for five years following the end of the treatment, and many other states have two-year bans.²²

Substance abuse therapists in North Carolina may not have sexual contact with their own former clients, or with the former clients of therapists working at the same agency, within two years of therapy.²³ Substance abuse therapists may not have sex with former clients for five years after treatment in Virginia,²⁴ and for an undefined time period in Oklahoma.²⁵

Marriage and family therapists may not have sex with former clients within two years of treatment in Kentucky or New Jersey.²⁶

Social workers may not have sex with former clients within one year of treatment in Oklahoma, within eighteen months of treatment in Montana, and for an undefined time period in Massachusetts and Minnesota.²⁷ In Pennsylvania, they may not have sex with former patients, or with the family members of former patients, for seven years following the end of treatment.²⁸

21. Of course, the dichotomy is not perfectly clear. Some chiropractors, for instance, believe that holistic chiropractic treatment should address both physical and mental issues. See *infra* Part IV.C. Nonetheless, I use the term psychotherapy only in reference to those professions listed above that primarily treat a patient's mental health.

22. MO. CODE REGS. ANN. tit. 20, § 2235-5.030 (2007); 18 VA. ADMIN. CODE § 115-20-130 (2006).

23. 21 N.C. ADMIN. CODE 68.0509(d)(2), (d)(4) (2008).

24. 18 VA. ADMIN. CODE § 115-60-130(D)(2) (2006).

25. OKLA. ADMIN. CODE § 38:10-3-4 (2006).

26. 201 KY. ADMIN. REGS. 32:050(2)(c), 38:060(2)(c) (2007); NJ ADMIN. CODE 13:34-28.3 (Supp. 2008).

27. OKLA. ADMIN. CODE § 675:20-1-4(d) (2006); MONT. ADMIN. R. 24.219.2305(e) (2004); 258 MASS. CODE REGS. 20.06 (2003); MINN. R. 8740.0325(8) (2007).

28. 49 PA. CODE § 47.63 (2005).

B. Regulations in Nonpsychotherapeutic Professions

Occupational therapists in Arizona may not “mak[e] sexual advances” to former clients within six months of treatment.²⁹

Chiropractors may not have sex with a former client within one year of treatment in Utah, or six months of treatment in Tennessee.³⁰ Chiropractors in Massachusetts may not have sexual contact with someone to whom they gave professional consultation within three months of that consultation.³¹

Acupuncturists in Missouri may not have sex with former clients within six months of treatment.³²

Massage therapists in Minnesota, and professionals in any other “complementary and alternative health care” practitioners, including practitioners of “aroma therapy,” “folk practices,” and “meditation,” may not have sexual contact with clients or former clients to whom they have given service within the past two years.³³

Opticians, massage operators, and dental hygienists in Washington may not have sexual contact with former clients for two years after treatment, or with “immediate family members” of clients or anyone else “who would be reasonably expected to play a significant role in the health care decisions of the patient or client.”³⁴

II. IDENTIFYING THE PROBLEM AND HOW TO PREVENT IT

In identifying the problem with sexual intimacies between healthcare professionals and their clients, we are not concerned with cases where some other law or regulation would obviously cover the conduct at issue. For instance, nonconsensual sexual contact with a client or unwanted exposure

29. “Sexually inappropriate conduct” is prohibited for six months following treatment in ARIZ. ADMIN. CODE § R4-43-101(5)(j) (2000). It is defined to include “[m]aking sexual advances” in ARIZ. REV. STAT. ANN. 32-3401 (Supp. 2008).

30. UTAH ADMIN. CODE r. 156-73-501(4) (2003); TENN. COMP. R. & REGS 0260-2-13(8)(d) (2007).

31. 233 MASS. CODE REGS. 4.06(14) (2005).

32. MO. CODE REGS. ANN. tit. 20, § 2015-3.020(2)(E) (2006).

33. Complementary and alternate health care practices are defined in MINN. STAT. § 146A.01(4) (2006). The prohibition on sexual contact is set out in MINN. STAT. § 146A.08(d) (2006 & Supp. 2007).

34. The restriction is set out for all “health care provider[s]” in WASH. ADMIN. CODE § 246-16-100(1), (3) (2007). Opticians and massage operators are healthcare providers under WASH. ADMIN. CODE § 246-16-020(2) (2007) and WASH. REV. CODE ANN. § 18.130.040 (2)(a)(i), (2)(a)(v) (West Supp. 2009).

of private parts to a client would likely be criminal under sexual assault³⁵ or indecent exposure³⁶ statutes, and the professional could be sanctioned by the licensure board for having committed the crime. Blackmail or extortion—threats to expose the secrets of a client if the client does not do something sexual—are not criminal in most jurisdictions, but such acts would clearly violate any professional’s fiduciary duty to keep secret what has been disclosed in confidence.³⁷

Consider the case of the Washington optician who exposed himself to a client. He would be guilty of indecent exposure, and would be subject to his licensure board’s disciplinary sanctions for his crime. Similarly, a dentist or a gynecologist who improperly touches a patient under anesthesia would likely be guilty of sexual assault, and could lose his license for that crime.³⁸

The purpose of sexual misconduct regulations can thus be limited to those cases of sexual contact that are not criminal but for some other reasons still should be prohibited. Figuring out these reasons is the goal of this Part. The discussion focuses on psychotherapists and current patients, because that’s where we find the most scholarship, and the most harm to patients.

A. The Harms of Sex Between a (Psycho)Therapist and a Current Patient

There are three distinct harms risked by sexual contact between a psychotherapist and a current patient. First, sexual contact risks causing the patient emotional and mental harm.³⁹ Second, sexual contact risks impairing the psychotherapist’s judgment and harming the effectiveness of the therapy.⁴⁰ Third, sexual contact risks harming the reputation (and consequently the general success) of the profession.⁴¹ In this section I explain the risk and gravity of each of these harms.

35. See, for example, CAL. PENAL CODE § 11165.1 (West Supp. 2008), which defines sexual assault to include rape, sodomy, and sexual penetration, and N.Y. PENAL LAW § 130.20 (McKinney 2004), which defines “sexual misconduct” as “engag[ing] in sexual intercourse with another person without such person’s consent”.

36. This conduct is criminal under indecent exposure statutes, which prohibit exposing “private parts . . . in any place where there are present other persons to be offended.” CAL. PENAL CODE § 314 (West 2008).

37. See BLACK’S LAW DICTIONARY 545 (8th ed. 2004) (defining fiduciary duty as “[a] duty of utmost good faith, trust, confidence, and candor . . . a duty to act with the highest degree of honesty and loyalty”). Clearly disclosing secrets would breach a duty of confidence and loyalty.

38. See, e.g., *Sex Charges for Dentist*, N.Y. TIMES, July 27, 2003 §14WC (Westchester Weekly Desk), at 7.

39. See *infra* Part II.A.1.

40. See *infra* Part II.A.2.

41. See *infra* Part II.A.3.

It turns out that the three harms are for the most part derivative of two concerns. The first is the concern that patients of psychotherapists often can not adequately appreciate the risks of engaging in a sexual relationship with their psychotherapists, which diminishes their capacity to make autonomous decisions about those risks. Second, a psychotherapist who engages in a sexual relationship with a patient risks creating a conflict of interest that may reduce the effectiveness of therapy.

1. Harm to Patient's Health

Patients who have sexual contact with their psychotherapists have reported many symptoms. Kenneth Pope and Jacqueline Bouhoutsos describe a particular syndrome that includes, among other things, "ambivalence, guilt, feelings of emptiness," "inability to trust," "sexual confusion," and "increased suicidal risk."⁴² Other effects have included "depression and other emotional disturbances, impaired social adjustment, and substance abuse."⁴³

These harms, of course, are not uniquely risked by patients of psychotherapists, but are consequences of many failed relationships. To distinguish harms to psychotherapy patients from ordinary relationship harms—and to justify sexual misconduct regulations generally—commentators turn to a few buzzwords: vulnerability, transference, and exploitation.⁴⁴ In their ordinary meanings these terms apply to many situations that deserve and receive no legal sanction. Rarely do commentators clarify what the words mean in the context of harm to a patient. Elucidating the real meaning of these buzzwords will help to understand the justification for treating harm to a patient of psychotherapy more seriously than harm to someone else.

Vulnerability. Patients of psychotherapists often must expose intimate details of their lives for effective treatment.⁴⁵ This means the patient effectively "set[s] aside his or her customary defenses," leaving the patient "uniquely vulnerable to the influence of the therapist."⁴⁶ Consider the following explanation from two prominent scholars:

42. KENNETH S. POPE & JACQUELINE C. BOUHOUTSOS, *SEXUAL INTIMACY BETWEEN THERAPISTS AND PATIENTS* 64 (1986). See generally *id.* at 57–68 (providing a general discussion of the "consequences of therapist-patient sexual intimacy").

43. GERALD COREY ET AL., *ISSUES AND ETHICS IN THE HELPING PROFESSIONS* 249 (1998).

44. See discussion *infra* notes 63–92.

45. See POPE & BOUHOUTSOS, *supra* note 42, at 46 ("Discussion of the necessity of a trusting relationship is customarily a part of therapy, and therapists frequently emphasize complete trust as a requisite for progress in the therapeutic process.") (citing Judd Marmor, *Designated Discussion*, in *ETHICAL ISSUES IN SEX THERAPY AND RESEARCH* 157, 159 (William H. Masters et al., eds., 1977)).

46. Marmor, *supra* note 45, at 159.

We speak to therapists about our deepest secrets. We let them see us in our darkest and worst moments. . . . [I]n the same way that we allow a health care professional concerned with our physical health to examine and interact with our most private bodily parts, we allow a health care professional concerned with our emotional and psychological well-being to “see” our most private emotional and psychological aspects. Just as a careless move by a surgeon can have lethal consequences, careless words and other interventions by a psychotherapist can produce enormously destructive—sometimes lethal—consequences.⁴⁷

Such exposure is, of course, a condition of many ordinary relationships, and its consequences can be just as destructive in ordinary relationships. The vulnerability with which we are concerned must be one unique to the psychotherapeutic relationship. It could be unique in two ways.⁴⁸

First, many patients are more likely to disclose to their psychotherapists intimate details that they would not share with any other person, and their exposure is one-sided; the psychotherapist does not reciprocate.⁴⁹ For a patient to feel comfortable with that one-sided vulnerability, she must intimately trust her psychotherapist.⁵⁰ This trust or reliance includes in it the belief that the therapist, perhaps like a parent, will make good decisions and not hurt the patient.⁵¹

This increases the risk of the harmful symptoms described above because a patient who firmly believes that her therapist makes the best decisions for her will be less likely to identify and appreciate on her own the risks of carrying on a sexual relationship. She may think, “If my therapist is willing, then it must be OK for me.” In this sense, vulnerability refers to a patient’s sacrifice to the therapist of some of her usual ability to make autonomous decisions and look out for her own interests.⁵²

47. POPE & BOUHOUTSOS, *supra* note 42, at 22–23.

48. One author makes the same distinction that I do, noting that vulnerability has “two major factors to be considered, namely, the presence of a preexisting condition, and the operation of the transference process.” Shirley Feldman-Summers, *Sexual Contact in Fiduciary Relationships*, in *SEXUAL EXPLOITATION IN PROFESSIONAL RELATIONSHIPS* 195 (Glen O. Gabbard ed., 1989) [hereinafter *SEXUAL EXPLOITATION I*].

49. See JERRY EDELWICH WITH ARCHIE BRODSKY, *SEXUAL DILEMMAS FOR THE HELPING PROFESSIONAL* 95 (1982) (“Lovers normally get to know each other by sharing intimate information on an equal basis. A clinician gets to know a client by being given privileged, unreciprocated access to the most vulnerable parts of the client’s being, including fears and insecurities about intimate relationships.”).

50. See POPE & BOUHOUTSOS, *supra* note 42, at 46.

51. *Id.* at 53.

52. A couple of scholar-therapists have suggested, albeit without much analysis, similar interpretations of the significance of vulnerability. See, e.g., Feldman-Summers, *supra* note 48, at

Defining vulnerability in this way helps to legitimate the state's involvement in preventing harms that appear ordinary. Where a patient—or any person, for that matter—fully appreciates the risk of harms resulting from a sexual relationship, we presume that she knows better than anyone else, including the state, whether she should enter that relationship. If the patient cannot fully appreciate those risks, we might accept the state's involvement to the extent that the state can help her identify the risks or avoid accepting risks that she did not fully appreciate.

Second, patients of psychotherapy are more likely to be victims of preexisting conditions⁵³ that could make them experience the harms above more frequently or more seriously.⁵⁴ The harms are not unique to psychotherapist-patient relationships, since preexisting conditions are not unique to patients of psychotherapists. But the risk of those harms is very likely uniquely high, due to a greater rate of preexisting conditions among patients of psychotherapists.⁵⁵

Transference. Some patients of psychotherapy experience transference, wherein the patient unconsciously assigns or redirects to her therapist feelings and attitudes previously associated with another figure in the patient's life.⁵⁶ A patient may, for instance, begin to feel that she loves her psychotherapist, when in fact she has merely transferred to him feelings that she has (or had) for a past boyfriend.⁵⁷

195 (identifying as one aspect of vulnerability preexisting conditions that “interfere[] with judgment [or] diminish[] the client’s ability (or desire) to make rational decisions”); Paul S. Appelbaum & Linda Jorgenson, *Psychotherapist-Patient Sexual Contact After Termination of Treatment*, 148 AM. J. PSYCHIATRY 1466, 1469 (1991) (noting that patients of psychotherapists often have a “significantly impaired ability to decide whether to have sexual contact with the therapist”).

53. Examples include “depressed patients . . . patients who have a history of child sexual and physical abuse; patients with serious psychiatric illness or substance abuse problems,” and others. Elizabeth F. Kuniholm & Kim Church, *Psychotherapist Malpractice* 7 (2002), http://kuniholmlaw.com/articles_briefs_pdf/article_PM_efk_kc_2002.pdf.

54. The “severity of the impact of the sexual relationship can be predicted by prior vulnerability and by the martial [sic] status of the practitioner. That is, patients who already have severe problems will suffer more damage from a sexual relationship with a therapist than those who are not as vulnerable to begin with.” POPE & BOUHOUTSOS, *supra* note 42, at 61. See also Kuniholm & Church, *supra* note 53, at 6–8.

55. See POPE & BOUHOUTSOS, *supra* note 42, at 23 (“[W]e customarily seek out health care professionals when we are hurting, when there is something wrong in our lives In extreme cases, our fundamental ability to perceive, think, and remember clearly may be impaired.”).

56. Richard G. Kopff, Jr. & Edward Nersessian, *Introduction to Section III*, in TEXTBOOK OF PSYCHOANALYSIS 419, 419 (Edward Nersessian & Richard G. Kopff, Jr. eds., 1995).

57. “When this [the therapist-patient] trust is betrayed, the impact is often as damaging as familial incest.” Glen Gabbard, *Introduction to SEXUAL EXPLOITATION I*, *supra* note 48, at xi, xi.

Some courts have rested their condemnations of psychotherapist-patient sexual relations completely on the psychotherapist's obligation not to mishandle transference. The Ninth Circuit wrote:

The crucial factor in the therapist-patient relationship which leads to the imposition of legal liability for conduct which arguably is no more exploitative of a patient than sexual involvement of a lawyer with a client, a priest or minister with a parishioner, or a gynecologist with a patient is that lawyers, ministers and gynecologists do not offer a course of treatment and counseling predicated upon handling the transference phenomenon.⁵⁸

The frequency and intensity of transference are, of course, difficult to estimate, but for at least two reasons it seems that this line of reasoning overstates the relevance and significance of transference.

First, there are reasons other than the transference phenomenon to worry more about sexual relationships between psychotherapists and their patients than relationships between lawyers or gynecologists and their clients. As just discussed, patients of psychotherapists are uniquely vulnerable for two reasons,⁵⁹ and those reasons don't apply in most other contexts: a lawyer's client, for instance, doesn't rely on the lawyer's judgment about matters related to sexual relationships, and a lawyer's client is presumably much less likely than a psychotherapist's client to have preexisting conditions that would diminish her ability to appreciate the risks of a sexual relationship with her lawyer.

Second, when transference is the reason for the relationship, the emotional damage that may result is relevant only if the patient is unaware that she is risking it.⁶⁰ She would be unaware of the risk if she were also unaware that her attraction to her therapist was based on transference emotions and not genuine attraction. In this sense, transference emotions can cause a patient to "consent to sexual contact without appreciating its damaging consequences."⁶¹ Transference, then, like a patient's vulnerability, is a relevant consideration to the extent that it makes a patient less able to appreciate the harms risked by a sexual relationship with her psychotherapist before making the decision to engage in that relationship.

58. *Simmons v. United States*, 805 F.2d 1363, 1366 (9th Cir. 1986). O'Laughlin, *supra* note 11, at 718–20 provides a list of cases in which courts have held that sexual relationships between psychotherapists and their patients constitute a mishandling of transference and grounds for liability. He persuasively argues that this justification is simplistic or just mistaken.

59. See *supra* text accompanying notes 49–54.

60. See discussion *supra* page 994.

61. Kuniholm & Church, *supra* note 53, at 1.

This is a very different concern than the simple existence of transference, because transference happens in all human relationships and is not unique to psychotherapy.⁶² Just like the harms above, it's only a significant concern if it is more intense or more frequent in psychotherapy. In psychoanalysis, the "elucidation of transference" is considered central to patient healing.⁶³ Psychoanalysts may encourage their patients to experience transference, which would likely increase its prevalence or intensity.⁶⁴

But psychoanalysis (and perhaps general acceptance of transference's prevalence) appears to be on a steady decline as a method of psychotherapy.⁶⁵ And certainly we would expect transference to be less frequent and intense in other types of psychotherapy, where it isn't encouraged. At the very least, we should be wary of claims that transference is the sole (or even a significant) concern driving sexual misconduct regulations in psychotherapy. If it becomes clear that transference in psychotherapy is simply not that different from transference in ordinary human relationships, it is much less persuasive as an explanation for why states should prevent sexual relationships between psychotherapists and their patients.

Exploitation of power imbalance. The state of Washington's Uniform Disciplinary Act for healthcare practitioners has claimed that "[s]exual misconduct exploits the health care practitioner-patient relationship, is a violation of the public's trust and causes immeasurable harm, both physically

62. Edward M. Weinshel & Owen Renik, *Psychoanalytic Technique*, in TEXTBOOK OF PSYCHOANALYSIS, *supra* note 56, at 423, 430 ("Transference is an element of all relationships. . . . However, the arena in which the most definitive elucidation of transference takes place is the relationship between analyst and analysand."). It is difficult to come by statistics on the prevalence of transference in the area of psychotherapy where it is most encouraged: psychoanalysis. My suspicion is that it is overstated, perhaps because most of those writing on it are therapists themselves who I suspect have been indoctrinated to believe in its prevalence or who enjoy (unconsciously or not) thinking that their patients fall in love with them. Some patients only attend two or three therapy sessions, and it is hard to believe transference could occur in such a short period of time; others attend for longer, but with relatively minor problems whose resolutions often do not require deep invasions into the psyche of the sort that are more likely to cause transference.

63. *Id.* at 432 ("Elucidation of transference is the point of analysis and the source of its therapeutic benefits.").

64. "Far from being viewed as an impediment, the development of the transference and its analysis are now viewed as the very heart of the psychoanalytic process." Ethel Spector Person, *Introduction to ON FREUD'S "OBSERVATIONS ON TRANSFERENCE-LOVE"* 1, 5 (Ethel Spector Person et al. eds., 1993). See also SIGMUND FREUD, *Observations on Transference-Love*, in 12 THE STANDARD EDITION OF THE COMPLETE PSYCHOLOGICAL WORKS OF SIGMUND FREUD 157, 167-68 (James Strachey ed. & trans., 1958) (distinguishing genuine love from transference love by claiming that transference love is "provoked by the analytic situation").

65. See generally NATHAN G. HALE, JR., *THE RISE AND CRISIS OF PSYCHOANALYSIS IN THE UNITED STATES: FREUD AND THE AMERICANS 1917-1985* (1995); O'Laughlin, *supra* note 11, at 720-27.

and mentally, to the patient.”⁶⁶ The American Counseling Association (ACA) explains that “multiple relationships” (encompassing sexual intimacies with current clients) are unethical because they risk “exploitation”.⁶⁷ The American Psychiatric Association (APA II) warns that “the inherent inequality in the doctor-patient relationship may lead to exploitation of the patient.”⁶⁸ A textbook on ethics in counseling tells us: “Across the board, codes of ethics place a ban on ‘exploitation’ of clients.”⁶⁹

But what is exploitation?⁷⁰ Psychotherapists understand exploitation generally to be “using their positions of authority or power for personal gain,”⁷¹ or “[s]exual situations in which an adult in an authority position uses sex to take advantage of another person with less power.”⁷² Unfortunately, people use positions of authority or power for personal gain all the time, and while their behavior might be immoral or their gain unfair, they are not (and I suspect most people believe they should not be) legally punished.

A more specific definition provides that sexual exploitation is “a health professional’s intention to misuse the clinical setting for sexual contact.”⁷³ But what counts as misuse? Presumably not any use of the clinical setting is a

66. American Massage Therapy Association, Washington Chapter, Concise Explanatory Statement for WAC 246-16-010, -020, and -100 Standards of Professional Conduct (Sexual Misconduct), http://www.amta-wa.org/clientuploads/GR/WAC_246_16_Explanatory_Statement_9_06.pdf (last visited Mar. 11, 2009).

67. “A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist’s objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.” AM. PSYCHOLOGICAL ASS’N, *supra* note 19, at § 3.05(a). “Exploitation,” with no definition, also appears later in a general prohibition on “exploitative relationships,” and as the justification for prohibiting sexual intimacies with former clients even after the two-year wait period has passed. *Id.* §§ 3.08, 10.08.

68. AM. PSYCHIATRIC ASS’N, *THE PRINCIPLES OF MEDICAL ETHICS: WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY* 5 (12th ed. 2001).

69. R. ROCCO COTTONE & VILIA M. TARVYDAS, *ETHICAL AND PROFESSIONAL ISSUES IN COUNSELING* 31 (2d ed. 2003); *see, e.g.*, AM. COUNSELING ASS’N, *supra* note 19, at § A.5.b (requiring inquiry into “whether the interactions or relationship can be viewed as exploitive in some way and/or whether there is still potential to harm the former client; in cases of potential exploitation and/or harm, the counselor avoids entering such an interaction or relationship”); AM. ASS’N FOR MARRIAGE AND FAMILY THERAPY, *supra* note 19, at § 1.5 (requiring the therapist to prove “that there has been no exploitation or injury to the former client or to the client’s immediate family”).

70. Lest you think the concept of exploitation is intuitive, consider the fact that multiple books have been written just to explore the meaning of the word. *See, e.g.*, RUTH J. SAMPLE, *EXPLOITATION: WHAT IT IS AND WHY IT’S WRONG* (2003); ALAN WERTHEIMER, *EXPLOITATION* (1996).

71. Ofer Zur & Arnold A. Lazarus, *Six Arguments Against Dual Relationships and Their Rebuttals*, in *DUAL RELATIONSHIPS AND PSYCHOTHERAPY* 3, 3 (Arnold Lazarus & Ofer Zur eds., 2002).

72. *Part 1: Introduction to the Problem*, in *SEXUAL EXPLOITATION OF PATIENTS BY HEALTH PROFESSIONALS*, 4 *SEXUAL MEDICINE* 1, 1 (Ann W. Burgess & Carol R. Hartman eds., 1986) [hereinafter *SEXUAL EXPLOITATION II*].

73. *Id.*

misuse; that understanding would effectively preclude a psychotherapist from ever having sexual or romantic relationships with patients or former patients, unless they could completely disregard everything they had learned in the clinical setting.⁷⁴ Of course, some people might take a view like this, particularly in the context of psychotherapy. But they still must explain why the use of information learned in psychotherapy is different than the use of information learned, for instance, in social work or chiropractic therapy. What would make the former misuse, and the latter acceptable?

The concern underlying talk of a power imbalance or exploitation must be that it would be improper in some special way for a psychotherapist to use his position of power to seduce a vulnerable patient. But it would only be improper—it would only be “exploitative”—if the patient was unwilling to have a sexual relationship with her psychotherapist or could not fully appreciate the relationship’s risks. So the psychotherapist’s power is simply the converse of the patient’s vulnerability: the patient, for reasons discussed above, might lack some ability to fully appreciate the risks of engaging in a sexual relationship with her psychotherapist.⁷⁵

This point is well illustrated by thinking about how a psychotherapist would exploit the power imbalance between himself and a Steve Jobs or a Hillary Clinton. The psychotherapist would not be able to exploit his position as an educated and wealthy professional, since his patient would be more educated and more wealthy. Rather, in the psychotherapeutic setting, certain preexisting conditions, transference emotions, or just a unique reliance on the therapist’s judgment, can make even an ordinarily powerful patient rely on the psychotherapist’s advice about relationships without (consciously or not) making her own judgment about the risks.

In summary, these vague concepts—vulnerability, transference, and exploitation—should be understood to refer precisely to the patient’s diminished capacity to appreciate the risks of a sexual relationship with her psychotherapist and to make autonomous decisions regarding those risks.

74. An extreme view of sexual misconduct actually takes the view that psychotherapists should never have sexual contact with former patients, no matter how much time has passed. I do not believe this merits much discussion. The result of such a view would be prohibiting a relationship between a patient and a psychotherapist where the patient saw the therapist once on a whim, realized therapy was not effective for her, left for ten years, became a psychotherapist herself, and then ran into the therapist at the local Starbucks.

75. One seminal text hints at this distinction, but unfortunately does not seem to give it enough weight relative to other less persuasive interpretations of power. See EDELWICH WITH BRODSKY, *supra* note 49, at 43 (“A different type of power emanates from the clinician’s very being, as perceived by the client. To someone who is unhappy or in trouble, the helping professional . . . appears . . . as a repository of the ‘answers’ that will bring fulfillment.”).

2. Harm to the Effectiveness of Therapy

Commentators have noted at least four ways in which the effectiveness of therapy can be impaired by a sexual relationship between psychotherapist and patient.

First, a psychotherapist who carries on a dual relationship with a patient could have his professional judgment about that patient's therapy impaired by the sexual relationship, diminishing the quality of treatment.⁷⁶

Second, even if the psychotherapist's judgment is not affected by a sexual relationship with his patient, the patient might discount the value of the therapy if she feels she was taken advantage of.⁷⁷ A patient who feels that the therapist lied about his attraction to her or just used her for sex might also believe that the therapist's diagnostic and therapeutic pronouncements should not be trusted. This could moot much, or even all, of the therapy.

These first two harms are especially risked in psychotherapy because a psychotherapist analyzes and gives advice on his patients' personal and intimate relationships. A psychotherapeutic patient who suspects that her therapist lied about his attraction to her would be smart to discount the value of his advice about many of the things for which she might be being treated, since his professional advice and judgment extends to matters of her romantic life. A patient of a physical therapist, on the other hand, would have much less reason to believe that her therapist's advice and judgment about her physical therapy was insincere following a romance gone sour.

Third, commentators have also claimed that a sexual relationship between a psychotherapist and his current patient necessarily ends the patient's treatment.⁷⁸ "The physician, as a source of healing, support, and succor, becomes lost to his patient when he changes roles and becomes a lover."⁷⁹ This shouldn't be considered an independent justification for sexual misconduct regulations. It's more sensibly understood as a possible consequence of the harms supporting the above two justifications: a psychotherapist "becomes lost to his

76. See, e.g., COREY ET AL., *supra* note 43, at 249–50 ("[S]exual contact destroys the objectivity that is necessary for effective therapeutic relationships . . .") (citation omitted); POPE & BOUHOUTSOS, *supra* note 42, at 24 (claiming that psychotherapists who have sex with patients "forfeit the unbiased objectivity and clarity necessary to render professional assessment and treatment").

77. COREY ET AL., *supra* note 43, at 250.

78. See, e.g., POPE & BOUHOUTSOS, *supra* note 42, at 62 ("When sexual intercourse begins, therapy ends' . . . Control of the course of therapy appeared to pass out of the hands of the therapist once sexual intimacy occurred.") (citation omitted).

79. Sheldon H. Kardener, *Sex and the Physician-Patient Relationship*, 131 AM. J. PSYCHIATRY 1134, 1135 (1974).

patient” when he can no longer effectively treat her because his professional judgment is impaired or because she no longer trusts his judgment.

Finally, a psychotherapist who has had sexual contact with a patient may create in subsequent patients the belief that a sexual relationship with the psychotherapist is a possibility.⁸⁰ This could harm treatment by distorting the patient’s honesty and openness. A patient who wished to have a relationship with her therapist might decide to help her cause by selectively sharing with her therapist only the details that cast her in the best light. A patient who wished not to be pursued might decide to selectively share only details that made her seem unattractive or unavailable. In situations like these, the therapist might not have complete or correct information needed for an effective diagnosis and treatment, hindering the patient’s therapy. Thus, even harmless sexual relationships between psychotherapists and current patients risk impairing the effectiveness of future patients’ therapy by adding a possible distraction to the therapy session.⁸¹

3. Harm to the Profession’s Reputation

In addition to impairing the treatment sought by the client, psychotherapists who have sex with their clients can damage the reputation of the profession.⁸² If, due to reports of rampant sexual misconduct, the public cannot trust that psychotherapists in a certain profession have the patient’s mental health as their only concern, many people might be discouraged from seeking treatment in that profession and many current patients might believe that the treatment they’re receiving is of less value. Public reputation, then, is valuable to the extent that a negative reputation would reduce the demand for or the effectiveness of therapy.

The sort of negative public opinion that would have these results is likely formed from cases that are harmful for one of the reasons discussed above.⁸³ For this reason, there’s little need to independently take into account public reputation: It will be protected as a result of (1) protecting patients from entering into relationships that might carry unappreciated risks, and (2) protecting against conflicts of interest that risk diminishing the effectiveness of therapy.

A small number of situations likely remain that do not fit into (1) or (2) above but still risk creating negative public opinion. For instance, a professional

80. See Glen O. Gabbard & Kenneth S. Pope, *Sexual Intimacies After Termination: Clinical, Ethical, and Legal Aspects*, in *SEXUAL EXPLOITATION I*, *supra* note 48, at 115, 122.

81. *Id.* at 122–23.

82. See WERTHEIMER, *supra* note 70, at 158.

83. See *supra* Part II.A.

who makes constant advances to his patients would appear very unprofessional, and would discourage from receiving treatment those patients who did not want to deal with refusing his advances. If all professionals did this, a negative opinion of the whole profession might develop.

But this shouldn't be a significant concern. First, it seems extremely unlikely that a substantial number of psychotherapists would engage in this type of conduct. Professionals in general (not just in healthcare) try to act professional and ensure that clients are comfortable seeking and receiving their services, because this will help them recruit and retain patrons. Their appearance of professionalism would suffer if they made constant sexual advances. Second, so long as the proportion of professionals engaging in this type of conduct is low (as it should be), clients who are bothered will be able to seek out another professional, and the reputation of the profession as a whole will not suffer.

B. The Legal Framework for Preventing Those Harms

The above discussion identified two principal reasons states ought to restrict sexual contact between psychotherapists and their patients. The first explains precisely what underlies the concept of exploitation: Patients of psychotherapists often have a diminished capacity to appreciate the risks of sexual relationships with their therapist and to make autonomous decisions regarding those risks. The second addresses a conflict of interest concern: Psychotherapists who engage in sexual relationships with patients can have their professional judgment impaired or can cause the patient to doubt the therapist's judgment, reducing the effectiveness of therapy.

In the following pages I propose a standard of sexual misconduct that addresses both of these concerns through the psychotherapist's fiduciary duty.⁸⁴ This obligation—well recognized in many areas of law—gives to the harms risked by psychotherapist-patient sexual relations a legal significance that does not exist in ordinary relationships.

84. The fiduciary duty obligates the psychotherapist to act "[i]n all cases . . . to advance the welfare of the client" in matters related to the treatment the professional offers. COTTONE & TARVYDAS, *supra* note 69, at 39. The fiduciary duty would not obligate, for instance, a massage therapist not to sleep with a patient's husband even though the adultery might cause the patient emotional harm.

1. Why a Consent-Based Model Is Inadequate

Before explaining the fiduciary model in more detail, a popular alternative must be discussed: consent.⁸⁵ Consent, rather than fiduciary duty, could explain why harms and risks that usually are not legally significant become so in psychotherapy. That is, patients who lose some capacity to look out for their own interests are not just more likely to make bad decisions; they have lost the capacity to refuse consent to sexual intimacies, and certainly the state may punish someone who has sex with a nonconsenting person.⁸⁶

There are at least three reasons that this view of psychotherapist-patient sexual relations is inadequate. First, a diminished capacity to look out for one's own interests doesn't fit with the customary understanding of legal consent. The law generally requires that consent be (1) given by a competent person, and that it be (2) free and (3) informed.⁸⁷ None of these requirements can explain the diminished capacity of the patient to appreciate the risks of a sexual relationship.

(1) A patient's diminished capacity to appreciate risks does not have to be to the extent that it renders her incompetent. The competence requirement generally refers to the low level of competence that disqualifies people such as minors or the mentally challenged.⁸⁸ Plenty of psychotherapeutic patients are not minors or mentally challenged.

(2) Certainly a patient may freely engage in a sexual relationship that nonetheless should be prevented because she has an inadequate understanding of its risks; this is evident in the case of a patient who tries to convince her psychotherapist to have sex with her when her attraction to him is caused by transference of which she is unaware.

(3) A patient may also give informed consent although she did not adequately appreciate the risks of a sexual relationship. If she proposes the relationship, and the psychotherapist agrees, but only after explaining to her

85. See WERTHEIMER, *supra* note 70, at 180 (“[Consent] may be the right view, but it is not the only view.”).

86. Many scholars have suggested that patients of psychotherapists are unable to consent. Pope and Bouhoutsos have written that “[t]he multifaceted vulnerabilities of the patient create an enormous power differential, raising questions about the ability to give or withhold informed consent to participate in such intimacies.” POPE & BOUHOUTSOS, *supra* note 42, at 23. Coleman argues that “[i]f the patient is merely reacting to transference, she cannot give truly voluntary consent to a sexual relationship.” Coleman, *supra* note 11, at 16. Another scholar assumes, without explaining, that because sexual relationships between psychotherapists and their patients have a high risk of harm, “it is probably best to adopt a per se rule that treats all patient consent to sexual relations as invalid.” ALAN WERTHEIMER, CONSENT TO SEXUAL RELATIONS 230 (2003).

87. See *id.* at 174.

88. See *id.* at 175.

that she may experience extraordinary emotional harm when he leaves her in a year, she has been informed according to the law but she may still fail to truly appreciate the likelihood of harm.⁸⁹

If a lack of consent could explain the patient's diminished capacity to appreciate risks, just like exploitation, vulnerability, or transference, the diminished capacity would not be unique to psychotherapy. If preexisting conditions or the phenomenon of transference could incapacitate someone's ability to refuse consent, it would be true no matter the setting. Harmful sexual intimacies would be legally redressable on a theory of consent no matter if they occurred in a relationship that began in or outside of the therapy hour. And this of course is not true—we would not hold a psychotherapist liable for going to a bar and seducing a woman with a diminished capacity to appreciate the risks of a sexual relationship.

But perhaps there is room still for a model based on consent: "We may think that even if the quality of the patient's consent is no weaker than the adolescent's, the *standards* for valid consent are higher . . ." ⁹⁰ But why would we set higher standards? Certainly not because of some characteristic unique to patients of psychotherapy; as explained earlier, many people who are not in psychotherapy suffer from the same preexisting conditions, or from the same degree of transference, as some psychotherapeutic patients. It is the unique character of the relationship, not the individual, that justifies setting a higher standard of consent. And the relationship is unique because of the psychotherapist's fiduciary duty.

Finally, even if the above difficulties are remedied, a model of consent is inadequate because it doesn't account for the second concern underlying psychotherapist-patient sexual relations: the impairment of the psychotherapist's judgment about the patient's treatment. This is not fatal to a model of consent, of course, but if a different model can account for both concerns justifying sexual misconduct regulations, it seems its comprehensiveness should be preferred.

2. A Model Based on Fiduciary Duty

A model based on fiduciary obligations accounts for both concerns justifying sexual misconduct regulations. The psychotherapist's fiduciary duty obligates him to compensate for a patient's diminished capacity to look out for her own interests, perhaps by refraining from engaging in a sexual

89. See *id.* at 179–180 (explaining how transference might explain a lack of informed consent, but then acknowledging that transference exists in many relationships and does not obviate consent).

90. *Id.* at 178. Wertheimer appears to reject a fiduciary duty model in favor of this Standards of Consent model. See *id.* at 180–94.

relationship with her if she has a particular preexisting condition or if she gives any indication that she is experiencing transference.⁹¹ A different psychotherapist would not have the same obligation with respect to that patient—he could meet her in a bar, seduce her, and not suffer legal sanction, even if he knows that she is emotionally troubled and will likely be harmed by his conduct. The fiduciary duty also requires that the psychotherapist be aware of the risk that a sexual relationship with a patient could impair his judgment about her treatment and thereby reduce its effectiveness. The same psychotherapist does not have that responsibility with respect to his girlfriend, even if she would trust his relationship advice as strongly as his patients would.

The incorporation of the harms above into a fiduciary duty standard means that most, if not all, of the cases of harmful sexual contact between a psychotherapist and patient may be viewed and punished as breaches of the fiduciary duty. Certainly we can characterize the sensational and newsworthy cases this way: A psychiatrist who tries to convince his patient that having sex with him is part of her treatment has very likely violated his obligation to act in his patient's best interest, since, as her reluctance indicates, sex is probably not in her best interests.⁹²

III. A MODEL CODE STANDARD, ITS BENEFITS, AND SHORTCOMINGS

A. A Model Code

My model sexual misconduct regulation is based on the professional's fiduciary duty.

Fiduciary duty. The fiduciary duty obligates the healthcare professional to act always in the patient's best interest in matters related to the professional's treatment of the patient.

This definition of fiduciary duty limits the healthcare professional's obligation to act in the patient's best interests to the decisions and conduct of

91. The fiduciary duty of a psychoanalyst in particular requires that he be extremely sensitive to the patient's transference, and attempt to cure the false attraction instead of acting on it. See Weinschel & Renik, *supra* note 62, at 431–32 (“[I]t is important to pay attention to the patient's orientation toward the analyst because that orientation is determined in part by transference, and careful investigation of the treatment relationship itself is a crucial opportunity for the analysis of transference. . . . Elucidation of transference is the point of analysis and the source of its therapeutic benefits.”).

92. This happened recently in Washington. See *Woman Suing Spokane Psychiatrist Over Affair*, SEATTLE TIMES, Nov. 20, 2007, available at http://seattletimes.nwsourc.com/html/localnews/2004025130_webaffair20m.html.

the healthcare professional that are within the professional's practice and treatment of the patient. This reflects the fact that the scope of the psychotherapist's fiduciary duty is greater than the scope of the physical therapist's fiduciary duty. Thus, a physical therapist, whose practice relates primarily to the physical well-being of patients, would likely not breach his fiduciary duty to a patient by sleeping with the patient's wife, although his conduct might cause emotional harm to the patient. A psychotherapist who did the same thing, on the other hand, very likely would breach his fiduciary duty to the patient, since the psychotherapist must care for his patient's emotional health.

Sexual misconduct should be defined as a sexual relationship that breaches the fiduciary duty. The regulation should explicitly account for our two primary concerns with sexual relationships between psychotherapists (and other professionals) and their patients, perhaps like this:

(a) A sexual or romantic relationship with a current patient constitutes a breach of the fiduciary duty when the therapist's professional judgment about the patient's treatment is impaired by the sexual or romantic relationship.

(b) A sexual or romantic relationship with a current or former patient constitutes a breach of the fiduciary duty when the patient has a diminished capacity to appreciate the risks of such a relationship or to make autonomous decisions regarding those risks.

Subsection (a) means to prevent the conflicts of interest described earlier. The more the healthcare professional's role relates to sexual or romantic relationship advice, the greater the risk that his professional judgment will be impaired by a sexual or romantic relationship with the patient.⁹³

Subsection (b) means to prevent the exploitation of a patient by a healthcare professional. It defines in one sentence the effect of vulnerabilities, power imbalances, and transference emotions, recognizing that these conditions are relevant to the extent that they diminish a patient's ability to appreciate the risks of a sexual relationship and make autonomous decisions regarding those risks. Certain factors, derived from the causes of a patient's vulnerability,⁹⁴ might be helpful in determining how diminished is the current patient's ability

93. This subsection would also prohibit a healthcare professional from treating someone with whom the professional had a prior sexual or romantic relationship, if that prior relationship impaired the professional's judgment of the patient's treatment. I do not explicitly mention this in the statute or the commentary since it is not within the scope of this Comment.

You might recognize that the subsection does not address all four ways in which the effectiveness of therapy may be impaired by the conflict of interest risked by a sexual relationship. The reasons for this omission are discussed in the next section on the model code's shortcomings. See *infra* Part III.B.1.

94. See *supra* text accompanying notes 45–55.

to appreciate the risks of a sexual relationship with her therapist: the extent to which personal and intimate details were shared during the therapy, and the nature of the patient's condition before and during therapy. An additional factor might be helpful in determining how diminished is a former patient's ability to appreciate the risks of a sexual relationship: evidence of the termination of the professional relationship. The significance of this factor will be discussed later; it's mentioned now only because it should be included as a factor in the model code.

Finally, the model code should include a presumption of guilt.

Presumption of guilt: A healthcare professional who engages in a sexual or romantic relationship with a *current* client is presumed guilty of violating the fiduciary duty. The professional may rebut the presumption of guilt by establishing that, when he decided to enter into the sexual or romantic relationship, there was no reasonable doubt that the relationship would not breach the fiduciary duty. *Psychotherapists* who engage in sexual or romantic relationships with *former* patients are presumed guilty for a period of *one year* after termination, after which the burden rests on the former patient to establish that the psychotherapist breached the fiduciary duty.

This presumption of guilt ensures that a healthcare professional can be held liable for negligently failing to recognize that a sexual or romantic relationship with a patient will breach the fiduciary duty. This intends to discourage professionals from engaging in sexual or romantic relationships that have uncertain consequences. If a professional knows, before engaging in a sexual or romantic relationship with a patient, that he will have to prove that there was no reasonable doubt (a) that his judgment about the patient's treatment would be affected and (b) that the patient fully appreciated the risks of the relationship, then he should be extremely reluctant to engage in the relationship in the first place. In particular, psychotherapists who consider sexual or romantic relationships with current or former patients must be wary of even the slightest indication of a patient's diminished capacity to look out for her own interests, since the existence of any such indication would normally give reason to doubt that the sexual or romantic relationship would not breach the fiduciary duty. Thus, the burden not only deters reckless behavior by healthcare professionals but encourages more careful and thorough diagnoses and treatments.

B. Benefits and Shortcomings

This model code standard could apply to any healthcare profession. Whether it should be applied in a given profession depends on whether its overall benefit is greater than that of a categorical ban. Before doing the math in specific contexts, the benefits and shortcomings of the model code—as they compare to a categorical ban—should be understood.

1. Benefit of the Model Code

The model code has one simple benefit: It respects the sexual autonomy of consenting adults by permitting psychotherapists (or any healthcare professional) and their patients to have sexual and romantic relationships with each other. It frees from potential punishment therapists who seek and have sincere and healthy relationships with patients, and it opens the dating choices of patients or former patients by not categorically eliminating therapists as possible partners.

The value of this benefit should not be understated, for two reasons. First, harmless relationships—such as those in cases like the Minnesota massage therapist's or the Florida psychiatrist's, mentioned earlier⁹⁵—might appear rarely in the courts, but this does not mean they occur rarely. If an illicit relationship is harmless, there's little reason to think that a disciplinary board would get involved in the first place. But because of the risk that a third party—a fellow professional, another patient, a family member—would notify the board, many participants in harmless sexual relationships are forced to carry on their relationships in secret. Any professional who didn't wish to sneak around or to take the risk of losing his license would be prevented from engaging in a harmless sexual or romantic relationship.

Because professionals are forced to hide their relationships, or are deterred from engaging in them completely, it's difficult to tell the extent of the burden. There's little research documenting such relationships—and much of what does exist relies on notoriously unreliable self-reporting⁹⁶—but there

95. See *supra* notes 8–9.

96. Most studies ask the therapists who engaged in the sexual relationship to report its effects, which very likely results in overestimated positive effects. See generally Annette M. Brodksy, *Sex Between Patient and Therapist: Psychology's Data and Response*, in *SEXUAL EXPLOITATION I*, *supra* note 48, at 15, 15–25. Several studies have used what appear to be more reliable methods. One of the more thorough of the first studies asked therapists how their patients who had had sexual relationships with former therapists were affected; the study reported 25 percent of patients who were sexually intimate with their psychotherapists were either not affected (9 percent) or "became healthier or improved emotionally" (16 percent). Jacqueline Bouhoutsos et al., *Sexual Intimacy Between*

should be little doubt that harmless relationships certainly do exist, and the model code therefore does have an identifiable (if not easily quantifiable) benefit.

Second, and perhaps more importantly, the U.S. Constitution and many state constitutions recognize rights of sexual autonomy that meaningfully protect the rights of adults to enter into consensual sexual relationships.⁹⁷ So even if the number of romantic relationships developing from professional relationships is small, the burden on those relationships caused by categorical bans is significant for a greater reason than an abstract commitment to liberty: Sexual relationships are constitutionally protected—they were and are considered so fundamental to America's commitment to personal liberty that they have been written and read into federal and state constitutions. Thus the model code also has the considerable benefit of respecting constitutional rights to sexual autonomy.

2. Shortcomings of the Model Code

The model code has two shortcomings: It's more ambiguous than a categorical ban, and it has a narrower scope.

Ambiguity: for the court and professional. The standard's ambiguity has two consequences: It creates problems of proof for the adjudicatory court or agency, and it fails to provide clear guidance to psychotherapists. As to the first, the proposed standard may frequently require the adjudicator to engage in difficult fact-based inquiries into the professional's judgment or the patient's ability to appreciate risks. These sorts of inquiries could impose serious time and resource costs.

Three points should be kept in mind when evaluating the weight of this difficulty, however. First, these sorts of evidentiary problems would not be unique to sexual misconduct regulations. Adjudicators make difficult factual determinations all the time; the question is whether an alternative would be more efficient while adequately protecting the competing interests at stake. Second, the factors stated in subsection (b) of the proposed model code will help to mitigate evidentiary difficulties by identifying the primary sources of impairment of the patient's ability to look out for her own interests. Finally,

Psychotherapists and Patients, 14 PROF. PSYCHOL.: RES. & PRAC. 185, 190 (1983). A recent study reports that three of thirteen sexual relationships between psychologists and clients, students, or trainees, were ongoing and rated by the psychologists as "mostly to extremely positive." Douglas H. Lamb et al., *Psychologists Reflect on Their Sexual Relationships With Clients, Supervisees, and Students: Occurrence, Impact, Rationales, and Collegial Intervention*, 34 PROF. PSYCHOL.: RES. & PRAC. 102, 104 (2003) (emphasis omitted). The author does not say which of these relationships were with clients, but, no matter the partner, the harms risked and the implication are similar.

97. See *infra* Parts V & VI.

and perhaps most importantly, the presumption of guilt strongly mitigates problems of proof by directing the adjudicator to a verdict when the evidence does not otherwise clearly lead there.

This last point is an important one. To the extent that sexual misconduct regulations are needed to prevent professionals who think they can get away with sexual misconduct from doing so,⁹⁸ the presumption of guilt should have the same effect as a categorical ban (so long as it is understood by the professionals). Healthcare professionals may not exploit the standard's ambiguity by relying on a lack of evidence or claiming unawareness if, in the absence of evidence, they are presumed guilty and punished for their recklessness.

Scope: a profession's reputation and the effectiveness of therapy. The standard also incompletely addresses two additional potential harms: negative public opinion resulting from sexual relationships, and impaired effectiveness of therapy.

First, if the public views as harmful or improper more professional-client sexual or romantic relationships than are in fact breaches of the fiduciary duty, then to preserve a profession's reputation, the law may need a categorical rule that sanctions more behavior than is covered by the model code standard. But the public's views are likely based on instances of actual harm to the patient or impropriety by the professional, and the model code standard addresses these concerns. Professional reputation is threatened more by a model code standard than by a categorical rule, then, only in proportion to how many more cases of sexual misconduct slip through the cracks of the model code standard (since a failure to punish discourages people from seeking or receiving treatment). The reason cases would slip through the cracks is, as discussed, the model code standard's ambiguity. The more that ambiguity allows negligent mistakes to go unpunished in a profession, the more likely a negative public opinion will develop that discourages people from seeking and receiving treatment.

98. Anecdotal evidence suggests this is a common misconception, which is partly why I mention it here. Research in fact indicates that most psychotherapists who have sex with patients either have their own problems that they are dealing with (that lead them to desire a sexual relationship with the patient) or are simply inadequately educated about the risks. Both circumstances indicate that many of those psychotherapists would have sex with the patients no matter what sort of regulation existed. See generally POPE & BOUHOUTSOS, *supra* note 42, at 33–45. See also *id.* at 36 (“[D]ata suggest that for many—but by no means all—therapists the external systems of restraint and prohibition may be relatively ineffective in preventing therapist-patient sexual involvement.”). On the psychotherapist's own problems, see Andrea Celenza, *Precursors to Therapist Sexual Misconduct*, 15 *PSYCHOANALYTIC PSYCHOL.* 378 (1998). On education, see Linda M. Housman & Jayne E. Stake, *The Current State of Sexual Ethics Training in Clinical Psychology: Issues of Quantity, Quality, and Effectiveness*, 30 *PROF. PSYCH.: RES. & PRAC.* 302 (1999); Steven E. Samuel & Gregg E. Gorton, *National Survey of Psychology Internship Directors Regarding Education for Prevention of Psychologist-Patient Sexual Exploitation*, 29 *PROF. PSYCH.: RES. & PRAC.* 86 (1998).

Second, sexual relations between healthcare professionals and their clients risk impairing the effectiveness of therapy in more ways than simply creating a conflict of interest for the healthcare professional. Sexual relationships might cause the patient to discount the value of the therapy, and they might lead future patients, in anticipation of a sexual relationship, not to be completely forthcoming. To the extent that these risks are not derivative of circumstances that would lead a professional to have impaired judgment of the patient's therapy, they are not addressed by the standard. Nor could they be, since including requirements in the standard that a professional be aware of how a patient might reflect on the sexual relationship months or years into the future could have little effect on the professional's behavior. A patient's future attitudes are practically unpredictable, and they do not become less so by giving guidance in a standard to psychotherapists. Including a requirement that the psychotherapist not engage in a sexual relationship with a patient when that relationship would cause a future patient to withhold information would be similarly futile, as the psychotherapist cannot predict how future patients will react.

IV. THE MODEL CODE STANDARD APPLIED TO PROFESSIONAL-CLIENT SEXUAL RELATIONSHIPS

The model code should be preferred to a categorical ban in contexts where its benefit is great (where many harmless relationships are suppressed) and its shortcomings negligible (where ambiguity and the risk of negligent mistakes are minimal). This Part explores four different contexts: psychotherapists and current patients, psychotherapists and former patients, nonpsychotherapists and current patients, and nonpsychotherapists and former patients.

A. Psychotherapists and Current Patients

1. The Harms Risked by a Sexual Relationship

The harms risked by a sexual relationship between a psychotherapist and a current patient are discussed in Part II above. As a reminder, they are for the most part derived from two concerns: (1) that patients cannot appreciate the risks of sexual relationships with their psychotherapists; and (2) that a sexual relationship might harm the effectiveness of therapy, by impairing the psychotherapist's judgment or by lessening the patient's level of confidence in her treatment.

2. Whether the Model Code Can Adequately Address Those Harms

In relationships between psychotherapists and their current patients, harms to the patient or to the effectiveness of therapy are so likely that a categorical ban does not have much overinclusiveness, and the standard's benefits are therefore quite limited.⁹⁹ Researchers report that patients frequently experience serious harms resulting from their incapacities to appreciate the risks of the sexual relationship.¹⁰⁰ Since psychotherapists often analyze and treat issues related to personal relationships, there is frequently a conflict of interest created when the therapist inserts himself into the material for analysis and treatment. For these reasons, the benefit of the model code standard is small. The model code's shortcomings, on the other hand, are pronounced.

First, its ambiguity is troublesome for psychotherapists and adjudicators. Psychotherapeutic diagnoses and treatments are enormously difficult to assess concretely. A psychotherapist has to be able to recognize and measure both a patient's diminished capacity to appreciate risks and his own impaired professional judgment. The first of these has abstract and hard-to-identify causes: transference and preexisting conditions, both of which vary in intensity and can have unpredictable symptoms.¹⁰¹ Indeed, "[t]he most usual explanation offered for sexual involvement on the part of a therapist with a patient is that he or she 'did not know any better.'"¹⁰² Psychotherapists who engage in relationships—even if they know the ethical boundaries—often simply cannot anticipate when there will be harmful results.¹⁰³

99. See, e.g., POPE & BOUHOUTSOS, *supra* note 42, at 57 (“[S]uch relationships have traditionally been assumed to be harmful to patients. . . . [T]he majority [of authors] have found therapist-patient sexual involvement harmful . . .”).

100. See *id.* at 58 for a list of research results.

101. This results in cases where a psychotherapist can (rightly) be held liable for not adequately diagnosing or treating the preexisting condition and for mishandling transference, even though he was unaware of the harmful consequences. See, e.g., *St. Paul Fire & Marine Ins. Co. v. Love*, 459 N.W.2d 698 (Minn. 1990).

102. POPE & BOUHOUTSOS, *supra* note 42, at 37.

103. One researcher asked psychologists to identify the “circumstances or reasons that influenced their decision to pursue” a sexual relationship with a client, student or trainee. Lamb et al., *supra* note 96, at 105. Seventy-two percent of the responses (some responders marked more than one answer) said that, before engaging in the relationship, they viewed it as posing “no harm, thus I proceeded,” or they “consulted and/or negotiated” with the sexual partner or another professional to ensure that the relationship would be harmless. *Id.* At the end of the sexual relationships, however, fifty percent of the respondents rated stated that “all in all, the relationship was not worth having,” *id.* at 106, and ninety percent of the respondents strongly believed that they would never engage in such a relationship again, *id.* at 104. The sample size of the study was extremely small (thirteen of 368 respondents stated they had engaged in sexual relationships), but the implication is that psychologists are often unable to tell when a relationship will be harmful. *Id.* at 103. The authors propose “provid[ing] psychologists with more information and discussion forums in order to explore issues related to what constitutes ‘harm’” *Id.* at 106.

Additionally, adjudicators would have an especially difficult time enforcing the model code. It's likely more difficult for a court (ex post) than a therapist (ex ante) to determine the therapist's objectivity or the patient's capacity to appreciate risks.

This means some cases would slip through the cracks of the model code. This is one reason that the model code's narrower scope is pronounced in the context of psychotherapy. More than in any other context, it seems that relationships between psychotherapists and their current patients are viewed by the public as harmful no matter their actual nature. The model code might work to exacerbate this perception by permitting largely harmless relationships that are nonetheless viewed by the public as harmful.

Perhaps more significantly, the model code does not address two harms to the effectiveness of therapy that are especially pronounced in psychotherapeutic relationships. First, patients who have had sexual relationships with their psychotherapists would be especially likely to discount the value of the therapy received when that sexual relationship ended.¹⁰⁴ Since psychotherapists offer advice and treatment on issues closely related to a patient's romantic life, the patient could easily view the psychotherapist's judgment (and the treatment he offered) as distorted by the desire to have a nonprofessional relationship with her. Second, since patients of psychotherapists frequently share personal details of their sex lives with their therapists, there's enormous opportunity for incomplete disclosure, or simple dishonesty, if a patient wanted to help her chances of having (or not having) a relationship with the therapist.¹⁰⁵

For these reasons, it seems a categorical ban on sexual relationships between psychotherapists and their current patients makes good sense. It does not overreach too much, and it helps to prevent negligent mistakes by psychotherapists, maintain the effectiveness of therapy, and lessen adjudication costs.

B. Psychotherapists and Former Patients

1. The Harms Risked by a Sexual Relationship

In relationships between psychotherapists and their former patients, it's extremely difficult to assess whether a categorical ban should be preferred to the model code, because it's difficult to assess the extent of the harms to the patient or to the effectiveness of therapy. The most extreme views take hard

104. See *supra* text accompanying note 77.

105. See *supra* text accompanying notes 80–81.

positions that appear to be unsupported by evidence, yet are relied on for policy decisions. For instance, take the following:

To argue that the taboo against therapist-patient sexual relations can be broken at some future date in the course of any therapeutic approach would be just as absurd as an argument suggesting that the taboo against parent-offspring sexual relations can be broken once the child has grown up, has left home, is independent and knowledgeable, and has the right, as an adult, to give informed consent to a sexual relationship with any other adult, including a parent.¹⁰⁶

There are many reasons to doubt the truth of this statement.¹⁰⁷ But most important for our purposes, both the available evidence and the theories explained in Part II suggest that this view is far overstated.

Available evidence does not prove that former patients are harmed to the same degree or as frequently as current patients—in fact it appears to establish the opposite.¹⁰⁸ This makes sense: After therapy, patients will be more able to appreciate the risks of a sexual relationship. First, therapy would hopefully have begun to cure preexisting conditions that might have led the patient to rely on the psychotherapist's judgment about sexual relationships instead of assessing the risks herself.

Second, transference would hopefully have been resolved or lessened. It's true that most commentators believe that transference may linger after the

106. Gabbard & Pope, *supra* note 80, at 118.

107. One reason is the fact that the taboo is not caused by a lack of consent, but by public disgust and the risk of biological harm.

108. See Douglas H. Lamb & Salvatore J. Catanzaro, *Sexual and Nonsexual Boundary Violations Involving Psychologists, Clients, Supervisees, and Students: Implications for Professional Practice*, 29 PROF. PSYCH.: RES. & PRAC. 498, 502 (1998) (“[T]hose relationships that occurred after the termination of the role relationship were generally perceived as less harmful to the participants.”); Susan N. Shopland & Leon VandeCreek, *Sex With Ex-Clients: Theoretical Rationales for Prohibition*, 1 ETHICS & BEHAVIOR 35, *passim* (1991) (noting a “lack of an empirical basis for extending the prohibition” on sex with current clients to posttermination relationships, and commenting that “[t]he fact that ethics committees, state licensing boards, and even the APA Insurance Trust act as if posttermination sex with clients is harmful does not directly prove it is. . . . There is a need for research. . . .”). Kenneth Pope and Glenn Gabbard are strong advocates of the persistence of a risk of harm. They have written that “[i]n so many ways, the power differential and the patient’s vulnerability persist regardless of the termination of the therapy sessions.” Gabbard & Pope, *supra* note 80, at 122. Pope has also reported that, according to responses to a questionnaire sent to psychologists, 80 percent of former patients who had sex with former therapists were harmed, while 90 percent of current patients were harmed. Unfortunately, “the questionnaire did not enumerate the various possible forms of sexual intimacy and harm.” See Kenneth S. Pope & Valerie A. Vetter, *Prior Therapist-Patient Sexual Involvement Among Patients Seen by Psychologists*, 28 PSYCHOTHERAPY 429, 429–30 (1991). It’s certainly possible that some psychologists answered “yes” to the “harm” question when the patient suffered the typical degree of emotional harm from a failed relationship.

end of therapy,¹⁰⁹ putting patients at risk of “consent[ing] to sexual contact without appreciating its damaging consequences”¹¹⁰ even once therapy had been terminated. But certainly the intensity of transference would, for most former patients, decline with time.¹¹¹ And given the plausible claim that transference is not very frequent in the first place, the lingering transference argument seems somewhat weak.¹¹²

Nonetheless, there are still good reasons to worry about sex between psychotherapists and former patients. Earlier I discussed three ways in which the effectiveness of treatment for a current patient may be harmed: by impairing the judgment of the professional, by causing the patient to discount the value of the therapy, and by causing the patient not to be completely forthcoming with the psychotherapist.¹¹³ All three of these harms would remain to a significant extent if all relationships with former patients were permitted.

As for the first, to some extent it doesn't matter if the psychotherapist's judgment is no longer objective, since he no longer treats the former patient. However, if relationships with former patients were permitted, a psychotherapist could be more likely to have his judgment about a current patient's treatment impaired, through contemplation of a future relationship with that patient once the therapy ended.¹¹⁴ A psychologist might, consciously or not, offer advice that would increase the chances that his current patient would be romantically available once she became a former patient.

109. Gabbard & Pope, *supra* note 80, at 116, provides a list of studies purporting to prove that “transference is never fully resolved. . . . [T]ransference residues of varying intensity always remain.”

110. Kuniholm & Church, *supra* note 53, at 1.

111. See Appelbaum & Jorgensen, *supra* note 52, at 1470 (“[W]e find it reasonable to assume both that some transference continues after the patient leaves the consulting room for the final time and that for most patients the effect diminishes over time.”). *But see* Gabbard & Pope, *supra* note 80, at 116–17 (noting that studies indicate transference is strongest five to ten years after termination of therapy). I find Pope's conclusion hard to believe. Five years after therapy, perhaps having never encountered the therapist in that time, most former patients more strongly assigns feelings to that therapist than they did the week after therapy ended? Certainly this might be true in some cases, but most patients of psychotherapists probably are likely not that obsessed with their former psychotherapists, no matter how much the psychotherapists might like to think so.

112. Query also whether the psychotherapist even has a fiduciary duty not to mishandle transference once the professional relationship has ended. Of course, a few limited fiduciary duties do remain posttermination. See Gabbard & Pope, *supra* note 80, at 120–21 (giving a list of continuing fiduciary obligations such as confidentiality and retaining records). And a psychotherapist's fiduciary duty would make no sense if it obligated him to look out for a current patient's best interests by advising her not to gamble, but then it permitted him to encourage her to gamble once she was a former patient. But note that the fiduciary framework does not work as well for post-therapy prohibitions.

113. See *supra* Part II.A.2.

114. See Gabbard & Pope, *supra* note 80, at 123.

Moreover, if a former patient recognized this, she might be wise to discount the value of her previous therapy.¹¹⁵ As stated earlier, the likelihood of these first two harms increases if the psychotherapist's advice related to matters that could affect the patient's attractiveness or availability for a sexual relationship with the psychotherapist.¹¹⁶

Finally, a psychotherapist who engages in a relationship with a former patient could make his current patients contemplate the possibility of a future relationship, distracting the patient from the immediate therapy.¹¹⁷ The effect of this would be similar to that expressed earlier: A patient might selectively share only those personal details that made her the most attractive and ensured that therapy would end as soon as possible so that she could date her therapist.

The risk of these harms, however, diminishes over time. If relationships with former patients were permitted immediately on termination, the psychotherapist could give advice that would increase the chances that the patient would be immediately available for a relationship with him, since he could begin to date her when therapy ended. If relationships with former patients were prohibited for a period of one or two years after termination, on the other hand, the psychotherapist could say or do nothing that would make the patient immediately romantically available (at least legally). The benefit of giving (and the incentive to give) relationship advice in that case, then, is significantly diminished. In general, psychotherapists should become less inclined to give bad relationship advice as the prospect of a legal relationship moves further into the future and becomes less certain.

Likewise, if a current patient knows that she will not be able to date her therapist for at least one year after termination, the benefit of withholding certain information or prematurely terminating the therapy is much less. In one year, there's a good chance that the psychotherapist will forget about the

115. See EDELWICH WITH BRODSKY, *supra* note 49, at 94.

116. See *supra* Part II.A.2.

117. Those patients who saw a future relationship as a desirable possibility could instead begin working on what may seem a much more pressing concern: how to ensure that the sexual union will actually take place once the termination is out of the way. Looking attractive may be important. Pleasing—and perhaps sexually teasing—the therapist may play a role. Not mentioning material about which one is ashamed or embarrassed may be crucial, since it may cause the therapist to see one in an unfavorable and less sexually desirable light. . . . In fact, eager patients may simply decide to terminate the therapy sessions promptly, with or without the concurrence of the therapist, so that the prohibition against sex will become inactive sooner.

Gabbard & Pope, *supra* note 80, at 122–23; see also EDELWICH WITH BRODSKY, *supra* note 49, at 93–94 (“The expectation of a possible love affair after termination is bound to lead to self-aggrandizing behavior (including subtle bribes and the avoidance of difficult issues) not only during termination, but throughout the course of therapy.”).

patient, find someone else, or simply lose interest; this is true for the former patient as well. Knowing this, there's little incentive for the psychotherapist or the former patient to attempt to increase the chances that the other one will be romantically available in a year, since their attempts will actually have little effect on the other person's availability.

2. Whether the Model Code Can Adequately Address Those Harms

So given all this, is the model code standard preferable? Its benefit is certainly greater in this context than in the context of psychotherapists and current patients: The number of harmless relationships is very likely greater, since harms to both the patient and the effectiveness of therapy are experienced less commonly and less severely. The number of harmless relationships increases marginally over time too. As just discussed, one month after the termination of the psychotherapeutic relationship, a sexual relationship risks many of the same harms that it would have risked a month earlier, meaning the categorical rule has little overinclusiveness and the model code standard thus has little benefit. But five years after treatment, the likelihood that the effectiveness of therapy could be impaired is much diminished, increasing the overinclusiveness of the categorical rule and the benefit of the model code standard.

Some of the model code's shortcomings remain, but they are not as strong as in the context of current patients. It would still be difficult to diagnose (and treat) preexisting conditions and transference that could impair a patient's ability to appreciate the risks of a sexual relationship, and the ambiguity of the model code would let some unappreciated risks slip through the cracks. But the model code standard alleviates this problem by suggesting an inquiry into the termination of the relationship. If the patient hears from her psychotherapist "I am no longer in the position to give you advice about your sexual relationships," she should be less likely to take his advice about sexual relationships without undergoing her own analysis of the risks. Such a comment would be helpful evidence that the former patient retained some of her ability to make autonomous decisions about sexual relationships.

Most significantly, a categorical ban serves the important function of ensuring that therapy sessions with current patients remain focused on the patients' therapy, and not on contemplating a future sexual relationship. The model code standard does not serve this function. Psychotherapists could engage in harmless relationships with former patients under the model code standard, which would indicate to psychotherapists and current patients that

a future relationship is a possibility, risking impairing the effectiveness of therapy. As discussed, however, this risk declines over time.

In sum, it's not clear whether the model code should be preferred. Nonetheless, with its one-year presumption of guilt posttermination, I believe it would be nearly, if not equally, as effective as a categorical ban. And given the benefit of permitting harmless relationships within that time period, I think it should be preferred.

C. Nonpsychotherapists and Current Patients¹¹⁸

1. The Harms Risked by a Sexual Relationship

Nonpsychotherapeutic professionals seem to take the justifications for sexual misconduct regulations in psychotherapy and apply them to their professions without much thought. Take, for instance, the textbook *Principles and Practices of Chiropractic*. In explaining a chiropractor's boundaries, the book offers the following: "Romantic involvement between *psychiatrists* and patients has been considered exploitation of emotions deriving from treatment and is almost always unethical."¹¹⁹ The book doesn't explain why exploitation in psychiatry should also be a concern in chiropractic therapy.

Such an explanation would be difficult to give. Exploitation, in the sense that a patient might lack some capacity to appreciate the risks of a sexual relationship, is extremely unlikely in nonpsychotherapeutic professions. Likewise, there appear to be fewer and less significant threats to the effectiveness of therapy and to the reputation of the profession. I discuss each in turn.

Diminished capacity to appreciate risks. There's good reason to believe that patients of most nonpsychotherapeutic professions (1) will have no greater rate of the relevant preexisting conditions than the public in general, (2) will not trust the therapists as blindly, and (3) will not experience transference.

First, unlike mental therapy, people who seek out physical therapy—chiropractic, massage, acupuncture—do so to resolve conditions that would normally not diminish their ability to recognize the risks of a sexual relationship with the professional and make autonomous decisions regarding those risks.

118. A dearth of literature on sexual misconduct regulations in professions other than psychotherapy means that the discussion here is informed mostly by literature on the psychotherapeutic profession. Glen Gabbard acknowledged this in his text on sexual relationships between healthcare professionals and clients: "There is little in the literature about forms of sexual exploitation that lie outside the psychotherapeutic realm." Gabbard, *supra* note 57, at xii.

119. Robert D. Mootz et al., *Professionalism and Ethics in Chiropractic*, in *PRINCIPLES AND PRACTICE OF CHIROPRACTIC* 201, 215 (Scott Haldman ed., 3d ed. 2005) (emphasis added).

Second, a patient would be quite silly to place special trust in or reliance on her physical therapist's judgment about sexual relationships, and for that reason we should not assume that she has a diminished ability to make her own autonomous decisions about a sexual relationship with her therapist. The trust in most nonpsychotherapeutic professions is not the same as in psychotherapy; the same breadth and depth of information is not exposed, and reliance extends (typically, at least) only to advice about muscle relaxation, bone structure, or general physical comfort, for instance.¹²⁰ A patient in psychotherapy, on the other hand, would likely trust her therapist's advice about relationships, without weighing costs and benefits herself, because the psychotherapist's function ordinarily extends to such advice and her trust in his advice is encouraged for effective therapy.

Perhaps, however, there's some kind of vulnerability simply in submitting oneself to treatment. The fact that a massage therapist has seen you naked might make you feel vulnerable in the ordinary sense of the word.¹²¹ However, the significance of vulnerability is that it risks impairing the patient's ability to make autonomous decisions, particularly about sexual relations. There's little reason to think that massage, chiropractic, acupuncture, dental, or any number of nonpsychotherapeutic treatments would risk making patients vulnerable such that they would not appreciate the risks of sex with the professional.¹²²

Likewise with transference: In some psychotherapeutic relationships, transference is more frequent or more intense than in relationships between peers because it is encouraged as central to healing.¹²³ Transference is not encouraged in any nonpsychotherapeutic professions. Chiropractors, massage therapists and even occupational therapists do not rely on an analysis of a patient's transference emotions for treatment. So if and when transference does occur, it's likely no different than the transference that is a part of ordinary relationships.

120. See generally AM. MED. ASS'N, HANDBOOK OF PHYSICAL THERAPY (3d ed. 1939).

121. This would not include cases where the sex occurred during the therapy hour, in the therapist's office. The conditions of this setting might warrant liability for other reasons, for instance if the patient could in fact not easily refuse consent. See, e.g., Wash. Ins. Guar. Ass'n v. Hicks, 744 P.2d 625 (Wash. Ct. App. 1987) (involving a chiropractor who had sex with a nineteen-year-old girl in his office, after which she attempted to prosecute him for rape).

122. See, e.g., EDELWICH WITH BRODSKY, *supra* note 49, at 101 ("The vulnerability we have been speaking of is nowhere greater than in psychotherapy."). Similarly, Plaut and Foster write: "Sexual intimacy between professional and patient carries somewhat different implications in psychotherapeutic and nonpsychotherapeutic settings. The psychotherapeutic relationship puts both the therapist and patient at perhaps the greatest level of vulnerability . . ." S. Michael Plaut & Barbara Hull Foster, *Roles of the Health Professional in Cases Involving Sexual Exploitation of Patients*, in SEXUAL EXPLOITATION II, *supra* note 72, at 5, 7. They do not define precisely what constitutes this difference; they offer "emotional dependence," but we have already seen why that cannot be a distinction that creates legal significance. *Id.*

123. See discussion *supra* notes 63–65.

Thus, it does not contribute to a patient's diminished capacity to appreciate the risks of engaging in a sexual relationship with the nonpsychotherapeutic professional, and its effect should be of little, if no concern.

Harm to effectiveness of therapy. The three ways in which sexual intimacies between a psychotherapist and patient reduce the effectiveness of therapy do not give much more reason for concern than the concept of exploitation.

First, since nonpsychotherapeutic professionals generally do not offer advice on these matters as part of treatment, it's unlikely that their judgment about the patient's treatment would be affected. But even if the nonpsychotherapeutic professional's judgment were influenced, the effect likely would be less grave than in psychotherapy. An optician, for instance, may advise a patient with whom he has a sexual relationship to wear contact lenses instead of glasses, because he likes the way she looks in contact lenses, and not because he thinks contact lenses would be best for her functional vision. But the consequence of this sort of breach of the fiduciary duty seems more easily remedied than the possible consequence of a psychologist advising his patient to break up with her boyfriend or to quit her job to spend more time with him.

Second, the patient who feels taken advantage of by a nonpsychotherapeutic professional would be unlikely to discount the value of the therapy where the therapy only treated her physical health. She would have little reason to believe that the professional's judgment or advice about her treatment was influenced by their sexual relationship.

Finally, for many nonpsychotherapeutic professions we should not be as concerned that a sexual relationship between the patient and the professional would harm the effectiveness of the therapy by making the patient less inclined to share necessary information. In psychotherapy the anticipation of a relationship risks giving an incentive to patients who seek a sexual relationship to selectively share certain details, which might hinder the therapist's diagnosis and treatment.¹²⁴ In most nonpsychotherapeutic professions, on the other hand, the patient would not share the sort of information that would affect the professional's treatment of her. Simply by visiting a chiropractor, for instance, a patient has indicated to the chiropractor that she has a certain type of physical ailment; once in the therapy session, she has little incentive to lie about or even incompletely describe the ailment.

Moreover, the nature of the information that could be withheld risks less severe consequences. A patient of a physical therapist may, for instance, tell her therapist that she injured herself overstretching in yoga, when in fact

124. See discussion *supra* notes 80–81.

she fell asleep on the couch. To the physical therapist, the cause might not be that significant in determining how to treat her.¹²⁵

Professional Reputation. One concern with professional reputation is particularly pronounced in, if not unique to, massage therapy. I have a friend who refuses to go to massage parlors in a certain part of town because he thinks they might ask him (and he doesn't want to be asked) if he would like to pay a little extra in order to receive more than just a massage. This little extra is the sort of activity that causes none of the other harms associated with sexual contact with a healthcare professional and current client (so long as a client who wishes to refuse will have the refusal honored), but does create opinions such as my friend's, and the resulting reluctance to seek out therapy.

Sufficiently preventing this harm might require a categorical rule. But the categorical rule need not prohibit all sex between massage therapists and their current patients; it need only prohibit sex between massage therapists and their current patients that's paid for (which prostitution laws cover) or that occurs in the massage parlor (which should be prohibited for different reasons and perhaps in a different rule). To the extent that these two sources of deterrence are inadequate, the resulting harm seems negligible. My friend is happy to go to a massage parlor in Beverly Hills instead, and that massage parlor is happy to offer nothing extra in order to maintain its appearance of professionalism.

2. Whether the Model Code Can Adequately Address Those Harms

The lack of harms risked by sexual relationships between nonpsychotherapeutic professionals and their clients suggests that the model code could be an adequate substitute for a categorical ban. The suggestion is bolstered by the fact that the model code's shortcomings are negligible in this context.

First, the risk that the ambiguity of the model code will pose serious time and resource costs on the adjudicator need not be a concern. The instances where a professional's objectivity was in fact impaired will for the most part be easily identified. In most nonpsychotherapeutic professions there are more concrete diagnoses and more evident treatment prescriptions that can be confirmed by fellow practitioners. An optician, for instance, who gave a current client inadequate glasses, because he didn't like the way she looked

125. I should note that this may be a concern in certain doctor-patient relationships. Perhaps the most salient example would be a patient seeking treatment for a sexually transmitted disease. The doctor would need to know the patient's sexual history. If the patient was engaged in a sexual relationship with the doctor, she may be reluctant to share her entire sexual history with him, which could affect his judgment about her treatment.

in glasses that would have been adequate, could easily be exposed by a fellow optician who tests the patient's eyesight.

Second, a standard like the model code in the psychotherapy context has the strong disadvantage of not providing professional guidance that would reduce the risk of negligent or reckless mistakes by psychotherapists.¹²⁶ Outside psychotherapy, a standard would not have this disadvantage. Most patients of most nonpsychotherapists don't have preexisting conditions or experience transference such that they lack some ability to appreciate the risks of engaging in sexual relationships with these professionals.

Moreover, there's less legal justification for holding a nonpsychotherapeutic professional liable for mishandling a situation where the patient's capacity to recognize the risks of a sexual relationship was impaired. A psychotherapist has the unique (and extremely difficult) duty to assess and care for his client's emotional and mental health, one aspect of which is helping to ensure that the patient's sexual relationships are not detrimental to the patient's emotional health. Few other professions require their practitioners to be responsible for the mental health of clients in this same way.¹²⁷ Some nonpsychotherapists rightly view their professions as holistic,¹²⁸ but even these professions would not suggest to their practitioners that they counsel clients about personal relationships; in fact, they would obligate the practitioner to refer the client elsewhere if such a situation arose.¹²⁹ So even if a chiropractor

126. See discussion *supra* Part II.B.2.

127. In fact a massage therapist may be prohibited from giving advice on mental health issues. The American Physical Therapy Association includes in its Guide for Professional Conduct a requirement that therapists only give advice that is "within the scope of his/her competence and commensurate with his/her level of education, training and experience." AM. PHYSICAL THERAPY ASS'N, GUIDE FOR PROFESSIONAL CONDUCT § 5.1 (2004), available at http://www.apta.org/AM/Template.cfm?Section=Ethics_and_Legal_Issues1&Template=/CM/HTMLDisplay.cfm&ContentID=24781. The same guide also says that therapists should "be guided at all times by concern for the physical, psychological, and socioeconomic welfare of patients/clients." *Id.* § 1.1(B). Later, it says that vulnerable patients "normally will rely on the physical therapist's advice." *Id.* § 2.1(A) Presumably this only means advice about matters related to the physical therapy treatment, since physical therapists would likely be unqualified to give advice on anything else.

128. "Therapists should have a wholistic [sic] concern for patients. . . . Wholistic [sic] concern does not imply that physical therapists are all things for all patients. Rather, it means that they engage in the therapeutic process with emphasis on their particular role and expertise but in the context of the 'whole' person with whom they are working." Beverly J. Schmoll, *Behavioral and Social Science: Considerations for Current Practice*, in SAUNDERS MANUAL OF PHYSICAL THERAPY PRACTICE 37, 57 (Rose Sgarlat Myers, ed. 1995).

129. The chiropractic textbook *Principles and Practices of Chiropractic* offers a good example. In various essays, scholars of chiropractic history and care acknowledge that chiropractors should be concerned with the patient's overall health but should not attempt to treat health issues outside of their expertise. Chiropractors are advised to ask about the client's emotional health and her family psychological history, but they should "realize that one is usually not expected to reach a diagnosis in this specialized field, but must be alert to any clues that may indicate the need for further

negligently and mistakenly determines that a patient fully appreciates the risks of a sexual relationship, he probably has not breached his fiduciary duty.

Negative public opinions are mostly derived from instances where professionals misbehaved in ways that would fit under the model code standard, which means that a profession's reputation need not be an independent concern. However, the model code and most categorical bans do not prohibit professionals from making unwanted sexual advances toward patients. This absence would place a burden on patients who didn't want to deal with such advances: They would have to seek out another professional. The burden, although it might seem significant in particular instances, would be infrequent and pose negligible harm generally. Most professionals would never engage in this behavior at all. They have strong incentives to appear as professional as possible, and to appear professional, they must not make sexual advances to patients.

In sum, the model code makes sense in nonpsychotherapeutic contexts, and the categorical ban seems unnecessary. Not only are the harms risked by sexual contact infrequent and mostly insignificant, but the model code's shortcomings that are pronounced in psychotherapy are trivial in other contexts. Ambiguity is not much of a concern, since professionals and boards can more easily determine when a professional has exercised bad judgment. And narrower scope is negligible: The failure of the model code to protect a profession's reputation imposes only a small burden on patients. Weighing the benefit of the model code standard against its shortcomings, it seems clear that categorical bans on sexual relationships between most nonpsychotherapeutic professionals and their current clients are not preferable.

D. Nonpsychotherapists and Former Patients

Everything argued in the section immediately above applies with more force to regulations that include former clients in their reach. The only plausible concerns relate to the effectiveness of therapy.

psychological/psychiatric evaluation." Palle Pederson, *The Clinical History*, in PRINCIPLES AND PRACTICES OF CHIROPRACTIC, *supra* note 119, at 487, 503. And in a later essay: "Just as it is important for chiropractors to know what they know, it is even more important for chiropractors to know what they don't know. Appropriate referral and/or second opinions for conditions outside the individual clinician's 'comfort zone' are mandatory. If the patient's best interests are always made a first priority, and the individual clinician is honest about his or her own knowledge base, doctors of chiropractic acting in a primary care setting can perform a valuable service for the public." Richard Sarnat & Brian Budgell, *Management of Nonmusculoskeletal Disorders*, in PRINCIPLES AND PRACTICES OF CHIROPRACTIC, *supra* note 119, at 1037, 1044-45.

A professional may, in contemplation of a future relationship, give bad advice to a patient that makes her more attractive or more likely to be available. But as with current patients, this concern seems minimal. Nonpsychotherapeutic professionals generally do not give advice that would affect a client's attractiveness or availability. To the small extent that some do, their advice would be much more easily reviewed by fellow professionals, eradicating the need for a categorical ban to dispel ambiguity.

A patient might, in contemplation of a future relationship, not share certain details necessary to treatment because she fears they would make her less attractive to the professional. But, as stated above, the amount of sharing in nonpsychotherapeutic professions is much more limited than in psychotherapy, its nature much different, and its consequences much less severe. Simply, the professional needs less personal or psychological information from the patient and he can more easily tell when the patient isn't providing the information that he does need.

Any justification relying on a patient's possible impaired capacity to look out for her own interests is extremely weak. The same arguments apply as were discussed in the context of relationships between nonpsychotherapists and current patients: Current patients are not likely to have preexisting conditions that limit their ability to appreciate the risks of a sexual relationship, and they are not likely to experience lingering transference.

Moreover, the fiduciary duty of the professional cannot possibly be used to justify legal sanction. Not only did the professional very likely not have a fiduciary duty to compensate for the patient's diminished capacity to look out for her own interests in the first place,¹³⁰ his fiduciary duty generally ends on termination of the professional relationship. The fiduciary duties that remain—things like confidentiality and record-keeping—only relate to treatment that the professional has given. Since nonpsychotherapists generally don't give advice about relationships as part of treatment, there's no reason to believe that the professional could, by engaging in sexual relationships with the former client, breach his fiduciary duty.

For all of these reasons, the model code standard does not impose any posttermination liability for nonpsychotherapeutic professionals. The justifications for restricting sexual relationships between most nonpsychotherapeutic professionals and their former clients are of very limited force. Whatever force they have certainly cannot overcome the benefit of a standard; since most rela-

130. Since the professional doesn't, and is not expected to, treat the patient's emotional health or capacity to make good decisions regarding sex, his fiduciary duty likely wouldn't extend to protecting her from making bad decisions regarding sex.

tionships between nonpsychotherapeutic professionals and their former clients cause no harms, the benefit of a model code in permitting those relationships is enormous. But this does mean a standard should be adopted. Indeed, because the risk of harms is so limited, and because the fiduciary duty does not impose any relevant obligation on the professional, sex between a nonpsychotherapeutic professional and a former client likely needs no legal sanction at all.

V. THE U.S. CONSTITUTION'S LIMITS ON THE SCOPE OF RESTRICTIONS

Constitutional rights to (a) sexual autonomy, (b) marriage, and (c) intimate association are burdened by any regulation restricting sexual relationships between consenting adults. Persuasive arguments that the burden is unconstitutional are rare, and have never been made under *Lawrence v. Texas*.¹³¹

A. The Right to Sexual Autonomy

Lawrence v. Texas overturned laws in twelve states that criminally penalized sodomy.¹³² The decision acknowledged “an emerging awareness that liberty gives substantial protection to adult persons in deciding how to conduct their private lives in matters pertaining to sex.”¹³³ But Justice Kennedy expressly limited the scope of this protection in several ways, and scholars have read the decision to imply other limitations. The first subsection below explains why none of these limitations should exclude from *Lawrence*'s reach consensual sexual relations between healthcare professionals and their current and former patients. The second subsection discusses *Lawrence*'s ambiguous level of review, and the final subsection applies *Lawrence* to current sexual misconduct regulations.

131. 539 U.S. 558 (2003). See, e.g., Bruce W. Ebert, *Dual-Relationship Prohibition: A Concept Whose Time Never Should Have Come*, 6 J. APPLIED & PREVENTIVE PSYCHOL. 137, 146 (1995) (discussing the right to privacy very generally, and in a single paragraph, as it relates to all dual relationships: “where people’s fundamental rights to privacy are at stake, regulations that affect those rights should be very carefully crafted”); O’Laughlin, *supra* note 11, at 705–07 (taking the too strong position that any categorical ban on psychotherapist-client sexual relationships violates the right to intimate association). But at least one state supreme court has held the opposite. See *Ferguson v. People*, 824 P.2d 803 (Colo. 1992) (holding that therapists did not have a fundamental constitutional right to have sex with clients).

132. *Lawrence*, 539 U.S. at 558.

133. *Id.* at 572.

1. *Lawrence's* Scope

Justice Kennedy explicitly excluded from the protection granted in *Lawrence* cases that involve “injury to a person or abuse of an institution the law protects.”¹³⁴ He also excluded minors, persons who may not easily refuse consent, public conduct, and prostitution.¹³⁵ Sex between a healthcare professional and a patient or former patient does not involve minors, public conduct, or commercial sex. Whether it injures patients, abuses the institutions of healthcare professions, or involves persons who may not easily refuse consent, will be discussed in turn below.

Injury to a person. Kennedy wrote that *Lawrence* did “not involve persons who might be injured.”¹³⁶ Since a person accepts the risk of ordinary emotional injuries by engaging in any relationship, he must be referring to injury that is risked unknowingly or unwillingly. Injury is risked unknowingly or unwillingly by a patient only when she cannot adequately appreciate the risks of a sexual relationship with the professional. Thus, the “injury to a person” limitation on *Lawrence's* scope would not permit the psychotherapist in such a situation to escape punishment by relying on a constitutional right to private sexual conduct. But so long as the risks are adequately appreciated by the client, the injury that might occur is not constitutionally relevant.

Consent. Kennedy wrote also that *Lawrence* did “not involve persons who might be . . . coerced or who are situated in relationships where consent might not easily be refused.”¹³⁷ Many patients of psychotherapists have a diminished capacity to look out for their own interests and cannot adequately appreciate the risks of a sexual relationship with the therapist. Such a patient trusts the therapist’s judgment over her own—importantly, in relationship matters—so if the therapist suggested that she have a sexual relationship, she likely would not refuse.

As explained earlier, the patient’s diminished capacity should not be considered a lack of legal consent.¹³⁸ But the patient’s situation nonetheless might fall outside the scope of *Lawrence*. Kennedy likely did not mean to limit *Lawrence's* scope to the definition of legal consent. He excludes persons who might be coerced in the same sentence as those who might not easily refuse consent; he later describes the relationship at issue in *Lawrence* as one

134. *Id.* at 567.

135. *Id.*

136. *Id.*

137. *Id.*

138. See discussion *supra* Part II.B.1.

of “full and mutual consent.”¹³⁹ A sensible reading of this could conclude that Kennedy was not concerned only with the incapacity to give or refuse legal consent; he likely wanted to ensure that the relationships protected by *Lawrence* had absolutely no indications—even if not strong enough to negate legal consent—of coercion or nonmutuality. Patients of psychotherapists who can give legal consent may still be somewhat coerced into a sexual relationship, and their level of consent is certainly not equal to the therapist’s, simply because they have likely sacrificed some of their decisionmaking ability and judgment to the therapist.

Nonetheless, this should not mean that all psychotherapist-patient sexual relationships fall outside the scope of *Lawrence* simply because there is the chance that the patient could not fully appreciate the risks of the relationship. It also certainly would not exclude nonpsychotherapeutic professional-client relationships where that risk is negligible. But it does mean that, even if we consider the patient to be capable of legal consent, a psychotherapist who has sex with a patient who cannot adequately appreciate the risks of that sexual relationship may not rely on *Lawrence*’s protection when punished.

Abuse of an institution. Kennedy excluded from *Lawrence*’s scope of protection relationships that “abuse . . . an institution.”¹⁴⁰ One could consider the institution of a healthcare profession abused when a professional has sex with a client in a way that damages the reputation of the profession, by diminishing the profession’s integrity and the public’s trust in that profession.

But this is too broad a reading of this limitation. Most likely, Kennedy is referring to the institutions of marriage and the family, in order to address Justice Scalia’s criticism that laws against “bigamy, same-sex marriage, adult incest, prostitution, masturbation, adultery, fornication, bestiality, and obscenity are . . . called into question” by the *Lawrence* opinion.¹⁴¹ By excluding from *Lawrence*’s scope of protection relationships that abuse the institutions of marriage or the family, Kennedy reaffirms “the likely continuing validity of laws prohibiting bigamy[,] adultery,”¹⁴² and incest,¹⁴³ and preempts

139. *Lawrence*, 539 U.S. at 578.

140. *Id.* at 567.

141. *Id.* at 590.

142. Mary Ann Case, *Of “This” and “That” in Lawrence v. Texas*, 2003 SUP. CT. REV. 75, 141 (2004).

143. See Laurence H. Tribe, *Lawrence v. Texas: The “Fundamental Right” That Dare Not Speak Its Name*, 117 HARV. L. REV. 1893, 1944 (2004).

readings of *Lawrence* that would have read into it a constitutional right to gay marriage.¹⁴⁴

Scholars have suggested a few other interpretations of *Lawrence* that might limit its scope. Three of these may be particularly relevant: the targeting of a specific class of people, morals-based legislation, and desuetude.

First, *Lawrence* may have been “concerned with how the statute targeted a specific class of people.”¹⁴⁵ Kennedy noted that the criminalization of “homosexual conduct” was “an invitation to subject homosexual persons to discrimination.”¹⁴⁶ Since sexual misconduct regulations don’t target or discriminate against homosexuals, perhaps a court should not apply *Lawrence* in reviewing their constitutionality. But Kennedy didn’t ground his opinion in equal protection.¹⁴⁷ He grounded his opinion in the substantive due process right of “adults to engage in private conduct in the exercise of their liberty under the Due Process Clause.”¹⁴⁸ This right applies in the absence of class-targeting or discrimination.

Second, *Lawrence* may reflect the Court’s “long-standing jurisprudential discomfort with explicit morals-based rationales for lawmaking.”¹⁴⁹ If so, any law that had a modicum of non-morals-based rationality presumably would not receive the protection of *Lawrence*. Regulations on healthcare professional-client sex have such a modicum if there’s even a small risk that the professional’s judgment will be impaired or that a negative public opinion will develop that discourages people from seeking treatment.

Third, *Lawrence* may have been a “due process variation on the old common law idea of desuetude.”¹⁵⁰ The Court had issue with laws that are based on “moral judgments lacking public support, as exemplified by exceedingly rare enforcement activity.”¹⁵¹ Under this view, if a law or regulation is not “hopelessly out of touch with existing social conventions,”¹⁵² then it would not be within the scope of *Lawrence*. Public reactions to professional-client sex, and enforcement

144. Kennedy writes elsewhere in the opinion that *Lawrence* “does not involve whether the government must give formal recognition to any relationship that homosexual persons seek to enter.” *Lawrence*, 539 U.S. at 578.

145. *Reliable Consultants, Inc. v. Earle*, 517 F.3d 738, 744 (5th Cir. 2008).

146. *Lawrence*, 539 U.S. at 575.

147. See, e.g., *Reliable Consultants*, 517 F.3d at 738.

148. *Lawrence*, 539 U.S. at 558.

149. Suzanne B. Goldberg, *Morals-Based Justifications for Lawmaking: Before and After Lawrence v. Texas*, 88 MINN. L. REV. 1233, 1234–35 (2004).

150. Cass Sunstein, *What Did Lawrence Hold? Of Autonomy, Desuetude, Sexuality, and Marriage*, 2003 SUP. CT. REV. 27, 49. Sunstein defines desuetude as “judicial invalidation of a law that has become hopelessly out of touch with existing social conventions.” *Id.* at 27.

151. *Id.* at 28.

152. *Id.* at 27.

of current regulations, suggest that sexual misconduct laws, however framed, are not “hopelessly out of touch with existing social conventions.”

These last two interpretations of *Lawrence* may provide insight into what motivated the Court to take the case in the first place, but they should not limit its scope. “Only on its surface is [*Lawrence*] a story about removing the sanction of criminal punishment from those who commit sodomy.”¹⁵³ At its most basic, *Lawrence* is a decision about “the right of adults to define for themselves the borders and contents of deeply personal human relationships.”¹⁵⁴ This liberty right would have little future meaning if it existed only in response to legislation justified by a particular interest (morality) or lacking social support. *Lawrence* says that morality alone is not a sufficient state interest to pass its level of review;¹⁵⁵ it does not say that the Court will only protect the right to sexual autonomy when it is infringed by laws justified by morality or lacking social support.

One final point about *Lawrence*’s scope bears mentioning: It is not limited to relationships that may be significant or meaningful in terms of emotional attachment or duration. *Lawrence* protects relationships that are “fleeting, lasting only one night and lacking any semblance of permanence or exclusivity.”¹⁵⁶ We should thus not be reluctant to rely on the Constitution to protect professional-client sexual relationships merely because those relationships might seem insignificant.

2. *Lawrence*’s Level of Review

Lower courts have held that *Lawrence* did not establish a fundamental right to consensual sexual relations between adults, and therefore have extended it no further than overturning restrictions on homosexual sodomy, upholding prohibitions on sex toys, incest, bigamy, and teacher-student relationships.¹⁵⁷ These readings of *Lawrence* are too limited. On this subject,

153. Tribe, *supra* note 143, at 1896.

154. *Id.* at 1915.

155. “All that was offered by the government to justify this statute is the judgment of the legislature that the prohibited conduct is ‘immoral’, which for the majority . . . is simply not enough to justify the restriction of liberty.” Randy E. Barnett, *Justice Kennedy’s Libertarian Revolution*, 2003 CATO SUP. CT. REV. 21, 36.

156. Tribe, *supra* note 143, at 1904.

157. See *Muth v. Frank*, 412 F.3d 808 (7th Cir. 2005) (upholding a ban on incest); *Williams v. Att’y Gen. of Ala.*, 378 F.3d 1232 (11th Cir. 2004) (upholding a ban on sex toys); *State v. McKenzie-Adams*, 915 A.2d 822 (Conn. 2007) (upholding a ban on teacher-student relationships); *State v. Holm*, 137 P.3d 726 (Utah 2006) (upholding a ban on bigamy). *But see* *Reliable Consultants, Inc. v. Earle*, 517 F.3d 738, 738 (5th Cir. 2008) (holding that a ban on the sale of sex toys violated *Lawrence v. Texas*).

I can add little to the arguments of scholars who have informed my opinion except by way of the following summary.¹⁵⁸

Lower courts that have so narrowly read *Lawrence* fail to recognize that the conspicuous lack of “magic words” indicating the level of review,¹⁵⁹ while it may make the decision “difficult to pin down,”¹⁶⁰ does not indicate a lack of intention to grant “meaningful constitutional protection to liberty interests without denominating them as fundamental rights.”¹⁶¹ Of course Kennedy was aware that he never used the words “rational basis” or “fundamental right”. The most likely reason, it seems to me, is not that he was applying rational basis review, but that “the Court found the applicability of those terms to be irrelevant.”¹⁶²

As Kennedy wrote, the liberty interest at work in *Lawrence* “gives substantial protection to adult persons in deciding how to conduct their private lives in matters pertaining to sex.”¹⁶³ The opinion does not need to tell us in exact words that sexual autonomy is a fundamental right for a level of review higher than rational basis to apply.

3. Applying *Lawrence* to Sexual Misconduct Regulations

There’s much confusion surrounding the level of review in *Lawrence*—and perhaps this is some indication that burdens on the *Lawrence* right shouldn’t be reviewed with one of the unitary standards—but this shouldn’t matter for

158. See Barnett, *supra* note 155, at 36 (“Justice Kennedy is employing here what I have called a ‘presumption of liberty’ that requires the government to justify its restriction on liberty, instead of requiring the citizen to establish that the liberty being exercised is somehow ‘fundamental.’”); Nan D. Hunter, *Living With Lawrence*, 88 MINN. L. REV. 1103, 1117 (2003) (“What is significant for future interpretation is that the Court characterized the sexual rights at issue in *Lawrence* as equivalent to those previously established as fundamental. . . . In both *Casey* and *Lawrence* the Court eschewed direct use of fundamental rights language, but made clear that the rights being compared were equivalent and therefore entitled, by whatever standard of review, to equivalent protection.”); Tribe, *supra* note 143, at 1917 (“[T]he strictness of the Court’s standard in *Lawrence*, however articulated, could hardly have been more obvious.”); Sunstein, *supra* note 150, at 48 (“The more natural interpretation is simpler: The Court’s assimilation of the *Lawrence* problem to that in *Griswold* and its successors suggests that a fundamental right was involved.”).

159. Tribe, *supra* note 143, at 1917 (“To search for magic words proclaiming the right protected in *Lawrence* to be ‘fundamental,’ and to assume in the absence of those words mere rationality review applied, is to universalize what is in fact only an occasional practice.”). In the *Lawrence* decision, the words “rational basis” appear zero times, and “fundamental right” appears only in reference to the *Bowers* decision and to the historic—and perhaps modified or overruled—method of identifying which rights qualify as fundamental.

160. Hunter, *supra* note 158, at 1103.

161. *Id.* at 1104.

162. *Id.* at 1116.

163. *Lawrence*, 539 U.S. 558, 572 (2003).

many of the regulations so long as something more rigorous than rational basis review is applied. Simply balancing the state's interest in restricting private, consensual sexual activity against the "substantial protection" that the Constitution affords to such activity invalidates many of the regulations.¹⁶⁴

The Supreme Court has recognized that "[s]tates have a compelling interest in the practice of professions within their boundaries, and that as part of their power to protect the public health, safety, and other valid interests they have broad power to establish standards for licensing practitioners and regulating the practice of professions."¹⁶⁵ Even the reputation of a profession has been found to be a substantial interest and may legitimately be protected within the state's power.¹⁶⁶ But these state interests do not justify all regulations; as such, for each regulation we must weigh how well it serves the state interests against how much protected activity it reaches and burdens.

Categorical bans on sexual relationships between nonpsychotherapeutic professionals and former clients do not pass this balancing test. They are supported primarily by the insignificant concern that the effectiveness of therapy with current patients may be impaired—a concern so insignificant, in fact, that any regulation whatsoever seems unnecessary. However, to the extent that some regulation might be needed, there's no doubt that the model code standard would equally fulfill that need; a therapist who gave bad treatment in anticipation of a sexual relationship could quite easily be exposed.¹⁶⁷

Since nearly all sexual relationships occurring after the termination of the professional relationship are harmless in the nonpsychotherapeutic context, categorical bans on these relationships substantially overreach into activity protected by *Lawrence*. This is a substantial burden on *Lawrence*'s sexual autonomy right, and one that can easily be prevented with no additional harm (if a standard is adopted) or with extremely limited additional harm (if regulations are done away with altogether). For all these reasons, it seems clear that categorical bans on sexual relationships between nonpsychotherapeutic professionals and former clients must be found unconstitutional.

164. The idea that the constitution requires a balancing test, and consequently that some regulations might be constitutional and others not, is apparently lost on two prominent advocates of posttermination sexual misconduct regulations, who took the mistaken view that "if the constitutional argument were taken seriously, one could extend it by saying that a professional organization has no constitutional right to prevent sex with a *current* patient." GLEN O. GABBARD & EVA P. LESTER, BOUNDARIES AND BOUNDARY VIOLATIONS IN PSYCHOANALYSIS 157 (1995).

165. *Goldfarb v. Va. State Bar*, 421 U.S. 773, 792 (1975).

166. See *Fla. Bar v. Went For It, Inc.*, 515 U.S. 618, 624–25 (1995) (recognizing that the state had a "substantial interest" in "preserv[ing] the integrity of the legal profession").

167. See discussion *supra* Part IV.D.

B. The Right to Marry

Marriage is a fundamental right, and the Supreme Court will subject laws that “interfere directly and substantially with the right to marry” to “rigorous scrutiny”.¹⁶⁸ Romance and sex are essential components of marriage. Regulations prohibiting any sexual contact, and certainly those that also prohibit suggesting a sexual relationship,¹⁶⁹ directly and substantially interfere with the right to marry by prohibiting behavior that is essential to marriage.

Unlike the state regulations discussed in *Zablocki v. Redhail* or *Loving v. Virginia*,¹⁷⁰ most sexual misconduct regulations do not absolutely and permanently prevent marriage (save ones that extend indefinitely). But requiring a professional to wait years after treatment to express his feelings to a former patient and begin dating her “significantly interferes”¹⁷¹ with his right to marry by putting a large obstacle in his path. During this time the former client could meet someone else, move away, or simply lose her patience, preventing the marriage. The same obstacle exists for the former client even though she doesn’t risk legal sanction by having sexual contact with the professional, since the professional whom she may want to marry won’t be able to accept her advances.

The right to marry protects the “*decision* to enter into the relationship that is the foundation of the family in our society.”¹⁷² This decision is preceded and informed by courting, dating, and intimacy; it could hardly be called the individual’s decision (“[t]he making up of one’s mind”¹⁷³) if the individual was prohibited from engaging in the conduct that would lead him to make up his mind. The right to marry, in other words, presupposes a right to engage in the conduct that leads people to marry. Categorical bans on sexual relationships between nonpsychotherapeutic professionals and their former clients burden the right to marry because, even if the individuals do not

168. *Zablocki v. Redhail*, 434 U.S. 374, 386–87 (1978); see also *id.* at 383–84 (noting that the Supreme Court’s “past decisions make clear that the right to marry is of fundamental importance” and “the right to marry is part of the fundamental ‘right of privacy’ implicit in the Fourteenth Amendment’s Due Process Clause”); *Loving v. Virginia*, 388 U.S. 1, 12 (1967) (“Marriage is one of the ‘basic civil rights of man,’ fundamental to our very existence and survival.”) (quoting *Skinner v. Oklahoma ex. rel. Williamson*, 316 U.S. 535, 541 (1942)).

169. See examples *supra* Part I.

170. In *Zablocki*, a state prevented persons who were obligated to pay child support from marrying without permission from a court. 434 U.S. at 375. In *Loving*, Virginia had banned all interracial marriages. 388 U.S. at 1.

171. *Zablocki*, 434 U.S. at 383.

172. *Id.* at 384 (emphasis added); see also *Loving*, 388 U.S. at 12 (describing the marriage right as one of “the freedom of choice to marry”).

173. IV OXFORD ENGLISH DICTIONARY 332 (J.A. Simpson & E.S.C. Weiner eds., 2d ed. 1989).

end up marrying, they are prevented from engaging in the conduct that would let them make the decision to marry.¹⁷⁴

Since the right to marry is burdened by sexual misconduct regulations, those regulations must be “supported by sufficiently important state interests” and be “closely tailored to effectuate only those interests.”¹⁷⁵ Sexual misconduct regulations protect the mental and physical health of healthcare patients by prohibiting relationships whose risks patients cannot adequately appreciate, and they protect the effectiveness of healthcare by preventing conflicts of interest.¹⁷⁶ States have compelling interests in the mental health of their citizens and in protecting the effectiveness of healthcare practices.¹⁷⁷

But many of the regulations are not sufficiently tailored to serve only those interests. In nonpsychotherapeutic professions, categorical bans prohibit many more relationships than threaten the state’s interests. Moreover, a less inclusive standard would be equally effective. This is true for restrictions on relationships with current and former clients. In both cases, the only harms not addressed by the model code standard—two that relate to the effectiveness of therapy being impaired¹⁷⁸—are so minimally threatened that they probably do not need to be addressed at all.

A categorical ban on sexual relationships between nonpsychotherapeutic professionals and their current clients, however, does not heavily burden the right to marry. If the professional and the patient want to have sex and marry, they can simply terminate the professional relationship, and the patient can find another professional. Thus, a categorical ban on relationships with current clients would not be unconstitutional.

Categorical bans on sexual relationships between nonpsychotherapeutic professionals and their former clients, on the other hand, do heavily burden the right to marry. Consider, for instance, Arizona’s regulation prohibiting occupational therapists from “making sexual advances” to a former patient for six months after the end of therapy,¹⁷⁹ or Washington’s regulation prohibiting opticians from “solicit[ing] a date” with a former client within two years of

174. See O’Laughlin, *supra* note 11, at 711 (“[T]he constitutional right to marry . . . presupposes that dating relationships and friendships are constitutionally protected, primarily because marital union almost inevitably entails a period of dating or friendship leading up to the decision to wed.”).

175. *Zablocki*, 434 U.S. at 388.

176. See discussion *supra* Part II.

177. See, e.g., *infra* note 201.

178. See discussion *supra* Parts IV.C. & IV.D.

179. See ARIZ. REV. STAT. ANN. 32-3401 (Supp. 2008) (including “making sexual advances” as “sexually inappropriate conduct”); ARIZ. ADMIN. CODE § R4-43-101(5)(j) (2000) (setting forth the six month limitation).

the termination of therapy.¹⁸⁰ These regulations impose a significant burden: They effectively prevent therapists from ever marrying anyone who seeks their services. Given the weight of the burden, and the ease of remedying it (the state's interest would be adequately served by eliminating the categorical ban in favor of the model code standard), it's very likely that a categorical ban on sexual relationships between nonpsychotherapeutic professionals and their former clients is an unconstitutional burden on the right to marry.

C. The Right of Intimate Association

The same balancing analysis from *Lawrence* would apply to certain intimate relationships that are not sexual in nature. The Supreme Court has “concluded that choices to enter into and maintain certain intimate human relationships must be secured against undue intrusion by the State because of the role of such relationships in safeguarding the individual freedom that is central to our constitutional scheme.”¹⁸¹ This right of intimate association includes the choice to form “a close and familiar personal relationship with another that is in some significant way comparable to marriage or a family relationship.”¹⁸²

The state has greater latitude in limiting the exercise of the intimate association right when the personal attachment threatened is “attenuated” and not “intimate.”¹⁸³ But many relationships prohibited by categorical sexual misconduct bans are personal, romantic, and extremely intimate, “distinguished by . . . smallness, a high degree of selectivity in decisions to begin and maintain the affiliation, and seclusion from others in critical aspects of the relationship.”¹⁸⁴ Many sexual, romantic, and even friendship relationships between healthcare professionals and their clients or former clients therefore fit within the right of intimate association.

The analysis under the right of intimate association would likely resemble the analysis under *Lawrence*, since *Lawrence* is a specific application and extension of the right of intimate association.¹⁸⁵ Moreover, since most regulations target sexual contact, *Lawrence*'s intimate association right is particularly at

180. See ARIZ. ADMIN. CODE § R4-43-101(5)(j) (2000); WASH. ADMIN. CODE § 246-16-100(1)(o) (2007).

181. *Roberts v. U.S. Jaycees*, 468 U.S. 609, 617–18 (1984).

182. Kenneth L. Karst, *The Freedom of Intimate Association*, 89 YALE L.J. 624, 629 (1980).

183. *Roberts*, 468 U.S. at 620.

184. *Id.*

185. Kenneth L. Karst, *The Liberties of Equal Citizens: Groups and the Due Process Clause*, 55 UCLA L. REV. 99, 139 (2007) (noting that *Lawrence* “renewed the Court’s support for the freedom of intimate association”).

issue. For these reasons, an independent assessment of the right to intimate association need not be undertaken, but it should certainly be acknowledged that more than sexual relationships are protected by the Constitution.¹⁸⁶

VI. STATE CONSTITUTIONAL LIMITS ON THE SCOPE OF RESTRICTIONS

A. How Some States Protect Sexual Autonomy

Many states recognize a right to sexual autonomy “far more extensive than the right of privacy protected by the U.S. Constitution.”¹⁸⁷ Seven states to date have interpreted into their constitutional due process clauses a fundamental right to privacy that encompasses the right to sexual autonomy. Of ten states that have a right to privacy explicitly guaranteed in the state constitution,¹⁸⁸ one has interpreted it to include a fundamental right to sexual autonomy, and eight are still open to doing so.

Substantive due process right. Prior to *Lawrence v. Texas*, the Arkansas Supreme Court invalidated a law prohibiting homosexual sodomy on grounds that it violated the Arkansas constitution’s substantive due process protections.¹⁸⁹ The court held that “[t]he fundamental right to privacy implicit in our law protects all private, consensual, noncommercial acts of sexual intimacy between adults.”¹⁹⁰ This is just one of seven similar instances; Georgia, Kentucky, Minnesota, New York, Pennsylvania, and Tennessee have all also recognized a fundamental right to private sexual relations between consenting adults.¹⁹¹

Explicit constitutional privacy right. Montana’s constitution guarantees that the “right of individual privacy . . . shall not be infringed without the

186. For an analysis under the right to intimate association that predates *Lawrence*, see generally O’Laughlin, *supra* note 11.

187. *Powell v. State*, 510 S.E.2d 18, 22 (Ga. 1998).

188. National Conference of State Legislatures, Privacy Protections in State Constitutions, <http://www.ncsl.org/programs/lis/privacy/stateconstpriv03.htm> (last visited Feb. 11, 2009).

189. *Jegley v. Picado*, 80 S.W.3d 332 (Ark. 2002).

190. *Id.* at 350.

191. See *Powell*, 510 S.E.2d at 23–24 (“[T]he constitutional right of privacy screens from governmental interference a non-commercial sexual act that occurs between persons legally capable of consenting to the act.”); *Commonwealth v. Wasson*, 842 S.W.2d 487 (Ky. 1992); *Doe v. Ventura*, No. MC 01-489, 2001 WL 543734 (Minn. Co. Ct. May 15, 2001); *People v. Onofre*, 415 N.E.2d 936 (N.Y. 1980); *Commonwealth v. Bonadio*, 415 A.2d 47 (Pa. 1980); *Campbell v. Sundquist*, 926 S.W.2d 250, 262 (Tenn. Ct. App. 1996) (granting fundamental right status to “an adult’s right to engage in consensual and noncommercial sexual activities in the privacy of that adult’s home [because it] is a matter of intimate personal concern which is at the heart of Tennessee’s protection of the right to privacy”).

showing of a compelling state interest.”¹⁹² The state supreme court interpreted this guarantee to include “the right to engage in consensual, non-commercial, private, same-gender sexual conduct with other adults free of governmental interference or regulation.”¹⁹³ Louisiana, on the other hand, explicitly guarantees a right to be free from “unreasonable searches, seizures, or invasions of privacy,”¹⁹⁴ but its supreme court held that sodomy laws did not violate that right.¹⁹⁵

The other eight states with explicit constitutional privacy rights appear not to have interpreted the scope of those rights as they relate to private sexual relations between consenting adults.¹⁹⁶ Certainly some of these states could follow Montana’s lead. In particular, Alaska, Arizona, California, Florida, and Hawaii all have constitutional rights to privacy contained in general privacy or autonomy clauses similar to Montana’s.¹⁹⁷ These states should, like Montana, ground a right to sexual autonomy in their explicit constitutional privacy protections.

B. Applying State Rights to Current Regulations

Regulations in the above states that burden “private, consensual, noncommercial acts of sexual intimacy between adults” will be subjected to strict judicial scrutiny.¹⁹⁸ Strict scrutiny requires the state to support its regulation with a compelling state interest, and to narrowly tailor the regulation such that there exists no less restrictive alternative.¹⁹⁹

192. MONT. CONST. art. II, § 10.

193. *Gryczan v. State*, 942 P.2d 112, 123 (Mont. 1997).

194. LA. CONST. art. I, § 5.

195. *State v. Smith*, 766 So. 2d 501 (La. 2000).

196. Although, Washington has upheld the criminalization of consensual sex between a bus driver and eighteen-year-old students on grounds that *Lawrence* did not guarantee a fundamental right. *State v. Clinkenbeard*, 123 P.3d 872 (Wash. Ct. App. 2005). The defendant’s failure to rely on the state constitutional right to privacy may suggest that he thought the state right was weaker than the federal right, but the courts have not explicitly addressed the issue.

197. ALASKA CONST. art. I, § 22 (“The right of the people to privacy is recognized and shall not be infringed.”); ARIZ. CONST. art. II, § 8 (“No person shall be disturbed in his private affairs, or his home invaded, without authority of law.”); CAL. CONST. art. I, § 1 (“All people are by nature free and independent and have inalienable rights. Among these are enjoying and defending life and liberty, acquiring, possessing, and protecting property, and pursuing and obtaining safety, happiness, and privacy.”); FLA. CONST. art. I, § 23 (“Every natural person has the right to be let alone and free from governmental intrusion into the person’s private life except as otherwise provided herein.”); HAW. CONST. art. I, § 6 (“The right of the people to privacy is recognized and shall not be infringed without the showing of a compelling state interest.”).

198. *Jegley v. Picado*, 80 S.W.3d 332, 350 (Ark. 2002).

199. This is similar to the analysis under the right to marry, but it likely reaches more types of conduct, since it would protect sexual relationships that both parties have no intention of developing into a marriage.

A sexual misconduct regulation has been challenged on sexual autonomy grounds only once, and it was held unconstitutional. In *Caddy v. State Department of Health*,²⁰⁰ the Florida District Court of Appeal overturned a regulation that set no limit on the time a psychologist was prohibited from having sexual contact with a former client. The regulation prohibited psychologists from engaging in sexual intimacies (such as kissing) with their clients, and defined the duration of the professional relationship “to continue in perpetuity.”²⁰¹

The court acknowledged Florida’s compelling interests in “protecting the mental health of its citizens,” and “protecting the integrity of the medical profession,” but was convinced that a more narrowly tailored regulation—such as “a rule calling for a decision based on the individual facts of a case”—was the only way to constitutionally restrict the sexual autonomy of the psychologist.²⁰² This sort of less restrictive alternative, one that calls for case-by-case considerations, would presumably also be less restrictive than restrictions that placed two-year time limits on sexual relationships with former clients. That is, in Florida, we would think that even the American Psychological Association’s recommended prohibition on relationships with former clients would not pass constitutional muster.²⁰³

Other states may weigh the state or private interests differently and reach slightly different results but, since the interests remain the same, the variation should be minimal. At the very least, prohibitions that continue in perpetuity should not escape even the loosest application of a less-restrictive-means test, since there would always be a widely used alternative that even professional associations advocate as sufficient to protect the state interests: time limits of one, two, or five years.

This means, for instance, that Minnesota’s time-unlimited ban on sexual relationships between social workers and their former patients, and Pennsylvania’s seven-year ban on sexual relationships between social workers and their former patients (or immediate family members of former patients), should both be found unconstitutional.²⁰⁴ There is no reason to believe that regulations on relationships between these psychotherapists and their former clients or family members could not be as narrowly tailored as the regulation in *Caddy*. These therapists perform many of the same functions as a psychiatrist (and perhaps to a lesser degree), meaning that the state interests are likely no

200. 764 So. 2d 625 (Fla. Dist. Ct. App. 2000).

201. *Id.* at 627.

202. *Id.* at 629.

203. Recall that the APA recommends a two-year ban. See *supra* Part I.

204. MINN. R. 8740.0325(8) (2007); 49 PA. CODE § 47.63 (2005).

different than those expressed in *Caddy* and a standard would be no less effective. Moreover, even the National Association of Social Workers recommends that social workers never engage in sexual relationships with former clients, and does not suggest a categorical, eternal prohibition.²⁰⁵

The principles expressed in *Caddy* mean also that any state applying strict scrutiny to sexual misconduct regulations must invalidate categorical bans on relationships between nonpsychotherapeutic professionals and their former clients. This would include, for instance, Tennessee's ban on sexual relationships between chiropractors and their former patients for six months following treatment.²⁰⁶ If categorical bans in psychiatry are unconstitutional because they are not supported by a state interest great enough to overcome a standard's sacrifice in effectiveness, certainly they would not be constitutional in nonpsychotherapeutic professions, where the state interest is weaker and the sacrifice in effectiveness much less.

Specifically, the regulation in *Caddy* was supported by a state interest in protecting the mental health of patients of psychiatrists. This interest does not exist to the same degree (if it exists at all) in nonpsychotherapeutic professions; their practitioners do not treat mental problems. Similarly, there's little reason to think that the former clients of nonpsychotherapeutic professionals have a diminished capacity to look out for their own interests, since they do not enter therapy with the same sort of preexisting conditions or dispose themselves to transference as do patients of psychotherapists.²⁰⁷

But most importantly, whatever harms are risked by sexual contact between nonpsychotherapeutic professionals and their clients or former clients, they are equally effectively addressed by the model code standard. The one significant risk—in the impairment of the professional's judgment about the patient's treatment—is included in the standard, and violations of the standard are easily identifiable.²⁰⁸ The effectiveness of the model code standard, and its substantial benefit of allowing people to engage in constitutionally protected behavior, strongly indicates that categorical bans on

205. NAT'L ASS'N OF SOC. WORKERS, CODE OF ETHICS § 1.09(c) (2006), available at <http://www.socialworkers.org/pubs/code/code.asp> ("Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client. If social workers engage in conduct contrary to this prohibition or claim that an exception to this prohibition is warranted because of extraordinary circumstances, it is social workers—not their clients—who assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally.")

206. TENN. COMP. R. & REGS. 0260-2-.13(8)(d) (2007).

207. See *supra* Part IV.

208. See *supra* Parts IV.C. & IV.D.

sexual relationships between nonpsychotherapeutic professionals and their current or former clients are unconstitutional.

CONCLUSION

This Comment attempts to bring precision to an area of law that currently rests on extremely vague justifications. Imprecisely understood, the harms risked by psychotherapist-patient sexual relations appear to justify the same restrictions on many healthcare professionals. Precisely understood, it becomes clear that categorical bans are unnecessary in many of the contexts where they currently exist.

Making this point comprised a large part of the Comment, but it should not diminish the significance of the later portions. Ensuring that the state's goal—preventing the harms risked by sexual contact—was precisely understood provided the foundation for arguing that many current regulations are unconstitutional. Exploitation and vulnerability are concepts so omnipresent that if they were accepted as justifications for preventing sex between healthcare professionals and their clients, every categorical ban would be as tailored as it needed to be.

The constitutional arguments are particularly significant because they require that sexual misconduct regulations not overreach even when few people are affected. Most healthcare professionals will never engage in sexual relationships with clients or former clients. Those who do have successful and happy sexual relationships can find protection only in constitutional rights; without rights to sexual autonomy, marriage, or intimate association, their claims are likely only as strong as their numbers.

Nonpsychotherapeutic professionals should be assured that constitutional rights to sexual autonomy (under *Lawrence*) and to marriage do not prohibit restrictions on sexual relationships with their former patients. And all professionals should be assured that any time-unlimited ban on post-termination relationships simply can not withstand strict scrutiny. In states where sexual autonomy is recognized as a fundamental right, time-unlimited bans are unconstitutional. If *Lawrence* is eventually affirmed as a fundamental rights case, time-unlimited bans will be unconstitutional in all states.

Of course it's unrealistic to think that courts will suddenly begin invalidating many of these unnecessary and unconstitutional laws; plenty of people won't agree with my ultimate conclusions. But at the very least, I hope that courts will not be hesitant in requiring states to be more precise when they attempt to justify categorical bans on sexual relationships between healthcare professionals and their clients or former clients. If they do, it should

become clear that doing away with categorical prohibitions will not risk rampant professional misbehavior or extraordinary patient harms. Professionals who do misbehave can still be punished under a less broad standard, and those professionals who wish to engage in harmless sexual relationships with their clients or former clients will be freed from an unnecessary, burdensome, and often constitutionally suspect restriction.