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Psychosocial Characteristics of Health Care Providers Who Sexually Offend Minor Patients

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
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Walden University
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Abstract

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MPhil, Walden University, 2020

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Male health care provider sexual misconduct with minor patients is an ongoing problem in the United States. Previous research has produced a scant amount of insight regarding the phenomenon, and there is a lack of causal model development. Multimodal self-regulation theory served as the guide for the research questions in this study, which explored the psychopathology, paraphilia, and negative childhood experiences of male U.S. health care providers who commit sexual misconduct against minor patients. The goal was to develop offender profiles for each of five health care provider groups. Exploratory research was used with a grounded theory design for data collection purposes. Purposive sampling was used to examine 25 archival cases of male U.S. health care providers who commit sexual misconduct with minor patients: five from each health care provider group: physicians, psychiatrists, psychologists, mental health counselors, and nurses. Data were collected from a researcher-provided data set and from publicly available sources of information. Data analysis was conducted through thematic analysis to develop familiarity and themes. In vivo coding was used to avoid potential biases and identify patterns in the data. The themes observed were (a) nonsexual behavior, (b) sexual behavior, and (c) offender childhood experiences. Examples of findings include the presence of antisocial personality traits, paraphilia, and negative childhood experiences. Potential implications for positive social change that could occur as a result of this study include structured interviews for future research, organizational review of policies to inhibit future incidents, and handling sexual misconduct complaints seriously without bias or assumption.

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Dedication

This work is dedicated to my mother, Patricia. For so many years, your work in the medical field caring for the sick and injured has not gone unnoticed. Although you could not see the completion of my doctoral program, I know you are smiling down from heaven. Furthermore, thank you for your continued support during my educational journey to both of my parents. Your endeavors were not in vain.

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Chapter 1: Introduction to the Study

Introduction

Health care providers are known for helping others recover from injuries, illnesses, and mental health problems. Providers abide by varying types of ethics-based oaths, such as the Hippocratic oath, to ensure the highest standard of care is provided to each patient. Although most health care providers seek not to harm their patients, some violate minor patients sexually. Past researchers have provided invaluable knowledge regarding health care providers who commit sexual misconduct against their patients, such as areas of specializations of greatest frequency of offenders, yet there is still much to be understood regarding this phenomenon. Existing studies regarding male U.S. health care provider sexual abuse of minor patients have been primarily quantitative as researchers have sought to understand the prevalence of the phenomenon; however, little knowledge is provided regarding early developmental characteristics of health care providers who offend sexually. The aim of this study was to explore the psychosocial characteristics of health care providers who commit sexual misconduct against minor patients guided by the multimodal self-regulation theory assessing for psychopathology, negative family and peer experiences, and paraphilic acts.

Background

The role of health care providers is to provide quality health care to their communities (World Health Organization, 2021). Unfortunately, some providers violate professional boundaries by committing acts of sexual misconduct with minor patients (AbuDagga et al., 2016; Burgess et al., 2000; Celenza & Gabbard, 2003; DuBois, Walsh,

et al., 2017; Spittal et al., 2016). When professional boundaries are crossed, victims can sustain a variety of injuries: emotional (AbuDagga et al., 2016; Kelley & Gidycz, 2019; O'Driscoll & Flanagan, 2016; DuBois, Walsh, et al., 2017; Wolff & Mills, 2016), physical (AbuDagga et al., 2016; Wolff & Mills, 2016), and psychosocial (DuBois, Walsh, et al., 2017; Kelley & Gidycz, 2019; O'Driscoll & Flanagan, 2016; Wolff & Mills, 2016). Examples of injuries include depression, anxiety (Turchik & Wilson, 2010), posttraumatic stress disorder (PTSD; DuBois, Walsh, et al., 2017; Kelley & Gidycz, 2019; O'Driscoll & Flanagan, 2016), traumatic brain injury, and difficulty maintaining close relationships (Wolff & Mills, 2016). More severe injuries, such as death, are observed less frequently (AbuDagga et al., 2016).

Although the numbers of child maltreatment victims change from year to year, there was a 2.7% increase from 2013 to 2017 (U.S. Department of Health and Human Services, 2019). The total number of victims abused by the general population is 674,000 in 2017; 8.6% were sexually abused (U.S. Department of Health and Human Services, 2019). Larry Nassar is an example of health care provider sexual misconduct against minor patients. Nassar, a formerly licensed physician, pleaded guilty to several counts of sexual abuse of minor patients (Hauser & Astor, 2018). Nassar had committed these acts in plain sight, violating at least 265 minor patients over 20 years (DuBois et al., 2019; Hauser & Astor, 2018).

Research regarding U.S. health care providers who have committed acts of sexual misconduct with their patients who are under the age of 18 is limited to identifying frequencies, demographic correlates, and the impact on patients (AbuDagga et al., 2016;

AbuDagga et al., 2018; DuBois et al., 2019; DuBois, Walsh, et al., 2017). DuBois et al. (2019) indicated that causal models have not yet been developed for serious ethical violations, including understanding psychosocial characteristics of male U.S. health care provider sexual misconduct with minor patients. Psychosocial characteristics such as psychopathology, negative childhood experiences, and paraphilia have been identified by theorists to negatively impact self-regulation among sex offenders (Stinson, Sales, et al., 2008). Exploration of psychosocial characteristics can lead to the development of causal models and theories specific to male U.S. health care providers who commit sexual misconduct against minor patients (Stebbins, 2001), which in turn can aid in the prevention of future incidents (Faupel, 2015).

Problem Statement

Previous research has provided sufficient evidence of a problem with health care providers committing sexual misconduct with minor patients (AbuDagga et al., 2016, 2018; Burgess et al., 2000; Celenza & Gabbard, 2003; DuBois, Walsh, et al., 2017). Despite this knowledge, there were several limitations, such as data secrecy within the national practitioner databank (AbuDagga et al., 2016; DuBois, Walsh, et al., 2017), issues with reporting (AbuDagga et al., 2016; DuBois, Walsh, et al., 2017), and study methodologies (DuBois, Walsh, et al., 2017). Based on the limitations encountered, scholars agree they do not know all the characteristics of male U.S. health care providers who commit acts of sexual misconduct with minor patients (AbuDagga et al., 2016; Burgess et al., 2000; DuBois, Walsh, et al., 2017); thus, more understanding of such characteristics is needed.

Researchers have indicated that the scant amount of research is likely because sex offenders are considered deplorable with an associated stigma (Schaffer & Zarilla, 2018). Another possible reason for limited research may be based in part on preconceived notions about health care workers, such as behavioral requirements to obtain a medical degree would not also support a diagnosis of antisocial personality disorder (Langevin et al., 1999). Regardless of the reasoning behind the amount of research conducted, there is a lack of research of causal models of male U.S. health care provider sexual misconduct with minor patients. Although the exploration of psychosocial characteristics of male U.S. health care providers who commit sexual misconduct against minor patients can aid in the development of causal models, continued research in this area can aid in preventing further incidents, the management and mitigation of risk, and decision making (Faupel, 2015).

Purpose of the Study

The purpose of this qualitative study was to explore the psychosocial characteristics of male U.S. health care providers who commit acts of sexual misconduct with minor patients. The findings of this study will aid in the development of causal models behind the phenomenon and continued research will further the prevention of future incidents and the management and mitigation of risk and will aid in decision making such as through legislation. Finally, this study will aid in making the general public more aware of the phenomenon.

Research Questions

The following research questions guided this study:

RQ1: What are the psychosocial characteristics (psychopathology, negative childhood experiences, and paraphilia) of male U.S. health care providers who commit sexual misconduct with patients under the age of 18?

RQ2: Based on observed psychosocial characteristics, what are the male offender profiles of U.S. health care providers who commit sexual misconduct with patients under the age of 18?

The U.S. health care providers analyzed in this study were participants from five health care provider groups deemed most likely to offend sexually against patients. Male offender profiles were developed based on an analysis of patterns of observed psychosocial characteristics.

Theoretical Framework

The framework for this study consisted of the multimodal self-regulation theory described by Stinson, Sales, et al. (2008). Using this theory permitted the identification of characteristics of sex offenders such as developmental characteristics, an environment providing an opportunity for the offense, and an inability to self-regulate normally. Developmental characteristics, the biological and temperamental qualities an individual is born with, may predispose an individual toward maladaptive behavior if they experience an unstable or hostile environment during their childhood (Stinson, Sales, et al., 2008). Developmental characteristics may include behavioral problems, increased emotional sensitivity, psychopathology, and a greater chance of experiencing negative-based emotions (Stinson, Becker, et al., 2008). An environment providing an opportunity for the offense could include several options, such as a lack of witnesses, witnesses who are

not likely to report the offender for misconduct, or if the risks associated with committing the offense are considered acceptable to the offender (Stinson, Sales, et al., 2008). Self-dysregulation, an inability to self-regulate normally, occurs when an individual is unable to control their thoughts, emotions, and behaviors (Stinson, Sales, et al., 2008). Unlike self-regulatory strategies, dysfunctional strategies typically offer immediate relief with little or no effort, such as paraphilic or antisocial behavior (Stinson, Becker, et al., 2008). The use of this theory is vital because offender characteristics are associated with this theory, and therefore, male U.S. health care provider offender characteristics should have some similarities. For example, characteristics of male U.S. health care providers who commit sexual offenses would likely present similarly with offender characteristics, including periods of opportunity to commit the act and the inability to self-regulate normally; otherwise, the act would likely have not been committed.

Nature of the Study

The nature of this study was qualitative, and I used a grounded theory design for data collection purposes. This approach is consistent with exploring sex offender behavior. The phenomena that were explored consisted of psychosocial characteristics, including the offender's developmental characteristics, characteristics denoting self-dysregulation, characteristics describing the environment providing opportunity, and the type of sexual misconduct. Other data collected included offender and victim demographics, the type of harm resulting from the sexual misconduct, and any resulting litigation or disciplinary measures to account for saturation and the development of offender profiles.

Characteristics describing the environment providing opportunity can include elements that may reduce the risk of committing the offense. Developmental characteristics may include behavioral problems, emotional sensitivity, psychopathology, negative-based emotions, and hostile childhood history, such as child mistreatment. Forms of maltreatment may include one or a combination of the following forms of abuse: emotional, physical, and sexual abuse (Stinson, Sales, et al., 2008). Other examples of a hostile childhood environment may include an arrest of a family member and substance abuse by one or both parents (Stinson, Becker, et al., 2008). Some examples of psychopathology may include anxiety disorder, bipolar disorder, antisocial personality disorder, and avoidant personality disorder (Stinson, Becker, et al., 2008). Characteristics denoting self-dysregulation can include paraphilic acts and antisocial behavior. Some examples of paraphilic acts may include pedophilia, exhibitionism, voyeurism, frotteurism, and rape (Stinson, Becker, et al., 2008). Examples of antisocial behavior may include egocentricity with limited perspective, sensation seeking, resentment with a sense of entitlement, impulsivity, and irresponsibility (Stinson, Sales, et al., 2008). Stinson, Becker, et al. (2008) provide a complete list of psychopathology and paraphilic acts observed in sex offenders related to the multimodal self-regulation theory.

Definitions

Health care provider: A classification for any individual who is appropriately credentialed through licensure or certification and is employed to provide medical, physical, or mental health care for patients. Examples include, but are not limited to,

nurses, nurse aides, home health aides, physicians, psychiatrists, therapists, counselors, psychologists, or paramedics. For this study, a health care provider must be working as a health care provider at the time of the offense.

Minor victim: For this study, this classification refers to any individual under the age of 18 who has been the recipient of sexual behavior from a health care provider.

Paraphilia: Paraphilia, also known as *deviant sexual behavior* (Pandita-Gunawardena, 1990), can be described as an intense sexual interest that differs from the normal sexual behavior that occurs between two consenting adult partners (Hickey, 2016).

Paraphilic attachments: Nonconsensual sexual relationships developed via offender paraphilic behavior (Hickey, 2016).

Psychopathology: Although the term *psychopathology* typically refers to the study of mental disease (Venes, 2013), it has also been used as an identifier for the various types of mental illnesses, mental disorders, and abnormal behavior observed (American Psychiatric Association, 2013). For this study, *psychopathology* was used to describe the mental diseases and abnormal behaviors observed.

Psychosocial characteristics: A term used to describe the influences of social factors on an individual's mental health and behavior (Vizzotto et al., 2013). For this study, psychosocial characteristics included psychopathology, negative childhood experiences, and paraphilia.

Sex offender: A term for any individual who commits a sex-related crime against another individual (American Psychological Association, n.d.).

Sexual misconduct: Inappropriate behavior of a sexual nature within a professional relationship (Littleton, 2009). Examples may include, but are not limited to, sexual harassment, sexual abuse, inappropriate sexual relationships (Littleton, 2009), sexual impropriety, and sexual violation (Swiggart et al., 2008). For this study, sexual misconduct is any behavior within a professional relationship that is perceived or intended to be sexual.

Assumptions

This study was based on the assumption that the use of secondary data would be appropriate to study this phenomenon. Another assumption was that available data analyzed would be sufficiently accurate in providing the understanding necessary regarding the phenomenon.

Scope and Delimitations

The scope of this study was to explore the psychosocial characteristics of U.S. health care providers who commit sexual misconduct with minor patients. Delimitations included researching health care providers from the United States only, as perceptions of sexual misconduct vary from country to country (Miller et al., 2012). Patients are another delimitation as health care providers are required to care for this group of individuals without causing harm. Minors are another delimitation as it is abnormal for an adult to consider a minor a sexual preference. Health care providers who are serial killers are another delimitation because serial killers typically are involved sexually with their victims regardless of whether the offender demonstrated overt signs of a sexual motive (Hickey, 2016). For example, Hickey (2016) noted one instance in which a serial killer

admitted to sexual arousal during killing. Finally, men were another delimitation because female sex offenders are not homogeneous with male sex offenders (Hickey, 2016).

Limitations

Certain inherent limitations are expected when conducting a study on sex offenders using secondary data. One such limitation included convenience sampling, as only known offenders can be studied (Stinson, Sales, et al., 2008). Because offenders are known to deny or minimize their offensive behavior, there is a potential for biased responses within the data (Stinson, Sales, et al., 2008). Previous researchers have indicated that offenders typically are male, thereby limiting the generalizability to all genders (Stinson, Sales, et al., 2008). Finally, not all secondary data may be considered trustworthy, and as such, it may be considered for exclusion to limit any biased results and maintain the study's internal validity (Stinson, Sales, et al., 2008).

Significance

This study addresses a gap in the literature by providing exploratory insight regarding male U.S. health care providers who commit acts of sexual misconduct with minor patients. This study is unique because, although there is research regarding U.S. health care providers who have committed acts of sexual misconduct with their patients who are under the age of 18, there is scant insight regarding all aspects of the phenomenon, such as a lack of research in the development of causal models (AbuDagga et al., 2016; DuBois, Walsh, et al., 2017). This study could lead to positive social change by providing the necessary insight into the phenomenon required to guide future research, such as the development of causal models behind male U.S. health care provider sexual

misconduct against minor patients. The findings of this study provide the necessary insight into the phenomenon required in developing causal models and theories that can aid in preventing further sexual misconduct against minor patients. Continued research of the psychosocial characteristics discovered in this study is expected to provide legislation with a deeper understanding of the phenomenon required to create better laws in protecting children from the health care providers who molest them.

Summary

Previous researchers have indicated that despite the requirement to prevent harm to patients, health care providers commit acts of sexual misconduct with patients. The assessment and prevalence of health care provider sexual misconduct have been well documented. However, a paucity remains within the literature concerning an understanding of the etiology of sexual misconduct among health care providers, such as psychosocial characteristics pertaining to the development of self-dysregulation or maladaptive coping mechanisms. Exploring the psychosocial characteristics of health care providers may provide a better understanding of the etiology of their behavior. Within the next chapter, a review of the theoretical framework is included, along with the literature review and the strategies employed to search for the literature.

Chapter 2: Literature Review

Introduction

Health care providers care for others, aiding in patient recovery from illness and injury. Integrity, beneficence, and fidelity are examples of attributes expected from health care providers (American Psychological Association, 2017). Unfortunately, not all health care providers abide by these principles, as evidenced by criminal activity and ethical violations (Blakinger, 2016; DuBois et al., 2018, 2019). Crimes and violations can include fraud (Blakinger, 2016; Branting et al., 2016; Bucy, 1996; DuBois, Chibnall, et al., 2017; Legal Information Institute, n.d.; Trousdale, 2012; van Capelleveen et al., 2016), embezzlement (Doroghazi, 2019; Shorr, 2015), sexual misconduct (DuBois, Walsh, et al., 2017), various ethical violations (DuBois et al., 2018, 2019), various drug-related offenses (Blakinger, 2016), various sex-related offenses (Blakinger, 2016; Teegardin & Norder, 2019), abuse (Petersilia, 2001), and murder (Barros et al., 2016; Blakinger, 2016; Goodman, 2016, 2017; Hickey, 2016; Pitt & Bale, 1995; Yorker et al., 2006). Victims include both the general public and the patients these health care providers care for (Blakinger, 2016; Petersilia, 2001).

Egregious violations such as sexual misconduct against patients violate everything that health care providers stand for (DuBois et al., 2018). Most of the research related to sexual offending focuses on the victim experience and the potential harm victims may encounter to provide effective treatment plans. For example, victims of sexual assault are at risk for developing PTSD, depression (Kelley & Gidycz, 2019; O'Driscoll & Flanagan, 2016; Wolff & Mills, 2016), sexual dysfunction (Kelley &

Gidycz, 2019; O'Driscoll & Flanagan, 2016), substance abuse (DuBois, Walsh, et al., 2017; Wolff & Mills, 2016), anger and trust issues (DuBois, Walsh, et al., 2017), suicidal ideation, different forms of physical harm, and psychosocial issues (Wolff & Mills, 2016). Forms of physical harm can include sexually transmitted infections, traumatic brain injuries, and unwanted pregnancy (Wolff & Mills, 2016). Psychosocial issues that victims can develop include poor social integration, difficulty maintaining close relationships, and struggling with long-term employment (Wolff & Mills, 2016). Although death and major injuries occur, they are not considered a likely result due to low percentages (AbuDagga et al., 2016).

Researchers have indicated a need for increased knowledge about health care provider sexual misconduct (AbuDagga et al., 2016; DuBois, Walsh, et al., 2017). For example, causal models have not been developed regarding male U.S. health care provider sexual misconduct with minor patients (DuBois et al., 2019). Exploration of psychosocial characteristics can lead to the development of causal models and theories specific to male U.S. health care providers who commit sexual misconduct against minor patients (Stebbins, 2001), which in turn can aid in the prevention of future incidents (Faupel, 2015). The purpose of this study was to explore the psychosocial characteristics of male U.S. health care providers who commit acts of sexual misconduct with minor patients.

This chapter includes a discussion of the literature search strategy employed including the databases and search engines, key search terms, and iterative search process used and how the issue of little current research was handled. Next, a detailed analysis of

the theoretical foundation for this study will be provided, including major theoretical propositions, a description of how the theory has been applied, and a rationale for the theoretical choice. Finally, an exhaustive review of the literature is discussed.

Regardless of the reasoning behind the amount of research conducted, there is yet a lack of research of causal models of male U.S. health care provider sexual misconduct with minor patients. Although the exploration of psychosocial characteristics of male U.S. health care providers who commit sexual misconduct against minor patients can aid in the development of causal models, continued research in this area can aid in preventing further incidents, the management and mitigation of risk, and decision making (Faupel, 2015).

Literature Search Strategy

An exhaustive literature search was conducted using the databases Academic Search Complete, Criminal Justice Database, Expanded Academic ASAP (Gale Academic OneFile Select), Project Muse, ProQuest Central, PsycArticles, PsycINFO, SAGE Journals, ScienceDirect, SocINDEX with Full Text, and Taylor and Francis Online. The key terms used for the literature search included *sexual misconduct*, *boundary violation*, *health care*, *healthcare*, *patient-therapist*, *therapist-patient*, *pediatric*, *provider*, *physician*, *crimes*, *fraud*, *murder*, *assault*, *misconduct*, *abuse*, *boundary*, *harassment*, *doctor*, *health*, *practitioner*, *nurse*, *aide*, *aid*, *EMT*, *paramedic*, *health-care*, *home health*, *PA*, *MD*, *physician assistant*, *therapist*, *counselor*, *psychologist*, *sex*, *rape*, *violation*, *accused*, *convicted*, *guilty*, *alleged*, *charged*, *arrested*, *minor*, *patient*, and *child*. An initial literature search was conducted using the terms

within all the databases. Following the initial literature search, a secondary search was conducted within the databases that use autofill for the search parameters: Expanded Academic ASAP (Gale Academic OneFile Select), Criminal Justice Database, Project Muse, ProQuest Central, SAGE Journals, ScienceDirect, and Taylor and Francis Online.

The following procedures were conducted to ensure a thorough literature review was established. First, a search of the literature was conducted on crimes committed by health care providers to gather other potential search terms not expected, followed by a search of the literature focusing on sex offending in general. The search then transitioned to focus on health care providers who commit acts of sexual misconduct. A review was conducted of all literature related to the focus topic regardless of the publication date.

Theoretical Foundation

The framework chosen for this study consisted of the multimodal self-regulation theory by Stinson, Sales, et al. (2008). This theory was developed due to limitations in explaining and predicting sexual offending observed in previous/earlier theories (Stinson, Sales, et al., 2008). The theory consists of various elements from previous theories and other psychological and psychosocial components, with self-regulation as the primary driving force behind the theory (Stinson, Sales, et al., 2008).

Stinson, Sales, et al. (2008) indicated that sexually deviant behavior stems from self-regulatory deficits. Early childhood experiences serve to shape self-regulation in individuals with certain biological predispositions and have been supported by past and current research (Stinson, Sales, et al., 2008). Biological predispositions include the level of neuroticism or temperament, psychopathology, and behavioral problems (Stinson,

Becker, et al., 2008). Behavioral problems can include being withdrawn, somatic complaints, feeling anxious or depressed, social problems, thought problems, attention problems, delinquent behavior, and aggressive behavior (Kubzansky, 2004). Children who are more sensitive and react more emotionally may present with negative-based emotional responses, such as frustration and irritability, and may have trouble calming down (Stinson, Becker, et al., 2008). These biological predispositions are not inherently positive or negative, but certain negative life experiences may predispose an individual to develop maladaptive behavior (Stinson, Sales, et al., 2008). Hostile parenting styles, childhood trauma, such as sexual abuse or exposure to incestuous behavior during critical development periods, may negatively impact a child's functioning, including the development of maladaptive coping skills (Hickey, 2016; Stinson, Becker, et al., 2008).

Maladaptive coping skills may cause the child to internalize hostile or ineffective regulatory strategies (Stinson, Becker, et al., 2008). Examples of maladaptive coping skills include emotional dysregulation, interpersonal distress, psychopathology, delinquency, and aggression (Stinson, Becker, et al., 2008). Children who have substantial difficulty regulating their emotions and behavior also evidence poorer social interactions in the presence of same-aged peers and may experience victimization within these peer relationships (Stinson, Becker, et al., 2008). Finally, certain cognitive beliefs such as egocentricity with limited perspective, sensation seeking, resentment with a sense of entitlement, impulsive, and irresponsibility have been deemed tantamount for committing sexual-based offenses (Stinson, Sales, et al., 2008).

Areas in which self-regulation has been studied include the impact of self-regulation on sex offender behavior and treatment models. For example, Freud (1962) indicated that deficits in self-regulation could impact sex offender behavior whereby an offender may resort to using children as a sexual object based on impulse. Researchers studying treatment and etiological models have identified deficits in self-regulation as a factor of relapse in sexual offending (Stinson, Sales, et al., 2008).

Moreover, the theory's major theoretical propositions and hypotheses have further been corroborated by other researchers. Stinson, Becker, et al. (2008) found that paraphilia such as pedophilia, exhibitionism, voyeurism, frotteurism, and rape along with antisocial behaviors were predictive of self-regulatory deficits. Henshaw et al. (2018) found that offenders who preferred child pornographic content demonstrated high rates of sexual deviance but low rates of antisocial traits, whereas contact offenders presented the opposite finding. Dual offenders presented with both high sexual deviance and high levels of antisocial traits (Henshaw et al., 2018). Puszkiewicz and Stinson (2019) found that adverse childhood experiences influence the onset, severity, and persistence of delinquent and sexually abusive behavior among youth. Contact sexual offending is a maladaptive coping mechanism resulting from insecure attachment and self-regulatory deficits often developed in a chaotic environment in which parents are either absent or use inconsistent parenting styles (Puszkiewicz & Stinson, 2019).

Due to similar findings in previous research, I selected the multimodal self-regulation theory to identify psychosocial characteristics among health care providers who commit acts of sexual misconduct with minor patients. This permitted identification

of characteristics observed in offenders. The selection of this theory was based on an offender's inability to self-regulate. Health care providers are expected to perform their duties professionally, which presents no risk of harm to the patient, and seek to minimize harm during instances that harm is unavoidable. An example where harm is minimized includes notifying appropriate authorities of an impending threat of patients harming themselves or others.

Literature Review Related to Key Variables or Concepts

An exhaustive literature search for research articles about U.S. health care providers who commit acts of sexual misconduct with minor patients revealed a paucity of research. Many researchers have focused on physicians and identifying the extent of the problem. Available literature regarding health care providers did include data surrounding victims but did not focus on a specific victim age group such as minors. Research regarding offender psychosocial characteristics was also limited. Finally, none of the research reviewed all health care providers in general but instead focused only on specific types of profession. I reviewed the literature surrounding sex offenders, sex offender spectrums, sex offender subtypes, and developmental characteristics to understand sexual offender psychosocial characteristics better. My review revealed potential psychosocial characteristics of health care providers who commit acts of sexual misconduct with minor patients.

Sex Offenders

Although the umbrella term *sex offenders* is used to define all sex offenders, not all sex offenders are the same. Individuals who commit sexual-based offenses are

classified as a heterogeneous group based on several factors. Hickey (2016) indicated a number of these factors: (a) the level of psychopathy, (b) the development of fantasy and paraphilia, and (c) the preferred victim of choice. Hall et al. (1986) further identified the heterogeneity of sex offenders through variables such as the victim's gender, age, relationship to the offender, and the details of the offense, such as using force and whether the victim was molested or raped. Moreover, Hall et al. (1986) indicated that sex offenders against minors are more heterogeneous than previously considered based on an evaluation of Minnesota Multiphasic Personality Inventory (MMPI) profiles.

Developmental Characteristics

Developmental characteristics are the predispositions offenders are born with or develop over their formative years, which serve to shape who they are and how they interact with others. Stinson, Becker, et al. (2008) indicated that these include biological predispositions and negative experiences from family and peer socialization. Examples of biological predispositions include a higher level of neuroticism, behavioral problems, and psychopathology (Stinson, Becker, et al., 2008).

The American Psychiatric Association (2013) provided numerous examples of psychopathology regarding the kinds of conditions. Previous researchers have conducted studies on sex offenders and have noted psychopathology within their studied populations. The combined observed personality disorders include antisocial, borderline, narcissistic, schizotypal, schizoid, histrionic, paranoid, obsessive–compulsive, avoidant, and dependent (Ahlmeyer et al., 2003; Stinson, Becker, et al., 2008). Other observed personality disorders include personality disorder not otherwise specified (Stinson,

Becker, et al., 2008), avoidant, depressive, dependent, sadistic, negativistic, and self-defeating disorders (Ahlmeyer et al., 2003). Clinical syndromes observed provide two unique listings. Ahlmeyer et al. (2003) observed anxiety, somatoform, mania, dysthymia, alcohol abuse, drug abuse, PTSD, thought disorder, major depression, and delusional disorder within their studied population. Stinson, Becker, et al. (2008) observed depressive disorder, anxiety disorder, bipolar disorder, psychotic disorder, attention-deficit/hyperactivity disorder (ADHD), adjustment disorder, impulse disorder, and other disorders. Other diagnoses observed include mild mental retardation and borderline intellectual functioning (Stinson, Becker, et al., 2008).

Of all the above-noted psychopathology, Ahlmeyer et al. (2003) indicated that particular psychopathology was more predictive of being a sex offender, including schizoid, avoidant, depressive, dependent, self-defeating, schizotypal, anxiety, somatoform, dysthymia, PTSD, thought disorder, major depression, and delusional disorder. Further, Ahlmeyer et al. (2003) indicated that sexual offenders typically present with severe comorbid psychopathology, including affective disorders and psychosis.

Negative Family and Peer Experiences

Negative family and peer experiences negatively impact young minds when coupled with biological predispositions (Stinson, Becker, et al., 2008). Negative experiences cover a broad range and can differ among offender types. Previous researchers have noted various negative experiences amongst offender populations subjected to as a child, including witnessing a family member being arrested, witnessing parents abusing alcohol or other drugs, and experiencing any form of abuse. Hickey

(2016) indicated that sexual deviance stems from traumatic childhood experiences such as exposure to sexual-based violence from parents and hanging out with sexually violent friends. In contrast, individuals who commit acts of sexual homicide may also mimic violent, pornographic acts (Hickey, 2016). Puszkiewicz and Stinson (2019) studied 285 sexually abusive male adolescents reviewing archival records for nonsexual delinquent behaviors, sexually abusive behaviors, adverse childhood experiences (ACEs) questionnaire items, and sexual boundary problems. Puszkiewicz and Stinson (2019) indicated that childhood experiences associated with their behavior could include sexual abuse, witnessing sex, and being exposed to pornographic material.

Paraphilic Acts and Diagnoses

Researchers have indicated that paraphilia are predictive of self-dysregulation (Stinson, Becker, et al., 2008). Although multiple paraphilia are common in one person, one paraphilia is typically dominant (Hickey, 2016). Moreover, the dominant paraphilia may be replaced with another as the sex offender behavior fantasy changes over time (Hickey, 2016).

Researchers have indicated that paraphilia among sex offenders vary between themselves. Groups of paraphilia can include courtship disorders, preparatory paraphilia, attack paraphilia, primary paraphilia, and secondary paraphilia (Hickey, 2016). Paraphilia can also be grouped based upon what is observed within study populations. Paraphilia observed within an inmate population of sex offenders include pedophilia, exhibitionism, voyeurism, sadism, masochism, fetishism, frotteurism, transvestic fetishism, paraphilia

not otherwise specified, rape, zoophilia, telephone scatologia, and urophilia (Stinson, Becker, et al., 2008).

Paraphilia observed among serial offenders consisted of more extreme behavior including animal torture, anthropophagy, autoeroticism, coprophilia, exhibitionism, fetishism, gerontophilia, klismaphilia, infibulation, erotophonophilia, necrophilia, pedophilia, pederasty, pornography, pyrophilia, rape, sadism, masochism, scatologia, scopophilia, somnophilia (Hickey, 2016). Although this listing of paraphilia is rather extensive, Hickey (2016) provided a listing of paraphilia and sexual behaviors observed among serial murderers to include rape, sodomy, various sexual tortures, deviations, mutilations, perversions, and desecrations. Other appealing practices included vaginal intercourse, voyeurism, oral sex, group sex, anal stimulation, use of dildos or vibrators, homosexuality, and having sex with a stranger (Hickey, 2016). Occasional paraphilic fantasies observed among serial offenders included sex with a young girl or boy, raping a woman, being humiliated during sex, and sex with an animal (Hickey, 2016).

Sexual Predators

Depending upon the level of dangerousness a sexual offender poses to the community, they may be classified as a sexual predator. Hickey (2016) identified factors determining the level of dangerousness of sex offenders to include an increased number of offenses, an increased number of victims or multiple offenses on one or more victims over a period of time, targeting of victims that are familial and stranger, tend to be sexually exploitative, demonstrate higher levels of psychopathy, tend to have multiple paraphilia, and typically are not amenable to treatment and control. These qualities

demonstrate the high risk of recidivism of this class of offenders regardless of their punishment, placing their community at continual risk for their safety.

Health Care Providers

Previous researchers have studied various populations within the medical field. These population groups include physicians (AbuDagga et al., 2016; Dehlendorf & Wolfe, 1998; DuBois et al., 2019; DuBois, Walsh, et al., 2017; Langevin et al., 1999; MacDonald et al., 2015; Roback et al., 2007; Sansone & Sansone, 2009; Swiggart et al., 2016; Teherani et al., 2005), nurses (AbuDagga et al., 2018; Burgess et al., 2000), and counselors (Celenza & Gabbard, 2003; Ellis et al., 2014; Even & Robinson, 2013; Seto, 2017).

Physicians

Much of the research regarding health care provider sexual misconduct is regarding physicians. Demographics of most physician offenders were male (DuBois, Walsh, et al., 2017; DuBois et al., 2019; Langevin et al., 1999; MacDonald et al., 2015; Roback et al., 2007; Sansone & Sansone, 2009; Swiggart et al., 2016), primarily over the age of 39 (DuBois, Walsh, et al., 2017), and were primarily middle-aged ranging from 40 to 59 years old (AbuDagga et al., 2016; Dehlendorf & Wolfe, 1998; DuBois, Walsh, et al., 2017; Langevin et al., 1999; MacDonald et al., 2015; Roback et al., 2007; Swiggart et al., 2016). Some researchers indicated a mean age ranging from 46 to 49 (Langevin et al., 1999; Roback et al., 2007; Swiggart et al., 2016) or 53 (MacDonald et al., 2015). More than 80% of physician offenders were born in the United States, and over 60% of physician offenders were trained in the United States (DuBois, Walsh, et al., 2017;

DuBois et al., 2019), with most offenders from Tennessee followed by Texas (Swiggart et al., 2016).

Although physician offenders were observed in several specializations, researchers agreed that family practice is one of the specializations with many offenders. Other specializations with an increased number of physician offenders included pediatrics (DuBois, Walsh, et al., 2017), internal medicine (Swiggart et al., 2016), general practice (Dehlendorf & Wolfe, 1998), obstetrics and gynecology (Sansone & Sansone, 2009), and psychiatry (Dehlendorf & Wolfe, 1998; MacDonald et al., 2015; Sansone & Sansone, 2009). Sansone and Sansone (2009) indicated similar results whereby most physician offenders specialized in family medicine, psychiatry, obstetrics, and gynecology (Sansone & Sansone, 2009). Hickey (2020) indicated that the top offender groups include psychiatrists, psychologists, physicians, nurses, and mental health counselors. Board certification of physician offenders elicited mixed results. DuBois, Walsh, et al. (2017) and DuBois et al. (2019) indicated that physician offenders were more likely not to be board certified. Dehlendorf and Wolfe (1998) indicated no differences in physician offenders' likelihood to either be board certified or not. Osteopathic versus allopathic physicians were four times more likely to encounter boundary violation allegations (Sansone & Sansone, 2009).

Descriptive data such as these were identified in a study by DuBois, Walsh, et al. (2017) involving an examination of 101 cases of sexual violations occurring between physicians and their patients. Content analysis was used to generate descriptive data and cross-case analysis to identify causal factors (DuBois, Walsh, et al., 2017). Findings

included descriptive data on case attributes, but no interpretable clusters of causal factors and typologies were identified (DuBois, Walsh, et al., 2017). The researchers claim this is likely due to a possible limiting factor of an overlap between sexual abuse and unethical behavior.

Researchers had identified psychosocial characteristics of physician offenders when conducting their studies. The psychosocial characteristics identified included areas of psychopathology (DuBois, Walsh, et al., 2017; Langevin et al., 1999), experienced significant personal problems (DuBois, Walsh, et al., 2017), exhibited poor professional skills (DuBois, Walsh, et al., 2017; Teherani et al., 2005), attempted to falsify assessment findings (Langevin et al., 1999), abnormal assessment findings (Langevin et al., 1999; Roback et al., 2007), criminal history (Langevin et al., 1999), and history of abuse (MacDonald et al., 2015). Although these findings present an initial idea of the psychosocial characteristics of physician offenders, the findings are not generalizable due to inherent limitations within the study, such as incomplete data due to reporting issues (DuBois, Walsh, et al., 2017) and small sample size (Langevin et al., 1999).

Findings of psychopathology such as antisocial personality traits were identified for over 30% of physician offenders among 101 cases (DuBois, Walsh, et al., 2017). Roback et al. (2007) had conducted a study comparing personalities among 88 physicians using the MMPI-2 and the Personality Assessment Inventory (PAI) and identified similar findings of antisocial features were demonstrated by 40% of physician offenders among 20 participants. Moreover, sexual boundary violators demonstrated the least number of normal profiles and had the greatest percentage of character disorder profiles (Roback et

al., 2007). These findings are contrary to an earlier study whereby no antisocial personality traits were observed among physician offenders (Langevin et al., 1999). Langevin et al. (1999) had conducted a comparative analysis of 19 male physicians, 19 male sex offender control subjects, and a general sample of sex offenders. The groups were compared substance abuse, mental illness, personality, history of crime, neuropsychological impairment, endocrine abnormalities, and sexual history (Langevin et al., 1999). Findings demonstrated that physicians formed a subgroup of sex offenders due to differences in education and age. Other findings of psychopathology included evidence of severe mental illness among three percent of offenders (DuBois, Walsh, et al., 2017), nearly 11% of physician offenders were psychotic (Langevin et al., 1999), nearly 70% were sexually deviant (Langevin et al., 1999), and mixed results of substance abuse.

DuBois, Walsh, et al. (2017) reported that five percent of offenders in their study had a substance addiction. In contrast, Langevin et al. (1999) reported that over 15% of physician offenders self-reported alcohol abuse, and over 15% of physician offenders self-reported drug abuse. Physician sexual boundary violators were twice as likely to demonstrate characterological features such as impulsiveness or anger (Roback et al., 2007). Abnormal assessment findings included over 30% of physician offenders demonstrated an impaired Halstead-Reitan Neuropsychological Test Battery (Langevin et al., 1999). Physicians who commit sexual boundary violations demonstrated fewer normal Minnesota Multiphasic Personality Inventory-2 (MMPI-2) and Personality Assessment Inventory (PAI) profiles than physicians with a different form of misconduct or disruptive behavior (Roback et al., 2007).

Attempts to falsify assessment findings included over 30% of offenders produced fake phallometric results, and nearly 85% attempted to falsify on the MMPI (Langevin et al., 1999). Similar findings of physician sexual boundary violators demonstrated more invalid MMPI-2 profiles than physicians of other violations (Roback et al., 2007). Additionally, findings of minimization or denial regarding childhood trauma occurred among physicians referred primarily for sexual boundary violations (MacDonald et al., 2015). The findings regarding sexually inappropriate behavior align with the tendency that sex offenders attempt to be deceptive (Stinson, Sales, et al., 2008). Other assessment findings included nearly seven percent experienced significant personal problems, nearly seven percent exhibited poor professional skills (DuBois, Walsh, et al., 2017), over 30% had an endocrine disorder, and nearly 11% had a criminal record (Langevin et al., 1999). Endocrine disorders reported include diabetes, hyperthyroidism, and sex-hormone functioning abnormalities (Langevin et al., 1999).

MacDonald et al. (2015) studied 100 health care providers who were primarily male physicians from the United States referred for sexual boundary violations through analysis of structured autobiographies, the Experiences in Close Relationships Questionnaire Revised (ECR-R), the Childhood Trauma Questionnaire (CTQ), the Young Schema Questionnaire (YSQ), clinician ratings of autobiographies, and data analyses. Findings of childhood trauma included 60% of at least one form of abuse or neglect (MacDonald et al., 2015). Findings of the type of trauma included 25% of violators experienced some degree of emotional abuse, 21% experienced physical abuse, 12% experienced sexual abuse, 86% experienced emotional neglect, and 21% experienced

physical neglect (MacDonald et al., 2015). MacDonald et al. (2015) concluded a possible connection between childhood adversity and boundary difficulties, partly mediated by insecure attachment and early maladaptive beliefs.

Findings of sexual violations committed by physicians included consensual sex, touching, comments, child molestation, sodomy, and rape (DuBois, Walsh, et al., 2017). Similar findings included physician sexually offensive behavior such as had sex or had been sexually provocative with patients or staff (Roback et al., 2007). Findings of harm resulting from sexual-based violations included emotional injury, death, quadriplegia, brain damage, lifelong care, permanent injuries, and temporary injuries (AbuDagga et al., 2016).

Nurses

Research related to sexual misconduct committed by nurses and other nurse-related occupations such as nurse aide was more limited than that of research focusing on physicians. A study conducted by AbuDagga et al. (2018) analyzed nurse sexual misconduct reports made to the national practitioner databank. Some of the findings included more than 60% of offenders being male, over 30% of offenders aged 35-44 years old, and over 60% were registered nurses and advanced practice nurses (AbuDagga et al., 2018). Other nurse specializations identified within sexual misconduct research include licensed practical nurses, licensed vocational nurses (AbuDagga et al., 2018), and nurse aides (Burgess et al., 2000).

The psychosocial characteristics of nurse offenders identified were minimal. A common characteristic among nurse aide offenders included low social competence

(Burgess et al., 2000). Other characteristics included nonsadistic, vindictive, and opportunistic (Burgess et al., 2000). The only respiratory therapist offender was classified as a muted sadistic (Burgess et al., 2000). One nurse aide offender was diagnosed with attention deficit disorder (ADD) and depression and had experienced childhood trauma of sexual assault by a cousin (Burgess et al., 2000). Other characteristics based upon investigations included preexisting sexual fantasy, expressive aggression, and sadism (Burgess et al., 2000). Similar findings with that of physician offenders and general sex offenders included denial and minimization of the sexual offense also occurred with nurse aides (Burgess et al., 2000). Health care providers within the nursing home setting held prior criminal records or egregious employment histories (Burgess et al., 2000). Forms of sexual misconduct include sexual intercourse, vaginal penetration with a foreign object, sexual assault, and rape (Burgess et al., 2000). Injuries sustained by their victims included over 90% with emotional injury only, insignificant injury, and temporary injuries (AbuDagga et al., 2018).

Counselors

Research regarding counselor sexual misconduct is just as equally sparse as with the nursing field. Findings indicated that therapists are not an overly psychopathic group of offenders, that they do not all offend against more than one victim, and that there are among them who are amenable to treatment based upon studies involving over 200 cases of individuals referred to treatment for sexual misconduct (Celenza & Gabbard, 2003). Findings included 25% of therapists or analysts who were multiple transgressors, less than 25% who were psychopathic or narcissistic, and 66% of offenders had only one

victim (Celenza & Gabbard, 2003). Findings indicated that health care providers who do not graduate from a Council for Accreditation of Counseling and Related Educational Programs approved program tend to encounter more ethical boundary violations (Even & Robinson, 2013).

Seto (2017) discussed the research about clergy sexual offenders as it pertained to chronophilia. Seto (2017) indicated that studies conducted on clergy who commit sexual offenses against children had produced unique results due to different age groups targeted by offenders. Victim age groups identified include adolescents between 13 and 17 years old and children 10 years old and younger (Seto, 2017). Of the offending sample, 11% of clergy were classified as ephebophiles (Seto, 2017).

Ellis et al. (2014) had conducted two studies to test Ellis's framework for inadequate and harmful supervision after revising the framework. Ellis et al. (2014) found that out of 363 supervisees, over 90% had received inadequate supervision, and over one-third, harmful supervision, with more than half had received harmful supervision. Some of the harmful supervision descriptors included have a sexual relationship, have been sexually intimate, and supervisors behaving sexually inappropriate (Ellis et al., 2014).

Justification

Previous researchers have studied the phenomenon of health care provider sexual misconduct through analyzing the extent of the phenomenon, more serious violations of the phenomenon, and the impact it has had on their victims using primarily quantitative and mixed methods designs (DuBois et al., 2019). Strengths of previous research approaches include an ability to identify offender and victim demographics, ability to

find weaknesses in data sets, ability to make recommendations for future research, ability to make recommendations to remedy problem areas within data sets, and an ability to make recommendations to aid in preventing future offending. Weaknesses of previous research approaches included an inability to identify all variables regarding the phenomenon, an inability to generalize to all health care providers, and an inability to understand the etiological factors behind the violations.

Psychosocial characteristics such as developmental characteristics, negative family and peer experiences, and paraphilia are an inherent aspect of the development of maladaptive behavior and are predictive of self-dysregulation (Stinson, Sales, et al., 2008). Using a qualitative approach to explore psychosocial characteristics will provide a better understanding of etiological factors associated with health care provider sexual misconduct with minors. Exploring health care providers who offend against minors will help to minimize heterogeneity that other researchers of the phenomenon did not account for.

Summary and Conclusions

Within this chapter, sex offenders, sex offender spectrums, and sex offender subgroups are known to offend against minors along with their respective psychopathology, negative family and peer experiences, and paraphilic behavior were reviewed. Available research from the literature review demonstrated that paraphilia and antisocial personality traits were predictive of self-dysregulation (Stinson, Becker, et al., 2008). Researchers demonstrated that certain biological predispositions when coupled with negative or traumatic childhood experiences and certain cognitive beliefs such as

egocentricity with limited perspective, sensation seeking, resentment with a sense of entitlement, impulsive, and irresponsibility lead to sex offending as adults (Stinson, Becker, et al., 2008).

Although researchers have identified some psychosocial characteristics of health care providers who commit sexual misconduct against their patients, their research findings are not complete, are not focused on a specific age group, and not all their findings are clearly defined. The aim of this study was to contribute detailed and thorough findings that can contribute to a deeper understanding of the phenomenon. The following chapter will include a discussion of the methodology behind this study.

Chapter 3: Research Method

Introduction

The purpose of this study was to explore the psychosocial characteristics of male U.S. health care providers who commit acts of sexual misconduct with minor patients. Previous researchers, such as DuBois, Walsh, et al. (2017), have conducted studies identifying psychosocial characteristics related to male U.S. health care provider sexual misconduct against minor patients but provide scant insight into the phenomenon. Furthermore, researchers have reported a lack of causal model development (DuBois et al., 2019), which may prove instrumental when coupled with further research to help prevent future incidents (Faupel, 2015). The intent is that the findings of this study would aid in the development of causal models behind the phenomenon and that continued research would further the prevention of future incidents, the management and mitigation of risk, and aid in decision making such as through legislation. Finally, the findings of this study may aid in bring greater public awareness of the phenomenon.

This chapter includes a discussion of the research method used. Included is the research design, the role of the researcher, the participant selection logic, and the data analysis plan. Finally, issues of trustworthiness and ethical considerations are discussed.

Research Design and Rationale

Research Questions

The following research questions guided the study:

RQ1: What are the psychosocial characteristics (psychopathology, negative childhood experiences, and paraphilia) of male U.S. health care providers who commit sexual misconduct with their patients who are under the age of 18?

RQ2: Based upon observed psychosocial characteristics, what are the male offender profiles of U.S. health care providers who commit sexual misconduct with their patients who are under the age of 18?

The U.S. health care providers analyzed consisted of members of the five health care provider groups most likely to offend sexually against patients. Male offender profiles were developed based on an analysis of patterns of observed psychosocial characteristics.

Phenomenon of the Study

The phenomena studied were the psychosocial characteristics of male U.S. health care providers who commit sexual misconduct with their patients under the age of 18. For this study, psychosocial characteristics are known as the influences of social factors on an individual's mental health and behavior (Vizzotto et al., 2013) and include psychopathology, negative childhood experiences, and paraphilia. For this study, psychopathology refers to various types of mental diseases and abnormal behavior such as antisocial personality disorder (American Psychiatric Association, 2013). Negative childhood experiences are the childhood experiences perceived by the subject to be negative or that societal norms consider negative, such as sexual abuse (Stinson, Sales, et al., 2008). Paraphilia, also known as deviant sexual behavior (Pandita-Gunawardena, 1990), can be described as an intense sexual interest that differs from the normal sexual

behavior that occurs between two consenting adult partners, such as frotteurism (Hickey, 2016).

Research Tradition

The research tradition employed for this study was exploratory research using a grounded theory design for data collection purposes. Exploratory research is defined as a special approach that is broad-ranging, intentional, and systematic (Given, 2008; Stebbins, 2001). This approach is useful when encountering limited knowledge for a given phenomenon as it is designed to maximize discovery of the phenomenon (Given, 2008; Stebbins, 2001).

Grounded theory is a form of research that generates a theory or theories grounded in the data (Charmaz, 2006). When using a grounded theory approach to collecting data, all forms of information can be considered potential data while showing caution for quality, relevance, and usefulness (Charmaz, 2006). Previous researchers have used this approach when studying phenomena with little to no preexisting knowledge regarding the phenomena being studied. For example, Hickey (2016) used a grounded theory approach with data from several areas, including interviews, newspapers, journals, and more until saturation was achieved.

Role of the Researcher

The role of the researcher was to analyze and interpret secondary data that were gathered from multiple sources such as data sets and public sources such as scientific journals and newspapers. Using secondary data and public sources of information removes contact with participants because other researchers have collected the data for a

different study purpose (Tripathy, 2013). Because there was no contact with participants, there were no relationships. Any potential or unknown biases were controlled through regular communication with the dissertation committee to ensure compliance with proper research methodology and scientific rigor. Although I was employed in a health care setting as an emergency medical technician–critical care tech, I did not conduct this study at or within my workplace setting and eliminated potential ethical issues associated with the work environment, conflict of interest or power differentials, and justification for the use of incentives.

Methodology

Participant Selection Logic

The population analyzed were male health care providers in the United States who have committed acts of sexual misconduct against minor patients. The health care providers analyzed were derived from five groups that have demonstrated the greatest numbers of offenders—namely, psychiatrists, nurses, psychologists, mental health counselors, and physicians (Hickey, 2020). The sampling strategy employed was purposive sampling. This sampling strategy involves choosing participants or cases that meet specific criteria as there is some connection to the research question, such as an experience or knowledge about a phenomenon (Ravitch & Carl, 2016). Secondary data must include a male U.S. health care provider who had committed some form of sexual misconduct against a minor patient while functioning in their position as a provider. For example, a nurse who was treating a minor patient and had inappropriately touched the patient.

The number of cases for this study began with five health care providers from each group of health care providers—five psychiatrists, five nurses, five psychologists, five mental health counselors, and five physicians—resulting in 25 cases. Stebbins (2001) has suggested 30 cases but has seen studies done with fewer. For this study, 25 cases were the starting point, with additional cases added until saturation was achieved. Saturation occurs when new themes or patterns have not emerged during data analysis and unexplained phenomena do not exist (Burkholder et al., 2016). The concept of saturation makes choosing a sample size difficult, but an option to continue with data collection and analysis should be employed until saturation is achieved (Burkholder et al., 2016).

Data Analysis Plan

Data analyzed were from secondary data sources. Secondary data sources included data sets from other researchers and public sources, such as news articles, publicly available legal documents, published articles, and historical documents. Other researchers have used similar methods where scant research has been conducted (Hickey, 2016). Data were connected to all research questions based on the inclusion criteria of a male U.S. health care provider who had committed sexual misconduct with a minor patient.

Data were coded and analyzed using NVivo, one form of computer-assisted qualitative data-analysis software. NVivo is a helpful product designed to process and query codes in various ways, enabling a researcher to conduct data analysis more efficiently (Hoover & Koerber, 2011). Coding with NVivo is accomplished by manually

coding portions of the data according to themes that can then be retrieved during analysis (Hoover & Koerber, 2011).

When conducting data analysis of historical documents, there is an expectancy to come across an absence of data regarding the research question for any given case studied. Other researchers have indicated this limitation does not mean the absence of data for any given document indicates an absence of data related to the case (DuBois, Walsh, et al., 2017). This absence of data may be one way the case could be perceived as discrepant. Discrepant cases, or discrepant data, can be described as evidence that does not fit a pattern within the study (Ravitch & Carl, 2016). Discrepant cases within qualitative analyses are handled a bit differently than other cases. Discrepant data should not be ignored or forced into a code (Kaczynski, 2004). Careful analysis of any discrepancies should be conducted and included in the final report as it supports credibility and dependability (Ravitch & Carl, 2016).

Issues of Trustworthiness

Issues of trustworthiness must be addressed to ensure value in research. With trustworthiness, researchers can be confident in their data (Burkholder et al., 2016). Concepts of trustworthiness include credibility, transferability, dependability, and confirmability (Ravitch & Carl, 2016).

Credibility is achieved when the research is perceived to be accurately represented despite its complexities (Ravitch & Carl, 2016). Processes such as triangulation and saturation were used to help achieve credibility. Triangulation involves using multiple data collection methods or a wide range of sources (Shenton, 2004). For

this study, I conducted triangulation using varying types of sources for data, such as secondary data sets, journals, and historical documents. Saturation was achieved when new themes or patterns were not observed during data analysis.

The concept of transferability refers to the degree to which the results from a study will transfer to other situations or contexts (Burkholder et al., 2016). I incorporated processes such as thick description, which permit the audience to draw comparisons (Burkholder et al., 2016; Ravitch & Carl, 2016). Thick description is a thorough description of data and context about a phenomenon (Ravitch & Carl, 2016; Shenton, 2004).

Dependability is described as stable data resulting in consistent research (Ravitch & Carl, 2016). I used an audit trail to help ensure the dependability of the study. An audit trail can include a description of the sequence of methods and rationale to provide the audience an understanding of the steps taken to conduct the study (Ravitch & Carl, 2016). I described the methodology used for this study and consulted with the dissertation committee to ensure dependability.

Confirmability is the representation of the source of information rather than the researcher (Shenton, 2004). Triangulation, audits, and reflexivity are methods confirmability can be demonstrated with (Ravitch & Carl, 2016). Although triangulation and audits were used in this study, reflexivity is another method employed to ensure transparency. Reflexivity is the transparency of a researcher's background, such as discipline and training, which may impact data analysis (Burkholder et al., 2016). Reflection on potential biases based on cultural background, nationality, and ability status

will aid in remaining reflexive (Burkholder et al., 2016). For this research, I considered potential biases and remained aware of them throughout this study.

Ethical Procedures

Ethics in research involves several concepts regarding the protection of research participants. These include protection of privacy through maintaining confidentiality or anonymity, obtaining informed consent, which serves to minimize harm (Ravitch & Carl, 2016). Confidentiality is a term that refers to changing or omitting information that can be used to identify participants (Ravitch & Carl, 2016). The term anonymity refers to the lack of contextual information to provide the audience a means to identify the research participants (Ravitch & Carl, 2016). There were no research participants for this study as data were gathered from secondary data, such as data sets and publicly available documents such as news articles and journals. There were no ethical concerns regarding the recruitment of participants, no informed consent procedures, and no data collection measures. Because data sources were from secondary data and publicly available sources and not from my work environment, other issues such as conducting a study within a researcher's work environment, conflict of interest, power differentials, and justification for the use of incentives did not exist for this study.

Despite the lack of participants, there were still ethical concerns that needed to be addressed regarding secondary data analysis. First, permission was obtained from the data set owner and acknowledgment to the data set owner (Tripathy, 2013). Institutional review board (IRB) approval was obtained prior to collecting any data. The IRB approval number for this study is 10-19-21-0709705 and expires May 2022. Consent may be

required for any participants listed within the data set unless certain conditions are met, such as the identifying information is publicly available, the identifying information is removed or coded, or there is no identifying information within the data set (Tripathy, 2013). For this study, any agreements to gain access to data sets were included. All data pertaining to this study is stored on my personal home desktop computer with password protection and encrypted file folders.

Summary

This chapter contained a discussion pertaining to the methodology of this research study. The research design provided the research questions, a description of the phenomena to be studied, and the research tradition to be used along with rationale. The role of the researcher was then discussed along with the methodology, which included the participant selection logic and data analysis plan. Finally, issues of trustworthiness and ethical procedures were discussed.

Chapter 4: Results

Introduction

The purpose of this study was to explore the psychosocial characteristics of male U.S. health care providers who commit acts of sexual misconduct with minor patients. The intent was that the findings of this study will aid in the development of causal models, support continued research, and inform the general public of the phenomenon. The research questions that guided this study were:

RQ1: What are the psychosocial characteristics (psychopathology, negative childhood experiences, and paraphilia) of male U.S. health care providers who commit sexual misconduct with their patients who are under the age of 18?

RQ2: Based upon observed psychosocial characteristics, what are the male offender profiles of U.S. health care providers who commit sexual misconduct with their patients who are under the age of 18?

This chapter includes a discussion of the data collection process, data analysis, evidence of trustworthiness, and the results.

Setting

Using secondary data analysis for this study provided the benefit of limiting undue influences from external factors. For example, data collection took place in my home. A space was set aside for the sole purpose of conducting this study to eliminate distractions. Other potential issues such as changes in personnel, budget cuts, and trauma were nonexistent.

Demographics

Cases included within this study were collected only from a secondary data set from another researcher and public access sources via the internet as approved by the institutional review board (IRB). Case demographics were aggregated per IRB requirements. Offenders ranged in age from 24 to 81, with nurses being the youngest offenders and psychiatrists being the oldest. Most offenders' race classification was White; two were Black, one was Indian, and five were unknown. Offense dates ranged from the 1960s to 2020.

Data Collection

The total number of cases collected was 25 (n = 25), resulting in five cases for each of the five groups of health care providers: mental health counselors, psychiatrists, psychologists, physicians, and nurses. First, names of cases known through the provided data set were used. When case names were exhausted from the data set, I conducted a search on the internet to locate other potential cases from online databases such as the PsychCrime Database, the National Institute of Justice, the Bureau of Justice Statistics, Leagle, Psychologist-reputation, ProPublica, the U.S. Attorney's Office Southern District of California, 4patientsafety, *The Atlanta Journal-Constitution*, and the Mental Health Crime Chronicle. After enough cases were identified for inclusion, an internet search was conducted using databases including Casetext, and Google Search, with the case name as the search terms to ensure sufficient data were collected for each case. Data were recorded using the NCapture extension for the Google Chrome browser. Any pertinent

PDF files were downloaded. All NCapture files and PDF files were then imported into NVivo for data analysis.

The data collection plan was to collect data from other secondary sources such as data sets from other researchers. Although one data set was made available through a data use agreement as part of the IRB approval, there was no available access to other data sets for public viewing that would also provide access to names of cases. The open-source data sets I found on the internet either did not provide the data required to answer the research questions or required a data use agreement to gain access and, therefore, were not open to the public; a small number of cases presented with a greater amount of data available.

Data Analysis

Data were analyzed using thematic analysis. Using NVivo, all files were assigned to their relevant cases. Each case was reviewed to become familiar with the data. In vivo coding was conducted based on the results from a word frequency query. Categories were then generated from those codes based on observed criteria. For example, codes such as *pornography*, *oral sex*, and *sodomy* were placed under the category *forms of sexual contact*. Themes were then assigned to categories observed, including *sexual behavior*, *offender childhood experiences*, and *nonsexual behavior*. Themes were not attributed based on the expected variables identified within the research questions because they did not apply. For example, not all forms of sexual contact applied to a specific paraphilia such as *consensual*. As such, broader themes were used to account for the more specific psychosocial characteristics while accounting for all the data results observed.

Discrepant cases were either not considered high profile and did not have a high level of media coverage or were a more recent offense with little media coverage. High-profile cases involved offenders with vast numbers of victims over a long period, public officials, offenders with unique qualities, and offenders involved in other criminal cases such as murder. Character qualities were considered for analysis as provided in news articles and other journalistic entries to account for discrepancies. Discrepant cases demonstrated fewer articles available with less information for them. All cases were reviewed and analyzed equally regardless of the amount of data about them, understanding that some cases may not have been investigated as deeply as others, their data may not have been publicly available, or the data were not readily discoverable.

Evidence of Trustworthiness

Credibility

As described in Chapter 3, the processes of triangulation and saturation were used to help achieve credibility. Triangulation was conducted using multiple sources for data, such as a secondary data set made available by another researcher and public sources of information on the internet, such as news articles, legal documents, and government websites. I had expected that other sources of data publicly available would be a likely data source, such as journals and open-source data sets. However, none were discovered to apply to the cases of this study. When new themes or patterns were not observed during data analysis, saturation was achieved.

Transferability

I discussed in Chapter 3 that transferability would be accounted for using thick, rich description. This strategy was employed to provide the context and allow for transferability. Quoting sources to provide verbatim accounts was included during a discussion of themes and codes to help provide the context. No adjustments were made to the transferability strategies as previously described in Chapter 3.

Dependability

An audit trail was used to establish dependability. The sequence of methods and rationale behind the study provided the audit trail. In addition, I consulted the dissertation committee regarding the process. No adjustments were made to the dependability strategies as previously discussed in Chapter 3.

Confirmability

Confirmability was established through the application of triangulation, audits, and reflexivity. Triangulation and audit trails were previously discussed within this chapter's credibility and dependability sections. I remained transparent and considered potential biases throughout the study. There were no deviations from the strategies previously discussed in Chapter 3.

Results

This qualitative study involved secondary data analysis of a researcher-provided data set and publicly available sources of information to explore the psychosocial characteristics of male U.S. health care providers who commit sexual misconduct against minor patients.

Research Question 1

RQ1: What are the psychosocial characteristics (psychopathology, negative childhood experiences, and paraphilia) of male U.S. health care providers who commit sexual misconduct with their patients who are under the age of 18?

Themes identified during data analysis include nonsexual behavior, sexual behavior, and offender childhood experiences. Table 1 visually depicts the themes and categories identified during data analysis.

Table 1

Themes and Categories

Themes	Nonsexual behavior	Sexual behavior	Offender childhood experiences
Categories	Appearance	Forms of sexual contact	Parental behavior
	Descriptors	Victim preference	Personal behavior
	Diagnoses/treatment	Descriptors	Other family member behavior

Theme 1: Nonsexual Behavior

The theme of nonsexual behavior includes the categories and the respective codes for all nonsexual behavior identified within the cases analyzed. The reasoning for this decision was that not all data referred explicitly to psychopathology but referred implicitly to psychopathology, psychopathological traits, or no reference to psychopathology. Three categories were identified within the theme of nonsexual behavior, including *appearance*, *behavioral descriptors*, and *diagnoses/treatment*. Of the 25 cases analyzed, nine cases did not have identifiable data within this theme. The diagnoses/treatment category applied to only one case whereby the offender received

treatment for anxiety as he “had been taking anti-anxiety medicine for years.” The same offender had also “attempted suicide” and “was diagnosed as having a psychotic disorder.”

Public perceptions of offender behavior that were not identified as a clinical diagnosis nor received treatment for their behavior were categorized under behavioral descriptors. In one case, the offender was identified as a “former drug addict and alcoholic” who used this platform to aid other addicts. Thirteen of the 25 cases were identified as abusive based on their actions toward their victims, such as “sexual abuse of a child,” “abused dozens of other patients,” “raped and sexually abused scores of his young patients.” Four of the cases were identified as being “violent,” such as “violent, brutal, forced attack,” “bitter, violent, crotchety old man,” and “dark and ultimately violent secrets.” One of the cases was described as “delusional” and “crazed.” One of the cases was described as “aggressive,” “diabolical,” and “an expert at manipulation, deceit.” Two cases were identified as “controlling.” One case was described as “mean,” two cases were identified as a “monster,” and one case was identified as “scary.”

An offender’s appearance as perceived by the public was identified among the data. One case had several attributes associated with him, including “disheveled,” “eccentric,” “disgusting,” “weird,” “oddball,” “shy,” “socially awkward,” and “expressed no remorse.” Another case shared the same attribute of “disheveled.” One case was given the attribute of “scary.”

Theme 2: Sexual Behavior

Like nonsexual behavior, the theme of sexual behavior includes the categories and their respective codes for all sexual behavior identified within the analyzed cases. The term paraphilia was not used for this theme because not all data referred explicitly to a paraphilia. Although many of the codes refer to paraphilia, some would require further investigation to determine if the sexual behavior was associated with paraphilia. Finally, paraphilia identified may also be recognized as specific psychopathology. While this may be the case, paraphilia have been segregated to the sexual behavior theme based on the theoretical framework and research supporting the theoretical framework.

The theme of sexual behavior included the categories *forms of sexual contact*, *victim preference*, and *descriptors*. The category forms of sexual contact were well-documented among the data. Four cases involved "pornography" and 20 of the cases involved some form of intercourse. Thirteen of the cases involved "sexual abuse," 10 cases involved "sexual assault," two cases were identified as "consensual," two cases were identified as "intercourse," eight cases included "oral sex," seven cases involved "rape," and two cases involved "sodomy." Other forms of sexual contact included 15 cases involving "touching," nine cases involving "molestation," five cases that included kissing, and five cases of "sexual exploitation."

Regarding victim preference, age and gender were the two primary attributes. Most of the cases provided details of specific ages. Two of the cases identified the general age group of "teenagers," one case identified the age as "boys," and another case as "under 14." Victim ages ranged from 2 months old through 17 years. Nineteen of the

cases preferred teenagers, or the age range of their victims was primarily teenagers based on the reported ages of victims and the codes “teen,” “teenage,” and “teenager” where ages were not reported. Five of the cases involved victims who were 12 years old or younger, or the age range of the cases were primarily under the age of 13. Only one case preferred infant victims, but another included infants as part of the victim age range. Regarding victim gender, most cases preferred a specific gender, whereas two cases sexually offended against both genders. Seven cases were specific to male victims, and 16 were specific to female victims.

The category descriptors include titles the public has attributed to certain cases. One case was identified as “pedophile,” “predator,” “sadist,” and “molester.” A second case was also identified as “molester.” Three cases were identified as “pedophile” and three cases were identified as “predator.”

Theme 3: Offender Childhood Experiences

The theme offender childhood experiences was used instead of negative childhood experiences because the offender may not have been subjected to all the identified behavior. Similarly, not all the offenders’ childhood experiences may be considered negative. Offender childhood experiences discovered include the categories *parental behavior*, *other family member behavior*, and *personal behavior*. Only one case was identified having data for this theme. The parental behavior identified included “a mother who was a raging alcoholic” and “a father who stockpiled photographs of naked girls.” Another family member “was convicted of lewd behavior and exposing himself to young girls.” The offender’s behavior in high school included a lack of emotion

described as “did not crack a smile in his senior yearbook photo.” The offender’s “medical school yearbook page was decorated with cartoon doodles, along with a photo of” the offender “holding an unidentified girl about two years old” who “was not his daughter” and may potentially demonstrate the impact of his negative childhood experiences may have had on his worldview.

Outliers

Not all data demonstrated results according to the coding method described in this chapter. These outliers provide similar coding results without using an in vivo approach. Attributes identified included pornography and deceit. For example, an additional case of pornography was identified whereby the offender had possession of cameras, photos and videotaped his victims as he still had ownership of the videotapes.

The attribute deceit applied to several other cases with several unique identifiers, including “faking a condition,” “eluded,” “false identity,” “induce others to lie,” “making false claims,” “offender minimizing,” “managing the evidence,” “groom,” and “secrecy.” One case involved “faking or exaggerating his condition” with “a forensic psychiatrist” claiming the offender “had used his medical training to fake his mental illness.” Another case described the offender’s attorney saying, “he would base his client’s defense on mental health.” The term eluded was attributed to two cases describing the offender as having “eluded investigators and gossip” and “avoid punishment.”

Deceit was observed with the use of false identities in two cases. One was described as “using the false names” when acquiring child pornography. The other case

involved the offender having tricked students into thinking “they were sending the photos to classmates” or “to a modeling agency.”

Seven cases were identified whereby the offender attempted to induce others to lie on their behalf. Offenders would use various forms of pressure or threats to coerce others to lie on their behalf. Descriptions include “tried to pressure her into saying she had been present in the room during the Respondent’s entire examination of Patient B,” “harassing a nurse to induce her to lie,” “told her to deny the report and refuse to testify,” “if anyone found out or if I told anyone that he would come back and get me and nobody would believe me,” “used to threaten him if he ever told anyone,” “because if I didn’t do it, he would hit me,” “threatened to sue the hospital,” and “she kept it from me.”

Several cases involved the offender making false claims through false statements, false promises, denying the allegations, professing to be innocent, or minimizing the allegations by indicating the incident was due to some other circumstance. Two cases include “knowingly, intentionally and deliberately represented that she had been present during the entire examination” and “by falsely claiming that he had been trained.” One case involved the offender making false promises when asked to stop a relationship. Ten cases demonstrated a denial of wrongdoing or professing innocence.

Nine cases involved the offender offering reasons regarding the offense besides their guilt were identified as offender minimizing. Examples of offender minimizing include the offender attacking the victim, the victim’s family, or the offense. Examples include “was insisting she hadn’t seen what she thought she saw,” “would say the mother-poor, young, unwed-must have been trying to extort money from him,”

"described the victim as an emotionally disturbed girl with a history of sexual activity," and "argued that his actions were medical and not sexual in nature."

Five cases involving offenders using deceit by managing the evidence against them. Examples of managing the evidence were demonstrated by attempting to "conceal evidence," "did not document his actions," and "difficulties in finding witnesses or evidence." Issues during courtroom proceedings include paid testimony and conflict of interest. Paid testimony was described as "paid roughly $65,000 to two psychologists whose testimony raised the possibility the allegations against him were false and the result of the accusers being mentally ill," the use of fallacious arguments during witness testimony described as "because his colleagues at Austin State Hospital often dropped by his office and would have sensed something was amiss." Conflict of interest described as the offender's prosecutor "chose not to disclose to the Board that he had worked on" the offender's "criminal case and therefore had a potential conflict of interest." The use of "internal investigation" was another method offenders used to conceal evidence as unfounded complaints would be sealed from the public. Two cases demonstrated this attribute. A description of an internal investigation includes the hospital "undertook a new peer review of the allegations which had been leveled at" the offender with "his peers reportedly found no merit in them."

Finally, several cases demonstrated deceitfulness through secrecy to avoid detection. Examples of secrecy included a secret relationship, patient relocation, and relocation of a business. Other examples of secrecy include six cases that involved a lack of a chaperone present, one case involved the offender shutting and locking the door, and

one case involved the offender who “turned his lights off during counseling sessions.” A description of the case involving a secret relationship includes “her former husband and she began a relationship based on secrecy.”

One case involved relocating the patient and the business with descriptions such as “first examined the toddler in her presence, but then removed the victim to the basement of the office,” “as parents paid their bills, he led their infants to hidden, video-monitored rooms,” “took children to a separate room without their parents for examinations,” “often, he carried children to his basement or to another building on the property while parents checked out at the front desk,” and “would allow him to take their children to a separate room at his office where prosecutors say the abuse occurred.” The business relocation occurred following an investigation of complaints. Descriptions include the hospital “investigated a complaint of sexual misconduct on a patient” and “there was a second similar complaint” whereby “the hospital could not verify the claim and the records are sealed.” The complaints were “around that time that” the offender” closed up his… practice and moved to” another state.” It was indicated that “the move was so abrupt, it left many parents complaining that they were not notified that he was moving the practice or that appointments were cancelled.”

Eight cases included offenders who would groom their victims. Grooming was described as the use of devices such as “candy,” “popsicles,” “toys,” and “movies.” Offenders used signs of affection such as “kisses.” Finally, offenders would convince their clientele through “recognition of achievement,” an unblemished career,” “and “capitalize on their position as a doctor” to gain “trust.”

Discrepant Cases

Discrepant cases presented with less data than other cases. Despite the reasoning for this situation, cases that did not have identifiable data for a given theme were identified. Nine of the 25 cases included in this study did not have identifiable data on the theme nonsexual behavior. Twenty-four of the 25 cases did not have identifiable data on offender childhood experiences. The single case that demonstrated results on the theme offender childhood experiences provided data for all themes. This case would be considered a high-profile case as the offender had incidents in more than one state, had victim numbers exceeding 900 and held an offense history spanning more than one decade. As such, a greater amount of data were available for this case compared to the other cases in this study.

Research Question 2

RQ2: Based upon observed psychosocial characteristics, what are the male offender profiles of U.S. health care providers who commit sexual misconduct with their patients who are under the age of 18?

The second research question posited an interest in understanding any potential offender profiles identified during data analysis. Tables 2-6 provide a listing of the offender profiles identified. Total case numbers by attribute are listed in parentheses. Discrepant cases are cases that demonstrated no identifiable attribute for the theme is listed within each respective theme. Outliers are identified with an asterisk (*) next to the number of cases. The theme of sexual behavior demonstrated no discrepant cases for every offender profile category. The psychiatrist offender profile demonstrated no

discrepant cases for nonsexual behavior. Victim preference for age was separated into three groups: 14 and older, under 14, and those who demonstrated a preference for both age groupings. Victim preference for gender where total cases exceeded five within an offender profile indicates at least one case who has offended against both genders.

Offender Profile: Physicians

Public perceptions of physician appearance included the attributes of disheveled, eccentric, disgusting, weird, oddball, shy, socially awkward, and no remorse, which applied to one case. Attributes the public used to describe physician offender behavior included abusive, violent, aggressive, deceit, diabolical, and monster applied to one case with the attribute abusive shared by another physician offender case. Physician offender forms of sexual contact included abuse, assault, intercourse, oral sex, rape, sodomy, touching, molestation, kissing, and exploitation. Most cases involved kissing (3) and touching (4). The public labeled physician offenders as a pedophile, predator, sadist, and a molester. All labels applied to one case with predator shared by another case. Most physician offenders preferred female victims, but mixed results regarding victim age with a slightly higher preference for victims ages 14 years old and up.

Physician offender childhood experiences included parental behavior, other family behavior, and personal behavior. Parental behavior included a mother identified as a raging alcoholic and a father who stockpiled nude photos of young girls. Another family member's behavior involved an uncle who was convicted of lewd behavior and exposing himself to young girls. Physician offender personal behavior included a lack of emotion in his high school senior yearbook, his medical school yearbook decorated with

doodles, and a photo of himself holding an unknown 2-year-old girl within his medical school yearbook.

There were four discrepant cases for the offender childhood experiences theme and three within the nonsexual behavior theme. Outlier attributes in the nonsexual behavior theme included faking a condition, eluded, induce lying, making false claims, denial, minimizing, managing evidence, groom, and secrecy. Nearly every case included the attributes of denial, groom, and secrecy. Pornography was the only outlier for the sexual behavior theme and applied to only one case.

Table 2

Offender Profile: Physicians

Nonsexual behavior	Sexual behavior	Offender childhood experiences
Appearance	Descriptors	Parental behavior
Disgusting (1)	Molester (1)	Alcohol use (1)
Disheveled (1)	Pedophile (1)	Pornography (1)
Eccentric (1)	Predator (2)	Other family member
No remorse (1)	Sadist (1)	Lewd behavior (1)
Oddball (1)	Forms of contact	Exhibitionism (1)
Shy (1)	Abuse (2)	Personal behavior
Socially awkward (1)	Assault (1)	No emotion (1)
Weird (1)	Exploitation (1)	Doodled yearbook (1)
Descriptors	Intercourse (1)	Photo with young girl (1)
Abusive (2)	Kissing (3)	Discrepant cases (4)
Aggressive (1)	Molestation (2)	
Deceit (1)	Oral sex (2)	
Diabolical (1)	Rape (1)	
Monster (1)	Sodomy (1)	
Violent (1)	Touching (4)	
Denial (*4)	Pornography (*1)	
Eluded (*1)	Victim age	
Evidence (*2)	Both (2)	
False claims (*1)	Under 14 (1)	
Faking condition (*1)	14+ (2)	
Groom (*4)	Victim gender	
Induce lying (*2)	Female (4)	
Minimizing (*2)	Male (2)	
Secrecy (*4)		
Discrepant cases (3)		

Offender Profile Psychiatrists

Public perceptions of psychiatrist appearance included the attribute of disheveled for one case. Attributes the public used to describe psychiatrist offender behavior included scary, abusive, and violent, with four of the five cases accounting for abusive. Psychiatrist offender forms of sexual contact included pornography, abuse, assault, oral sex, rape, touching, molestation, and exploitation. Four out of five cases accounted for

the attributes of abuse, assault, oral sex, and touching. The public labeled two psychiatrist offenders as a pedophile. Most psychiatrist offenders preferred male victims, with all psychiatrist offenders preferring victims under 14 years old.

There were no discrepant cases for the nonsexual behavior theme. Outlier attributes for the nonsexual behavior theme included faking a condition, eluded, false identity, induce lying, making false claims, denial, minimizing, managing evidence, groom, and secrecy. Four out of five cases involved minimizing. Three out of five cases accounted for denial and managing evidence. There were no discrepant cases or outlier attributes for the sexual behavior theme. Offender childhood experiences included five discrepant cases with no outlier attributes.

Table 3

Offender Profile: Psychiatrists

Nonsexual behavior	Sexual behavior	Offender childhood experiences
Appearance	Descriptors	Discrepant cases (5)
Disheveled (1)	Pedophile (2)	
Descriptors	Forms of contact	
Abusive (4)	Abuse (4)	
Scary (1)	Assault (4)	
Violent (1)	Exploitation (2)	
Denial (*3)	Molestation (3)	
Eluded (*1)	Oral sex (4)	
Evidence (*3)	Pornography (1)	
Faking condition (*1)	Rape (2)	
False claims (*1)	Touching (4)	
False identity (*1)	Victim age	
Groom (*2)	Under 14 (4)	
Induce lying (*2)	Both (1)	
Minimizing (*4)	Victim gender	
Secrecy (*2)	Female (2)	
Discrepant cases (0)	Male (3)	

Offender Profile: Psychologists

Public perceptions of psychologist appearance included the attribute of scary for one case. Attributes the public used to describe psychologist offender behavior included abusive, violent, delusional, crazed, controlling, and monster. One case included attributes for the diagnoses/treatment category. These attributes included anxiety, psychotic, and suicide. Psychologist offender forms of sexual contact included abuse, assault, rape, sodomy, touching, and molestation. Three out of five cases involved the attributes of touching and molestation. The public labeled one psychologist offender as a molester. Most psychologist offenders preferred male victims, but balanced results regarding victim age with two cases for each specific age group and one case preferring both age groups.

There were three discrepant cases for the nonsexual behavior theme. Outlier attributes for the nonsexual behavior theme included induce lying, false promises, denial, minimizing, groom, and secrecy. There were no discrepant cases or outlier attributes for the sexual behavior theme. Offender childhood experiences included five discrepant cases with no outlier attributes.

Table 4

Offender Profile: Psychologists

Nonsexual behavior	Sexual behavior	Offender childhood experiences
Appearance	Descriptors	Discrepant cases (5)
Scary (1)	Molester (1)	
Diagnoses/treatment	Forms of contact	
Anxiety (1)	Abuse (1)	
Psychotic (1)	Assault (2)	
Suicide (1)	Rape (2)	
Descriptors	Sodomy (1)	
Abusive (1)	Touching (3)	
Controlling (1)	Molestation (3)	
Crazed (1)	Victim age	
Delusional (1)	Both (1)	
Monster (1)	Under 14 (2)	
Violent (1)	14+ (2)	
Denial (*1)	Victim gender	
False promises (*1)	Female (2)	
Groom (*1)	Male (3)	
Induce lying (*1)		
Minimizing (*1)		
Secrecy (*2)		
Discrepant cases (3)		

Offender Profile: Mental Health Counselors

There were no cases that included public perceptions of mental health counselor offender appearance. Attributes the public used to describe mental health counselor offender behavior included addict for one case and abusive for three. Mental health counselor offender forms of sexual contact included pornography, abuse, assault, intercourse, oral sex, rape, touching, molestation, and kissing. Three cases accounted for the attribute of abuse. There were no labels identified by the public for mental health counselor offenders. All mental health counselor offenders preferred female victims, with most offenders preferring victims 14 years old and older with four cases.

There were two discrepant cases for the nonsexual behavior theme. Outlier attributes included induce lying, denial, minimizing, and groom. There were no discrepant cases or outlier attributes for the sexual behavior theme. Offender childhood experiences included five discrepant cases with no outlier attributes.

Table 5

Offender Profile: Mental Health Counselors

Nonsexual behavior	Sexual behavior	Offender childhood experiences
Descriptors	Forms of contact	Discrepant cases (5)
Addict (1)	Abuse (3)	
Abusive (3)	Assault (1)	
Denial (*2)	Intercourse (1)	
Groom (*1)	Kissing (2)	
Induce lying (*1)	Molestation (1)	
Minimizing (*1)	Oral sex (2)	
Discrepant cases (2)	Pornography (1)	
	Rape (1)	
	Touching (2)	
	Victim age	
	Under 14 (1)	
	14+ (4)	
	Victim gender	
	Female (5)	

Offender Profile: Nurses

There were no cases that included public perceptions of nurse offender appearance. Attributes the public used to describe nurse offender behavior included abusive, violent, controlling, and mean. Three out of five cases included the attribute abusive. Nurse offender forms of sexual contact included pornography, abuse, assault, consensual, rape, touching, and exploitation. Three out of five cases involved the attribute

of abuse. The public labeled one nurse offender as a predator. Most nurse offenders preferred female victims who were 14 years old and older.

There were two discrepant cases for the nonsexual behavior theme. Outlier attributes included false identity, induce lying, and minimizing. There were no discrepant cases or outlier attributes for the sexual behavior theme. Offender childhood experiences included five discrepant cases with no outlier attributes.

Table 6

Offender Profile: Nurses

Nonsexual behavior	Sexual behavior	Offender childhood experiences
Descriptors	Descriptors	Discrepant cases (5)
Abusive (3)	Predator (1)	
Controlling (1)	Forms of contact	
Mean (1)	Abuse (3)	
Violent (1)	Assault (2)	
False identity (*1)	Consensual (2)	
Induce lying (*1)	Exploitation (2)	
Minimizing (*1)	Pornography (2)	
Discrepant cases (2)	Rape (1)	
	Touching (2)	
	Victim age	
	Both (1)	
	Under 14 (1)	
	14+ (3)	
	Victim gender	
	Female (5)	
	Male (1)	

Summary

The results from the data analysis process demonstrated several themes and categories which provide an inherent understanding of offender psychosocial characteristics. The themes observed included nonsexual behavior, sexual behavior, and

offender childhood experiences. Categories such as appearance, victim preference, and diagnoses/treatment were observed within the coded data. Offender profiles were grouped by profession, such as nurses, physicians, and mental health counselors. Discrepant cases were identified as cases with no observable data for a given theme and were included within the offender profiles. Chapter 5 will include a discussion regarding the interpretation of the findings, the limitations of this study, any recommendations, and implications.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative exploratory study was to explore the psychosocial characteristics of male U.S. health care providers who commit sexual misconduct with minor patients. I performed secondary data analysis using a grounded theory design for data collection purposes of a researcher-provided data set and publicly available sources. Offender psychosocial characteristics explored included psychopathology, paraphilia, and negative childhood experiences. The goal of this study was to support the development of causal models and to support continued research to further the prevention of future incidents, the management and mitigation of risk, and aid in decision making such as through legislation. Finally, the findings of this study may aid in increasing public awareness of the phenomenon.

I reviewed 25 cases involving male U.S. health care providers who committed sexual misconduct against minor patients in this study. During data analysis, I identified the themes of nonsexual behavior, sexual behavior, and offender childhood experiences. Nonsexual behavior categories included appearance, behavioral descriptors, and diagnoses/treatment. Sexual behavior categories included forms of sexual contact, descriptors, and victim preference. Offender childhood experiences categories included parental behavior, personal behavior, and other family member behavior. The themes and categories will be discussed in more detail within this chapter.

Interpretation of the Findings

The research questions in this study were created to provide insight into the phenomena behind male U.S. health care provider sexual misconduct with minor patients. I accomplished this by identifying the psychopathology, negative childhood experiences, and paraphilia of male U.S. health care providers who have committed sexual misconduct with their patients under the age of 18. I sought to develop offender profiles based on the observed psychosocial characteristics.

Psychopathology

Characteristics of psychopathology were observed in this study during data analysis. Findings confirmed previous research, including psychotic disorder, alcohol abuse, drug abuse, deceitfulness, the existence of mental illness, and antisocial personality traits. Psychotic disorder was indicated as part of one offender's personal history. Alcohol and drug abuse were indicated as part of one offender's history of being described as a drug addict and an alcoholic. Mental illness was observed in one case where the offender was being treated with anti-anxiety medication and had attempted suicide, implying another mental illness. Antisocial personality traits were observed in several cases.

Criteria for antisocial personality disorder are discussed in detail within the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; American Psychiatric Association, 2013). A demonstrable portion of these criteria was observed during data analysis, including unlawfulness, deceitfulness, impulsiveness, recklessness, remorselessness, and irresponsibility. Unlawfulness is described as a "failure to conform

to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest" (American Psychiatric Association, 2013, p. 659). Unlawfulness was observed when the offender would commit an act of sexual misconduct with a minor patient. Although laws differ among states, minors cannot provide consent (Ypdcrime.com, n.d.).

Additionally, some states have provisions indicating a crime has been committed when the victim cannot give consent (Ypdcrime.com, n.d.). Therefore, when the health care provider commits an act of sexual misconduct with a minor patient, they have infringed the law because minors and patients are unable to provide consent. As such, all 25 cases appear to have met this criterion.

Deceitfulness is described as behavior "indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure" (American Psychiatric Association, 2013, p. 659). Deceitfulness was observed in various ways, including making false claims, grooming, using false identities, faking a condition, eluded, inducing others to lie, offender minimizing, managing the evidence, and secrecy. An added form of deceit not indicated previously that may have occurred includes conning others for personal profit or pleasure. Conning others may have occurred in cases where the offender indicated the victim gave consent for the sexual contact, but allegations were brought against the offender. Consensual sexual contact was observed in two cases.

Impulsiveness is described as "impulsivity or failure to plan ahead" (American Psychiatric Association, 2013, p. 659). Impulsiveness was observed during one case

when the offender abruptly relocated his business. The relocation had occurred during a time when he was receiving complaints about his actions.

Recklessness is described as “reckless disregard for safety of self or others” (American Psychiatric Association, 2013, p. 659). Offenders demonstrated recklessness during each instance as victims experienced harm. Forms of harm victims experienced included “suffocation,” “broken” bone, and emotional injuries evidenced by “screaming and running away.”

Irresponsibility is described as “consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations” (American Psychiatric Association, 2013, p. 659). Irresponsibility was observed when offenders violate professional and ethical boundaries by committing sexual misconduct with patients. As discussed earlier, health care providers are expected to avoid harm and minimize harm in instances where harm is unavoidable. Sexual misconduct is an example of irresponsible behavior due to the harm it causes.

Remorselessness is described as a “lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another” (American Psychiatric Association, 2013, p. 659). Remorselessness was observed in several ways. First, it was indicated by the public as the offender demonstrated no remorse. Second, in several cases, the offender would rationalize hurting the victim by minimizing. During minimizing, the offender would offer reasoning behind the incident rather than accepting responsibility for his actions.

The findings within this study provide an extension of knowledge to previous research. The extension of knowledge can be observed through the specific attributes identified that previous research did not discuss. For example, specific antisocial personality traits were identified: unlawfulness, deceitfulness, impulsiveness, recklessness, remorselessness, and irresponsibility. Aside from these traits, this study included a discussion indicating how offenders were deceitful. Although previous research identified evidence of severe mental illness (DuBois, Walsh, et al., 2017) and others identified the specific diagnosis of ADD and depression (Burgess et al., 2000), specific findings that extend knowledge include treatment with anti-anxiety medication and attempted suicide. Other attributes not identified by previous researchers included disheveled, eccentric, disgusting, weird, oddball, shy, socially awkward, expressed no remorse, and scary. Attributes based on the public description of offender behavior included abusive, violent, delusional, crazed, aggressive, diabolical, an expert at manipulation, controlling, mean, monster, and scary.

Some of the data findings indicate the potential presence of another form of psychopathology. One case included attributes that may indicate the presence of schizotypal personality disorder. These attributes included eccentric, oddball, shy, socially awkward, and weird. Although not a diagnosis, the appearance of such attributes may indicate how specific offender groups behave around others.

Although the findings of this study did not necessarily disconfirm previous research, the findings did present differently from a proposed hypothesis. According to a study conducted by Langevin et al. (1999), a diagnosis of antisocial personality disorder

was nonexistent among all 19 physicians. Langevin et al. (1999) hypothesized that this was possibly due to a need for physicians to be prosocial, mentally stable, and of good health. There are a few possible reasons for this occurring. First, the sample size may have been too small to include a physician offender with this specific diagnosis. Second, the study's physician offender population may not have held this diagnosis, but a different population may demonstrate differently. Finally, Langevin et al. (1999) only discussed offenders with antisocial personality disorder as a diagnosis and did not identify if offenders exhibited only antisocial personality traits.

Paraphilia

Paraphilia observed included pornography, rape, pedophilia, frotteurism, pederasty, and sadism. Pornography, rape, and sadism were explicitly identified within the data. Frotteurism was identified in the data as touching. Pederasty was identified in the data as sodomy. Pedophilia, hebephilia, and ephebophilia were identified in the data based on victim preference for age. For this study, the victim age group for pedophilia was based on the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.) for those under 14 years of age (American Psychiatric Association, 2013). The ephebophilia victim age group was based on a description by Seto (2017), indicating the preference for adolescent minors and set for ages 15–17. I attributed the paraphilia hebephilia to offenders differently because the victim age group identified by Seto (2017) can overlap with the pedophilia age group indicated by the American Psychiatric Association (2013). Hebephilia is based on a preference for pubescent children and is associated with Tanner Stages 2–3 (Seto, 2017). Due to the complex nature and an inability to determine if the

victim was of pubescent age or not, if the victim's age was 14 years, the offender could be classified as a hebephile because this age did not fit the pedophile or ephebophile categories. Otherwise, the paraphilia was identified as one of the other two groups based on the victim's age group. All the paraphilia identified in this study extend the knowledge because previous researchers only identified forms of sexual contact and did not indicate specific paraphilia based on forms of sexual contact identified.

Forms of sexual contact that confirm previous research findings include consensual sex, touching, child molestation, sodomy, rape, sexual intercourse, sexual assault, and sadism. (Burgess et al., 2000; DuBois, Walsh, et al., 2017). Forms of sexual contact that extend the knowledge from previous research include pornography, sexual abuse, oral sex, kissing, and sexual exploitation. Previous researchers did not separate victims into age groups based on paraphilic interest; however, there has been interest in minors and both genders. As such, the findings from this study have demonstrated an extension of knowledge from previous research based on identifying specifics for age and gender groups toward paraphilic interest.

Negative Childhood Experiences

Negative childhood experiences were expressed in only one case. Substance use, pornography, and lewd behavior were prevalent among the offender's family. His mother was considered an alcoholic, his father was known for collecting pornography, and his uncle was convicted of lewd behavior and exposing himself to girls. The impact of the family member's behavior was reflected in the offender as evidenced by a lack of emotion in his senior yearbook photo, his medical school yearbook was full of doodles,

and a photo displayed the offender holding an unidentified girl who was about 2 years old.

These findings are an extension of previous research findings. Previous researchers had indicated that forms of abuse occur among offenders with few details, such as emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect (MacDonald et al., 2015). Details of abuse indicated by previous researchers included sexual assault by a cousin (Burgess et al., 2000).

Theoretical Framework

The framework for this study consisted of the multimodal self-regulation theory described by Stinson, Sales, et al. (2008). Maladaptive behavior may develop should an individual with developmental characteristics, such as psychopathology, experience a hostile or unstable environment as a child (Stinson, Sales, et al., 2008). Further research conducted by Stinson, Becker, et al. (2008) further supported the theory, having identified how maladaptive behavior was predictive of antisocial behavior and paraphilia.

The findings of this study reflect the description of the multimodal self-regulation theory and the supportive research of the theory. It was indicated that the offenders within this study demonstrated antisocial personality traits and paraphilia, indicating a presence of self-regulatory deficits. Furthermore, psychopathology was identified in many cases and the presence of a hostile or unstable environment for one case. Finally, researchers identified the need for an environment allowing an opportunity for the offense to occur (Stinson, Sales, et al., 2008). Forms of secrecy such as no chaperone

present were identified within the data accounting for the environment described by Stinson, Sales, et al. (2008).

Physician Offenders

Of all the offender profiles developed, the physician profile appeared to demonstrate the most insight into the phenomenon. The reasoning was due to a greater amount of available data. One of the physician cases was considered abusive and violent. The offender was labeled a monster and described as disgusting, leading the public to inquire how to prevent future occurrences. Public inquiry provided unique insight into the offender's professional behavior and background in hopes of understanding causation.

The specific public perceptions of one physician offender included eccentric, weird, oddball, shy, and socially awkward, indicative of schizotypal personality disorder. Although the offender may not necessarily have this disorder, it is interesting to note that this behavior was observed within an offender seen as a pedophile who treated his victims sadistically. The same offender also demonstrated several antisocial personality traits, including unlawfulness, deceitfulness, impulsiveness, recklessness, and irresponsibility. The data for the same offender indicated negative childhood experiences. The offender's mother was an alcoholic implying a hostile living environment whereby the mother could have either neglected him or abused him depending upon how alcohol impacted her behavior. The offender's father was known for collecting pornography, implying the offender likely had access to obscene material at an early age, potentially impacting his worldview and how he should treat others. The offender's uncle was convicted of lewd behavior and exposing himself to a young girl implying either a

potential negative influence on the offender's life or merely reflective of the offender's family worldviews.

Paraphilia observed among physician offenders included pedophilia, ephebophilia, pornography, rape, frotteurism, pederasty, and sadism. Pornography was observed as an outlier and applied to one case. Pedophilia, pornography, rape, pederasty, and sadism applied to one case. Forms of sexual contact among physician offenders that confirm previous research included consensual, touching, molestation, sodomy, and rape (DuBois, Walsh, et al., 2017). Forms of sexual contact observed within this study which extends the knowledge from previous research, included sexual abuse, sexual assault, sexual exploitation, kissing, and oral sex. Two cases demonstrated no preference for victim age as the age groups ranged from 13-15 and 12-17 years. One physician offender preferred male victims and four physician offenders preferred female, but one offender resorted to a male victim during one incident. This offender may have resorted to a male victim due to a lack of preferred female victims because the offender had over 400 female victims.

Psychiatrist Offenders

When considering previous research regarding psychiatrist offenders, psychiatrist offenders were typically categorized with other physicians. The lack of distinction between offender groups made it difficult to discern psychosocial characteristics between psychiatrist and non-psychiatrist offender groups. The lack of insight into psychiatrist psychosocial characteristics from previous research indicates that the current study provides fresh insight into the psychosocial characteristics of psychiatrist offenders as a

distinct offender group from other health care providers. As such, this study extends previous research regarding psychiatrist offenders.

Although psychiatrist offenders demonstrated no discrepant cases, most attributes observed were antisocial traits and the attribute abusive. Other attributes observed included disheveled, scary, and violent. Antisocial traits observed included unlawfulness, deceitfulness, recklessness, remorselessness, and irresponsibility. Attributes of deceitfulness observed included denial, eluded, managing evidence, faking a condition, making false claims, false identity, grooming, inducing others to lie, minimizing, and secrecy. Paraphilia observed included pedophilia, pornography, rape, and frotteurism. Forms of sexual contact included sexual abuse, sexual assault, sexual exploitation, oral sex, pornography, rape, and touching. One case indicated no preference for victim age as the age group was 13-17 years old. Psychiatrist offender preference favored males over females.

Psychologist Offenders

As with psychiatrist offenders, psychologists were not categorized separately within previous research. The current study provides fresh insight into the psychosocial characteristics of psychologist offenders. Therefore, this study extends previous research regarding psychologist offenders as a distinct group.

One case has been identified among the psychologist offender group, providing unique insight similar to the case within the physician offender group. The unique case was indicated of having a psychotic disorder. The offender was being treated for anxiety

and had attempted suicide on at least one occasion. The offender also demonstrated controlling behavior and was identified as being crazed and delusional.

Psychologists demonstrated antisocial traits like the previous offender groups, including unlawfulness, deceitfulness, recklessness, remorselessness, and irresponsibility. Deceitful behavior was observed as denial, false promises, grooming, inducing others to lie, minimizing, and secrecy. Other attributes identified within the nonsexual behavior theme included a scary appearance and abusive, monster, and violent descriptors. Paraphilia observed by psychologist offenders included pedophilia, ephebophilia, rape, frotteurism, and pederasty. Forms of sexual contact observed included sexual abuse, sexual assault, rape, sodomy, touching, and molestation. One psychologist offender demonstrated no preference for victim age as the age group was identified as teen. Psychologist offenders demonstrated a preference for male over female victims.

Mental Health Counselor Offenders

Mental health counselor offenders demonstrated antisocial traits like the other health care provider groups, including unlawfulness, deceitfulness, recklessness, remorselessness, and irresponsibility. The descriptors noted by the public of mental health counselors included addict and abusive. The singular case identified as a former addict indicates the offender having substance use among his psychopathologies. Paraphilia observed in this study among the mental health counselor offender group included pedophilia, ephebophilia, pornography, rape, and frotteurism. Forms of sexual contact included sexual abuse, sexual assault, intercourse, kissing, molestation, oral sex, pornography, rape, and touching.

Previous research of counselors provided little insight regarding psychopathology and paraphilia and no insight regarding negative childhood experiences. Psychopathology of counselors from previous research included psychopathy and narcissism among a small percentage of offenders. Psychopathology identified within this study is considered new insight and extends knowledge of previous research. Paraphilia observed within this study confirm previous research findings. All mental health counselors preferred female victims. All cases were indicated for preferring a specific paraphilic age group.

Nurse Offenders

Nurse offenders demonstrated antisocial traits, including unlawfulness, deceitfulness, recklessness, remorselessness, and irresponsibility. Nurse offenders' descriptions include abusive, controlling, mean, and violent. Forms of deceitfulness identified included false identity, inducing others to lie, and minimizing. Paraphilia observed by nurse offenders include pedophilia, ephebophilia, hebephilia, pornography, rape, and frotteurism. Forms of sexual contact identified included sexual abuse, sexual assault, consensual sex, sexual exploitation, pornography, rape, and touching.

The findings of this study that confirmed previous research included nonsadistic, sexual intercourse, sexual assault, rape, and minimization. Much like previous research of other health care provider groups, paraphilia were not indicated, implying an extension of knowledge for nurse offenders. One nurse offender demonstrated no specific age preference for victims as victims ranged from 12-17 years. Although most nurse offenders preferred female victims, one offender demonstrated no preference for gender.

Limitations of the Study

Most of the limitations encountered while conducting this study originated from the methodological approach used. Limiting the study to known male offenders through convenience sampling was well appreciated as most offenders were male, and only known offenders could be studied (Stinson, Sales, et al., 2008). The findings of this study confirmed what previous researchers had indicated, whereby offenders typically deny or minimize their offensive behavior leaving a potential bias within the data studied (Stinson, Sales, et al., 2008). Secondary data analysis was conducted on a researcher-provided data set and publicly available sources of information such as archived news channel reports, government website reports, and legal documents while avoiding online sources known to lack credibility, such as Wikipedia, to help alleviate this limitation.

Although using secondary data afforded the benefit of time and cost-effectiveness, limiting the data collected to a researcher-provided data set and public sources of information also had limited the amount of data available for collection. The likely reason was due to public sources such as news channels whose sole purpose was to inform the public of the offender and the offenses committed and not to conduct a deep investigation into the psychological aspects of the offender. Exceptions to this rule were observed in rare cases where the offenses were so horrific that the public demanded answers that further investigation.

Recommendations

Although the findings of this study have brought additional insight into the phenomenon, confirming and extending the knowledge from previous researchers, further

research is recommended due to the limited amount of research observed and the lack of causal model development. Due to the limited knowledge gained of the phenomenon using public sources, future studies should consider employing guided interviews with known offenders or attempting to acquire access to other data sources that are not openly available to the public. Guided interviews may prove more beneficial when exploring negative childhood experiences if possible.

Female offenders were not studied due to the limited number of offenders versus males. Future research should consider using a case study approach of female offenders. Future studies should also consider investigating offenders based on attributes. Examples include victim age preference, paraphilia, and forms of sexual contact, such as only approaching victims through consensual means. Future studies could focus on specific areas of offender behavior, including how offenders behave at work, in public, and during the offense.

Implications

Although it was understood that this study would serve primarily as a stepping stone for future research regarding the phenomenon, there are several implications for positive social change. This study intended that the public be more aware of the phenomenon and that the awareness would guide their future actions in a positive direction. These include the management of potential areas of secrecy through organizational review and the proper handling of complaints.

Offenders were indicated to be deceitful in several ways, such as secrecy, peer review, and a clean record to avoid detection. Examples of secrecy included no

chaperone, locked exam room, and lights turned off in the exam room. Organizational policymakers should consider evaluating methods to minimize potential areas of secrecy without negatively impacting the health care provider's role in effectively caring for the patient or negatively impacting the patient, such as passing on the additional cost of a chaperone present to the patient.

At least one offender used a peer-review method to have the hospital investigate a sexual misconduct complaint. While a peer review may be considered helpful in most instances, the offender went undetected and concealed the incident from the public. Policymakers should consider evaluating the peer review process of sexual misconduct complaints to determine where changes can be made to prevent a potential offender from going undetected and from having the details of the complaint concealed from the public.

It was observed within this study that offenders and the public would be dismissive of complaints due to the background of the alleged offender. Although not all allegations are necessarily true, there is an inherent risk of dismissing a complaint without giving heed to the potentiality of an actual incident has occurred. Moreover, due to the negative impact sexual misconduct has on victims, health care providers, their associates, and the public should be more acutely aware of sexual misconduct complaints and not be readily dismissive just because the alleged offender has a clean record. All sexual misconduct complaints should be taken seriously and handled promptly without bias or assumption for either party.

Conclusion

This study aimed to explore the psychosocial characteristics of male U.S. health care providers who commit sexual misconduct against minor patients and develop offender profiles for each of five health care provider groups. Using an exploratory research approach with grounded theory design for data collection purposes permitted a broad investigation of a researcher-provided data set and publicly available sources of information regarding the phenomenon. The themes observed were nonsexual behavior, sexual behavior, and offender childhood experiences. All 25 cases presented with sexual behavior attributes, one presented with offender childhood experiences, and 16 presented with nonsexual behavior attributes.

The findings of this study disconfirm a hypothesis, confirm previous research findings, and extend knowledge. For example, there is no support for Langevin et al.'s (1999) hypothesis that physicians have a prosocial requirement based upon notable antisocial personality traits observed within this study. Confirmed findings included the presence of antisocial personality traits, psychotic disorder, certain forms of sexual contact, alcohol abuse, drug abuse, and deceitfulness. The findings within this study also provided an extension of knowledge to previous research as it identifies specific attributes of offenders. Examples include details of antisocial and schizotypal traits, paraphilia such as pederasty, and negative childhood experiences such as substance abuse. Additionally, the findings of this study support the multimodal self-regulation theory due to the presence of antisocial personality traits and paraphilia among offenders, which are indicative of self-regulatory deficits.

Recommendations for future research include continued exploration through guided interviews and analysis of secondary data sets not open to the general public. Implications for positive social change are that organizations consider reviewing policies to inhibit forms of secrecy while not overly imposing on health care provider effectiveness or imposing costs onto the patient. Finally, sexual misconduct complaints should be taken seriously and not dismissed based on bias or assumption.

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