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**AN EXPLORATION OF SEXUAL CONTACT  
BETWEEN CLINICAL PSYCHOLOGISTS AND PATIENTS**



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**May 1996**

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Thesis submitted in fulfillment of the requirements for the degree of Doctor of  
Philosophy, Department of Psychology, University of Warwick.

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## DECLARATION

Some of the ideas and results from this thesis have been published by the author in journals and as book chapters, as follows:

Garrett, T. (1993) Grasping a hot potato: How understanding sexual feelings in therapy could help to prevent therapist-patient sexual contact. Clinical Psychology Forum, 54, 30-32.

Garrett, T. (1993) Non professional relationships with clients. Clinical Psychology Forum, 62, 7-8.

Garrett, T. (1994) Epidemiology in the U.S.A. In D. Jehu Patients as Victims: Sexual Abuse in Psychotherapy and Counselling. London: Wiley.

Garrett, T. and Davis, J. (1994) Epidemiology in the U.K. In D. Jehu Patients as Victims: Sexual Abuse in Psychotherapy and Counselling. London: Wiley.

Garrett, T. (1994) Sexual contact between psychotherapists and their patients. In P. Clarkson and M. Pokorny (Eds) Handbook of Psychotherapy. London: Routledge.

Garrett, T. and Davis, J. (1995) So who are we, anyway? Personal and professional characteristics of clinical psychologists. Clinical Psychology Forum, 78, 2-4.

Garrett, T. (1995) Sexual contact in therapy. The Psychologist, 8, 7, 303.

Some of the data described in this thesis were included in the author's thesis for the degree of Master of Science in Psychotherapy, submitted in 1992. Some data from 300 of the 581 returned questionnaires were used in the MSc thesis. Qualitative data were excluded and most data were presented descriptively. Few statistical analyses were presented, and, specifically, no logistic regression analyses were included in the MSc thesis. That thesis contains a considerably briefer review of the literature.

## SUMMARY

This thesis describes the first British empirical study in relation to therapist-patient sexual contact. North American research has suggested that a substantial minority of mental health professionals engage in such contact with their patients, and that both situational and characterological variables contribute to the sexualisation of the therapeutic relationship. A number of theoretical models are relevant to developing an understanding of this problem, including reversal theory, psychodynamic theory, and Finkelhor's (1984) four precondition model of sexual abuse.

A national random survey of clinical psychologists produced 581 usable responses. Under 4% reported sexual contact with patients in therapy or who were discharged. A substantial minority reported that they had treated patients who had been sexually involved with previous therapists, or that they knew through other sources of clinical psychologists who had engaged in sexual activity with their patients. Logistic regression analysis revealed that homosexuality, sexual involvement with educators during postgraduate training, and longer postqualification professional experience predicted sexual involvement with patients.

Responses to a small number of open-ended questions suggested that whilst the majority of respondents did not view sexual attraction to patients as inappropriate, a minority actively avoided it for ethical reasons. The majority of respondents who had not engaged in sexual contact with patients refrained from such behaviour for ethical reasons, but the responses of a minority suggested that were the opportunity to arise, or were negative consequences removed, they might engage in such behaviour. A minority of respondents were unaware of their duty to report colleagues engaging in such behaviour.

It is concluded that efforts to prevent therapist-patient sexual contact should focus on education, particularly in respect of codes of conduct, and that further research is required to enhance our knowledge of predisposing factors.

***"It scrambled my brain"***

(Client's description of the effect of sexual contact with his therapist, personal communication, 1995)

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CHAPTER ONE

CRITICAL REVIEW OF THE LITERATURE



## 1.1. INTRODUCTION

Defining sexual or erotic contact is problematic in so far as it is difficult to distinguish between a therapist's intention and the effect of his/her behaviour. Some professional organisations, such as the American Psychological Association, and some surveys have adopted the view that therapists should define sexual contact themselves (Holroyd, 1983).

In this thesis, the terms "therapist" and "patient" are used, respectively, to describe a variety of professionals and the recipients of their services. To avoid repetition, the term "therapist" is intended to represent professionals, regardless of their professional background, who conduct what is referred to in the text as "therapy", that is, psychotherapy, psychological therapies, or counselling. The term "client" has frequently been advocated as an alternative to "patient" but the latter is used here because of its traditional use in the psychotherapy literature, to which this research is most relevant, and because the professional-patient sexual contact considered here largely occurs in health service or medical settings.

It has been problematic to find a concise term which appropriately describes those therapists who have sexual contact with their patients. There are certainly problems in describing these individuals as "abusers" and, whilst I have examined the literature in relation to psychological models of sexual offending, it is not clear that those therapists who have sexual contact with their patients can readily or appropriately be

described as sexual offenders. This is because "offender" is primarily a legal rather than psychological term.

In this thesis, reference is made to various levels of sexual interchange between therapist and patient, including sexual attraction, sexual harassment, sexual contact, sexual violence, and sexual abuse. Sexual attraction patients occurs widely among therapists (Jehu, 1994) and is viewed as a natural process in therapy, provided it is not acted upon. Sexual harassment is a broader issue, which may be defined as, "unwelcome sexual advances, requests for sexual favours, and other verbal or physical conduct of a sexual nature" (Federal Register, 1980). Such behaviour may be instigated by the therapist, or indeed by the patient, but such behaviour on the therapist's part may be understood as an inappropriate use of the therapist's position. Thus, sexual harassment may be considered as an example of sexual abuse by therapists. Sexual contact with patients (eg kissing, genital exposure, touching the breasts, fondling the genital area, oral sex and intercourse) is widely regarded as misconduct and is prohibited by most professional ethical codes (Jehu, 1994). Touching and hugging are less controversial and may not always include a sexual component (Jehu, 1994). Sexual violence may be defined as sexual contact by the therapist, using physical force, threats and/or intimidation (Pope and Bouhoutsos, 1986).

Whilst sexual attraction, touching and hugging are relatively uncontroversial, there is a consensus, supported by most professional bodies, that any form of sexual contact, sexual violence or sexual harassment is inappropriate and constitutes professional

misconduct. In this sense, such behaviours may be regarded as sexual abuse. It has also been argued that there are parallels between therapist-patient sex, and rape and incest (Pope, 1990b). These include the power imbalance, secrecy and isolation, and the reaction of patients to sexual contact with their therapist, which includes guilt, shame and self-blame (Bouhoutsos, 1985; Luepker, 1989). The abusive nature of sexual contact between therapists and their patients is discussed further in Section 1.2, where the rationales for prohibiting sexual contact in therapy are reviewed, and section 1.15, where the effects of such contact on patients are considered.

In considering the issue of therapist-patient sexual contact, it has been suggested that sexual contact in other power based relationships such as that between lawyer and client, doctor and patient, clergy and parishioner, teacher and student, and general "mentor-protégé" relationships have important parallels and that much can be learned from these other areas (Rutter, 1989; Peterson, 1992). Peterson (1992) argues that all of these disciplines are obliged to place the needs of others ahead of their own. She argues that there is a spiritual dimension to the professional-client relationship and that "boundary violations occur in part because our society is increasingly minimising this dimension" (p3). She also makes the point that boundary violations in general must be considered rather than focusing exclusively upon sexual contact in therapy.

Sexual misconduct in professional relationships generally is a matter of increasing concern in many countries. For example, a recent paper by Schoener (1993, personal communication) documents publications and Task Forces which have examined the

issue of abuse by physicians in North America. In addition, Wilbers, Veenstra, van de Wiel, and Schultz (1992) describe doctor-patient sexual contact in the Netherlands.

Until relatively recently the issue of sexual contact between therapists and patients in psychotherapy had received little attention in the theoretical and research literature. It is now an established area of attention in the U.S.A., but it is only within the past few years that the issue has been taken up in the U.K. For example at the 1992 Annual Conference of the British Psychological Society a paper was given by Dr S Llewelyn in which the findings of the North American research were discussed. The Prevention of Professional Abuse Network (POPAN) based in London was set up in the late 1980's to deal with, amongst other issues, the effects upon patients of sexual contact with psychotherapists. No empirical research in the area has to date been undertaken in the U.K.

It is clear from North American research that sexual contact between psychotherapists and their patients is a significant problem, but that, like other forms of inappropriate sexual behaviour such as rape and child sexual abuse, it is probably under reported. In the U.S.A., half the money for professional malpractice cases is spent on complaints regarding sexual intimacy (Pope, 1991a). In Britain, little information is available, but the professional liability insurance scheme for British Psychological Society members excludes liability arising from deliberate acts which include sexual contact with a patient. The policy therefore only provides psychologists with a defence against *spurious* allegations of sexual impropriety (Johnson, 1996, personal communication).

Approximately 13% of allegations of professional misconduct handled by the American Psychological Association insurance trust in 1981, and 18% of the complaints to the American Psychological Association ethics committee in 1982 involved sexual "offences" against patients. Yet suits and complaints are rarely filed, only in about 4% of cases, and only half of these are completed (Bouhoutsos, 1985).

There are now several books available which provide detailed descriptions of the kinds of sexual contact which have been undertaken with patients. In his influential book, **"Against Therapy"**, Jeffrey Masson (1988) cites a number of examples of therapists who have abused their position in relation to patients, both sexually and otherwise. Masson (1988) describes legal action against John Rosen, a North American psychiatrist who apparently justified with therapeutic rationales coercive sex and other abuses with his patients, including fellatio, forcing patients to eat his faeces, and three way sex, both with adults and children.

The issue of therapist-patient sexual contact can be traced back over many centuries to its prohibition in the Hippocratic Oath (Bouhoutsos, 1985). In more recent times, the British mental health professions have indirectly in their ethics codes maintained this proscription by referring to, for example, the need for professional conduct which does not damage the interests of clients, or public confidence in the profession (e.g. British Psychological Society, 1991). It is only very recently that sexual liaisons between therapists and their patients have been explicitly prohibited by some British professional organisations (e.g. British Psychological Society/Division of Clinical Psychology, 1996). North American professions have, for some time, explicitly prohibited sexual contact

with patients in their Codes of Conduct and the Canadian Psychiatric Association has even produced a position paper on the subject (Sreenivassan, 1989), which discusses various issues such as the responsibility of the psychiatrist to resist patients' advances and to avoid sexual contact with patients. It recommends increased education of professionals and patients in this respect, and gives guidelines to those suspecting a colleague of sexual impropriety.

There have been, however, famous violations of the prohibition, among early psychoanalysts such as Ferenczi, Horney and Jung, who had sexual relationships with, or in some cases even married, their patients (Tansey, 1994). These behaviours were viewed at the time with mild disapproval among the psychoanalytic community, but no sanctions were invoked against the offending therapists, though a sound theoretical basis for the taboo on therapist-patient sexual contact was well-established in Freudian theory (Pope and Bouhoutsos, 1987).

In some states in the U.S.A., sexual contact between therapists and their patients has been directly addressed by the legal system, and redress is available to patients subject to sexual contact with their therapist, via common law remedies, criminal, civil and regulatory statutes (Jorgenson and Schoener, 1994). There are precedents for patients taking action through the common law, via malpractice/negligence suits, or via the principle of negligent breach of fiduciary duty. At the time of writing, civil statutes had been enacted in five states (Jorgenson and Schoener, 1994) governing patients' suits against sexually abusive therapists.

Patients may also pursue a therapist with whom sexual contact has occurred via criminal statutes: in five states, "sexual contact under the pretext of medical treatment is defined as assault" (Jorgenson and Schoener, 1994, p.158). This has been interpreted to include psychologists. Twelve states have, at the time of writing, specifically criminalised psychotherapist-patient sexual contact, both in the cases of licensed and unlicensed therapists. All but one of these statutes do not regard consent of the patients as a legitimate defence. In six states, post-termination sexual contact is prohibited by statute (Jorgenson and Schoener, 1994).

The taboo on sexual contact between therapists and their patients has been raised and challenged in recent years in the context of growing sexual freedom in society (Siassi and Thomas, 1973), and by articles in the popular press (e.g. Sinclair, 1991). The last few decades have seen an increasing acceptance of physical and emotional intimacy between therapists and their patients in the context of humanistic approaches to psychotherapy, and a few therapists have even openly advocated sexual relationships between therapists and their patients (McCartney, 1966; Shepard, 1971).

The process of data collection in this field has been problematic. Butler and Zelen (1977) were threatened with expulsion from a professional organisation when they suggested researching therapist-patient sexual intimacy, and when early research was allowed, the results were suppressed (Forer, 1968, cited in Bouhoutsos, 1985). Not until the 1970s, at least in the U.S.A., was concerted attention given to the problem (Bouhoutsos, 1985), with a proliferation of research and theoretical papers.

It has taken rather longer for the media, both in the U.S.A. and the U.K., to begin to show an interest in therapist-patient sexual contact. It has only been in the 1980's in the U.S.A. and in the 1990's in the U.K. that articles, television programmes, novels and films have begun to address this issue. "Newsweek" in the U.S.A. ran an article "Sex and Psychotherapy" in 1992, and in Britain, newspaper articles have proliferated, appearing in tabloid and broadsheet newspapers such as "The Guardian" (Mihill, 1995) and "Daily Telegraph" (Fletcher, 1995), focusing on cases of professional sexual misconduct and on this author's research which was discussed at a conference. Oprah Winfrey has dedicated a television programme to the issue and in Britain a B.B.C.2 programme "Public Eye" featured sexual abuse in therapy in one of its programme slots in 1992. A number of films bearing on the topic in recent years have included "Prince of Tides", "Final Analysis", "Mr. Jones", and "Lovesick" and some novels have concerned themselves with sexual contact in therapy, including "Final Session" (1991) by Mary Morrell.

Possible reasons for such interest include the increasing number of women in the mental health professions and related professions, the growth of the women's' movement, and the growth of consumerism. The latter has been slower to develop in the U.K., and this, together with a cultural difference between the two countries in their attitudes and openness towards sexual issues, as well as the fact that most North American therapists are in private practice, whereas most psychotherapy in the U.K. takes place within public settings, may partially explain the silence in this country until recently concerning sexual contact between therapists and their patients.

The accumulating professional and public interest in therapist-patient sexual contact may also be explained by the fact that a few therapists began to assert publicly that it could be a legitimate practice (e.g. McCartney, 1966; Shepard, 1971). Additionally, patients, initially in the U.S.A. began to press legal actions against therapists who violated the prohibition on sexual contact with patients (Pope and Bouhoutsos, 1986).

At present, little information is available from countries other than Britain and the U.S.A. in relation to psychotherapist-patient sexual contact but some academic articles are beginning to appear in other languages. Some significant developments have occurred in Holland, and these include an explicit prohibition against therapist-patient sexual contact in the Dutch Society for Psychotherapy's code of ethics, and, in statute, the **Legal Code for Recourse in Individual Health Care**, which registered health professionals and improved complaints procedures.

The Dutch government took a position on the broad topic of sexual violence, instructing its Council for Equal Opportunities to consider the question of helper-client sexual contact. The policy on sexual abuse of the Dutch Government's Department of Welfare, Public Health and Culture was given a remit to view sexual abuse by helping professionals as a special area for attention. A cross-professional working party was set up to address this topic which made recommendations in relation to ethical codes and complaints procedures. Sexual contact between professionals and patients is now specifically prohibited by law in Holland (Renfree, 1991).

## 1.2. WHY PROHIBIT THERAPIST-PATIENT SEXUAL INVOLVEMENT?

A number of reasons for the prohibition of psychotherapist-patient sexual contact have been advanced in the literature.

Sexual contact between therapist and patient is an example of a dual role relationship (Kitchener, 1988). A dual role relationship is one in which one or both members occupy two or more conflicting roles. Social psychology, and in particular role theory, has long recognised the strain caused by role conflict (Kitchener, 1988). Role conflict may arise from the strain experienced by the individual, from incompatible obligations and from different prestige and power associated with the roles. Failure to meet expectations regarding behaviour, rights and obligations which roles entail often leads to negative reactions in others. It is argued (Kitchener, 1988) that those dual role relationships which involve a high risk of harm to the client are unethical. In particular, Kitchener (1988) notes the finding from role theory that expectations are not consistently perceived: thus a client may not share a professional's perception that his/her actions are consistent.

In the case of sexual contact between therapist and patient, the therapist fulfills the dual roles of therapist and lover. These roles are highly incompatible and thus the therapist's objectivity and professional judgment are impaired. Role conflict may bring into question the ability of the professional to place the interests of the client above his/her own interests.

Kardener (1974) argues that sexual contact between therapist and patient is similar to incest. As a consequence of the therapist's caretaker role with the patient, the patient is in a vulnerable position, because of his/her disclosures to the therapist, his/her presenting problems, and the transference (Pope and Bouhoutsos, 1986).

Perhaps the most compelling argument against therapist-patient sexual intimacy is the power imbalance between therapist and patient, which renders any sexual contact exploitative. This power differential arises from the training, expertise and social status of the therapist, versus the vulnerability of the patients which results from their needs which they are unable to meet themselves, and because of which they seek therapy. Even when the patient requests or initiates sexual contact, it is the duty of the treating professional to resist such advances in order to protect the patient (Sreenivassan, 1989). Sexual contact with a patient is usually to do with meeting the therapist's, rather than the patient's needs (Hare-Mustin, 1974; Taylor and Wagner, 1976), which should never be the aim or purpose of therapy.

It may be argued that to prohibit all sexual contact between therapists and patients, particularly former patients, is inconsistent with the promotion of equality between therapist and patient, and thus infantilises the patient. Brown (1988) advances several counterarguments to this, as she sees it, spurious viewpoint. First, and perhaps most importantly, it is largely therapists and not patients who advocate post-termination sexual contact as a mark of equality (Brown, 1988). Second, to draw a parallel between the therapist-patient relationship and the parent-child relationship, our society does not sanction sexual contact between parents and their adult children since it is recognised

that whilst the adult child may function in many respects as his/her parent's equal, there remains in their relationship some of the earlier significant power imbalance:

*"to make the former client's sexual availability to me serve as the hallmark of equality and complete recovery is a mockery of egalitarian principles"*

(Brown, 1988, p.252)

Further, when sexual contact occurs, the therapist's role changes and it is questionable whether s/he can retain appropriate therapeutic objectivity. It is also noteworthy that therapists are not qualified as competent lovers (if the rationale for the sexual contact is therapeutic) by virtue of their training (Hare-Mustin, 1974).

Saul (1962) argues that sexual feelings towards the therapist should not be acted upon because to do so would encourage the patient into a "blind alley" with regard to sexual and dependent needs for love. The patient rather needs to be helped by the therapist to find the satisfaction in real life. Saul also suggests that sexual contact would be inappropriate since the essence of transference is the repetition of emotional patterns which cause patients difficulties. The therapist should, it may be argued, instead attempt to present a corrective image rather than repeat past maladaptive patterns.

Sexual involvement would also intensify the patient's involvement in the transference, thus causing harm by encouraging the patient to find satisfaction away from real life and making therapy problematic, if not impossible. It is also vital that the male therapist

should refrain from engaging in sex with female patients because it is an invaluable experience for many woman patients to discover that they can be close to a man whom they are unable to seduce, yet does not reject them (Klopper, 1974).

The research evidence which shows the damaging effects of sexual contact with a therapist upon the patient is a compelling basis for advocating prohibition (Pope and Bouhoutsos, 1986). Finally, of course, sexual contact with patients is specifically legally prohibited, at least in some states in the U.S.A., and is also prohibited, if not always explicitly, by ethical codes, which place certain responsibilities upon the therapist, both for professionalism and for the welfare of the patient (Pope and Bouhoutsos, 1986).

### 1.3. ETHICAL CODES

In recent years a number of professional bodies have rewritten their ethical guidelines to include more detail about sexual contact with patients, in particular those who have been discharged.

The Committee on Professional Practice of the American Psychological Association has only relatively recently adopted the view that sexual contact with patients, either current or former, is **always** unethical (Brown, 1988). This position is, however, somewhat contradicted by the same Association's new set of Ethical Principles/Code of Conduct (1992) which effected a two year ban on sexual contact with former clients, allowing such contact subsequently only in the most exceptional circumstances, and taking into

account a variety of considerations. The burden is on the psychologist to show that there has been no exploitation or other ethical violations.

Even in its latest (1991) general Code of Conduct for psychologists the British Psychological Society fails to make explicit reference to sexual contact with patients. Psychologists are exhorted to:

*"refrain from improper conduct....not (to) exploit the special relationship of trust and confidence that can exist in professional practice to further the gratification of their personal desires" (p.4).*

It is only the Division of Clinical Psychology (1996) in its professional practice guidelines, which explicitly states,

*"any form of sexual advance or contact between client and psychologists is unacceptable, harmful and is grounds for allegation of professional misconduct" (p14).*

In these recent guidelines, the British Psychological Society/Division of Clinical Psychology have adopted a similar position on post-termination sexual relationships with patients, to that of the American Psychological Association.

In its code of ethics and practice, "Spectrum", a psychotherapy organisation in London, explicitly forbids its staff to engage in sexual relationships with current or former

clients. Similarly, the Psychotherapy and Counselling Section of the Association for Neurolinguistic Programming states that members should not exploit their clients sexually and during the therapeutic relationship, and for a period of 6 months after its termination, members should not have sexual contact with clients.

The General Medical Council (1994) provides its members with four booklets in a pack entitled "**Duties of a Doctor**" which includes guidelines on good medical practice. There is a section entitled "Abuse of your professional position" which provides examples of abuses of patients' trust which must be avoided by medical practitioners. Whilst sexual contact with patients is not specifically mentioned, doctors are exhorted not to "use your position to establish improper personal relationships with patients or their close relatives". Psychiatrists are bound by these guidelines, having no separate ethical guidelines or code of conduct.

The Royal Australian and New Zealand College of Psychiatrists (1995) has a specific ethical guideline relating to sexual relationships with patients, which provides clear guidance in respect of members' professional duty to avoid exploitation of patients. The guideline specifically prohibits sexual contact of any form between psychiatrists and their current patients and gives the view that:

*"it is generally improper for psychiatrists to have sexual relationships with former patients unless the circumstances of the professional relationship have not rendered the patient vulnerable to a subsequent approach."*

Long term treatment precludes sexual contact between psychiatrists and their former patients, and members are advised to consult a "properly constructed body of colleagues" if they are contemplating a sexual relationship with an ex-patient.

#### 1.4. SEXUAL CONTACT WITH DISCHARGED PATIENTS

Sexual intimacy with discharged patients has, until recently, been little debated in the literature, and many surveys do not differentiate between sexual contact with current and discharged patients.

In a study which did draw a distinction between current and former patients (Gartrell, Herman, Olarte, Feldstein and Localio, 1987), 29.6% of respondents stated that they believed that post termination sexual contact with patients would sometimes be acceptable. Interestingly, 74% of the psychiatrists in this study who had had sexual contact with patients believed that such contact would be acceptable, and indeed used this as a means of rationalising their behaviour. Indeed, it is possible that therapists may terminate treatment *in order* to engage in sexual contact with patients (Coleman, 1988a).

In a brief report of another survey, Derosis, Hamilton, Morrison and Strauss (1987) state that the overall rate of sexual contact with patients reported by their psychiatrist respondents was 6.6%, whereas if post termination cases were dropped, the rate fell to 6.1%.

In a survey of complaints regarding inappropriate sexual behaviour filed to U.S. state licensing boards and psychological ethics committees between 1982 and 1983,

psychologists were held in violation even when sexual contact with patients began following termination of therapy (Gottlieb, Sell and Schoenfeld, 1988). In fact, one psychologist was deemed to be in violation when beginning a sexual contact with a patient whose therapy had been terminated four years previously. Gottlieb et al (1988) also note that, at least for North American psychologists, their professional liability insurance extends to former patients with no time limit in respect of monetary settlements for sexual impropriety. In Britain, the situation is less clear. The British Psychological Society professional liability insurance policy would determine the extent to which a sexual relationship between a former patient and a psychologist could be said to be a consequence of the business or profession of the psychologist. If the relationship is considered as such, then the policy would only provide cover against spurious allegations. If the relationship is not considered as such, no cover would be provided (Johnson, 1996, personal communication).

In legal terms, at least in some states in the U.S.A., the psychotherapist-patient relationship is held to continue in perpetuity for the purposes of the issue of sexual misconduct (Folman, 1991). This supports the view that sexual contact between a psychotherapist and a discharged patient is inappropriate, since the initial therapeutic encounter permanently and irrevocably establishes the prohibition against therapist-patient sexual contact on an "ethical contract" basis (Herman, Gartrell, Feldman, Olarte and Localio, 1987).

Many of the reasons discussed in Section 1.2 for rejecting the legitimisation of sexual contact with current patients are equally applicable to those who have been discharged,

particularly in the light of the empirical finding (Pope and Vetter, 1991) that harm to patients occurred in 80% of the cases in which therapists engaged in sex with a patient after termination of therapy. The decision making ability of discharged patients may continue to be compromised, either because of their presenting problems, or because of residual transference (Applebaum and Jorgenson, 1991).

It may be argued that post-termination relationships between therapists and their patients can never be equal since the therapist must always remain available for the patient to re-enter therapy if necessary. Equally, the transference issues persist and would influence any relationship between the parties. In relation to this latter issue, it has been argued that the initial power imbalance between the therapist and the patient can never be erased (Herman et al, 1987).

Strean (1993) suggests that post-termination sexual contact involves unresolved transference and countertransference issues which are being acted out rather than discussed, particularly in view of the fact that the goal of most therapies is separation between therapist and patient, not union. Vasquez (1991) argues in a similar vein that an absolute ban upon therapist-patient sexual contact after termination of therapy would allow the client and the therapist to use therapy as effectively as possible; the client being freed to feel safe, open and trusting when the option of sexual contact is not open, and the therapist being less likely to make errors in terminating therapy.

It has been proposed that in cases where the transference has been resolved (Coleman, 1988), or after a defined "cooling off period" (Applebaum and Jorgenson, 1991) post-

termination sexual contact may be appropriate. Coleman (1988) also proposes in cases of discharged patients that if no harm occurs to the patient as a result of sexual contact with a therapist, there should be no prohibition on this behaviour. However, of course the questions of who should determine whether the transference has been resolved, and whether harm has occurred are crucial, since clear problems would arise if this was left solely to the treating psychotherapist. There is some research to suggest that patients' thoughts of the therapist continue for some years after the termination of therapy, and that many patients consider returning to therapy in the 5-10 year period following therapy (Buckley, Karasu and Charles, 1981, cited in Shopland and VandeCreek, 1991). This would suggest that the notion of a "cooling off period" may be inappropriate, unless it were of more than 10 years' duration.

Gonsoriek and Brown (1989) propose a solution to this problem based on differentiating between types of therapy received by patients, suggesting that post-termination sexual contact should be permanently prohibited where transference played a central part in the therapeutic relationship, where therapy was long term, and where there was a clear power difference between therapist and patient. For other, short term, structured therapies, sexual contact between therapist and patient may be permissible, but only under specified conditions, such as following a two year period, and where the patient is not severely disturbed.

Rutter (1989) suggests that in his experience, most long term relationships/marriages which occur between therapists and patients (and others in similar positions) involve almost insurmountable difficulties and simply perpetuate exploitative power relations.

A novel perspective on this issue is provided by the research of Geller, Cooley and Hartley (1981-1982, cited in Vasquez, 1991) whose research suggests that improvement in psychotherapy patients is associated with their internal image of their therapist. Presumably, therefore, anything which interfered with this image of the therapist, would have a negative impact upon the client's progress after therapy, including, potentially, sexual contact (Vasquez, 1991).

Brown (1988) argues that female sexuality is such that the development of a sexual relationship is not, for women:

*"a demarcated phenomenon defined solely by genital contact, overt arousal, and orgasm. Rather, sexuality is perceived as developing along a continuum which begins with feelings of attachment and intimacy and expands over time to include physical and genital components"*

(Brown, 1988, p.251)

Thus in these terms, what is frequently referred to as a "post termination" sexual or romantic relationship between therapist and patient, where one of the parties is female, is impossible since the onset of feelings of attraction occurred within the context of the therapeutic relationship:

*"the possibility that the client **might** become a lover has entered the process of therapy, and contaminated it, however subtly"*

(Brown, 1988, p.251) (original emphasis)

Several attempts have been made to find a solution to the problem of post-discharge sexual contact between therapists and their patients, in the context of professional bodies' ethical codes. A number of professional bodies, both in the U.K. and the U.S.A., have made recent amendments to their ethical codes, to allow for sexual contact between therapist and patient after a specified period following discharge. The time period varies from twelve weeks (British Association for Counselling, cited in Jehu, 1992) to two years under certain conditions (American Psychological Association, 1992; British Psychological Society, 1996).

#### **1.5. THE ATTEMPTS TO ARGUE IN FAVOUR OF SEXUAL CONTACT BETWEEN PSYCHOTHERAPISTS AND THEIR PATIENTS**

There have been a number of attempts to argue on theoretical grounds in favour of sexual contact with patients as a positive psychotherapeutic approach. McCartney (1966) argues for an extension of usual psychotherapy practice to include "overt transference" or allowing the patient to act on transference feelings by touching the therapist's body, and, in some cases, engaging in sexual intercourse with the therapist. This, McCartney argues, is appropriate in 10-30% of cases, where the patient needs to develop in maturity: here, the therapist, is said to act as a parent-surrogate. McCartney suggests that such 'treatment' should be restricted to heterosexual intercourse only.

A number of criticisms may be directed towards McCartney, calling into question his whole approach and theory. He rejects homosexuality as immature, neurotic and

adolescent, a view which holds little current credence in scientific circles, and he offers no other coherent argument for restricting therapist-patient sexual contact to heterosexual encounters. The validity of any therapy which claims that the therapist who engages in sexual contact with patients is acting as a parent-surrogate is undoubtedly questionable for reasons discussed in Section 1.2, and there are many grounds for objecting to the view that sexual contact is necessary to enable patients to develop in maturity, not least the damaging effect of such interactions (Taylor and Wagner, 1976). McCartney certainly takes a limited perspective on the purposes and process of therapy, it would appear, to justify his aims. His claims regarding the extent of his psychoanalytic practice are clearly misrepresented and not only was his training poor, but he was expelled from the American Psychological Association (Pope and Bouhoutsos, 1986).

Shepard (1971) concluded on the basis of interviews with patients who had been sexually intimate with their psychotherapists that "sexual involvement can be a useful part of the psychotherapeutic process" (p199), indeed, it was so, he argues, in 8 out of 10 of the cases which he considered. This conclusion is based on the patient's report of the effect of the sexual contact, and on Shepard's own impression of whether or not the contact was helpful. He suggests guidelines for the therapist who is sexually involved with his/her patient to follow, and concludes that sexual involvement with patients should be "selective, meaningful and honest". However, there is considerable evidence to demonstrate that therapist-patient sex is overwhelmingly harmful to the patient (e.g. Pope and Vetter, 1991). Although it is not clear whether Shepard himself engaged in sexual contact with his patients, if this was the case, his advocacy of therapist-patient sexual contact on the basis of his view that the outcome for the patient was positive, may

be questioned. Research suggests that therapists who report that no harm occurred in cases of therapist-patient sexual contact are twice as likely to have had sexual contact with a patient than are therapists generally, and that therapists who have had a sexual involvement with a patient are more likely to report positive effects as a result (Holroyd and Bouhoutsos, 1985).

Another possible justification for sexual activity between patients and therapists is that such contact will prevent suicide in those vulnerable patients who are particularly likely to fall prey to sexual contact with their therapists (Gutheil, 1989). This argument is opposed by Eyman and Gabbard (1991) in a paper aimed to show that therapist-patient sexual contact actually led to a patient's suicide in one case, and that it cannot be justified as preventing suicide, on legal, ethical and clinical grounds. There is no reference, however, in Eyman and Gabbard's (1991) paper, to any published (or unpublished) attempt to make a case for therapist-patient sexual contact as a deterrent to suicide and it can only be assumed that such a justification has been encountered by the authors in their clinical practice with therapists who have been sexually involved with their patients.

#### **1.6. THEORETICAL APPROACHES TO UNDERSTANDING SEXUAL ISSUES IN THERAPY**

The prevailing approach in the literature to understanding sexual feelings in therapy is a psychoanalytic one. Until very recently, no other theoretical approach has made a direct contribution in this area, even in two recent books which dealt with the therapeutic relationship in behaviour therapy (Schaap, Bennun, Schindler and Hoogduin, 1993) and

interpersonal process in cognitive therapy (Safran and Segal, 1990). However, in 1993, an article was published by Lobovits and Freeman in the Dulwich Centre Newsletter, which attempted to develop a systemic approach to understanding professional sexual exploitation.

### **1.6.1. Psychoanalytic approaches**

The predominant means of conceptualising sexual attraction and contact between therapist and patient is within the language of transference and countertransference in the psychoanalytic tradition. The psychoanalytic approach, whilst arguing for a prohibition on therapist-patient sexual intimacy, has traditionally located therapist-patient sexual contact within the patient's transference reaction, rather than examining its origins in the therapist and/or in the therapeutic interaction (Davidson, 1977). It was only in 1972 that Marmor acknowledged that the therapist could be seductive and could exhibit "countertransference acting out". However, Marmor controversially concludes that marrying a patient is an "honourable end-point" of the seductive therapeutic relationship.

#### **Erotic transference**

There are a variety of views within the psychoanalytic approach concerning the development of patients' sexual feelings towards therapists. Most writers (e.g. Fine, 1965) regard the phenomenon as essentially to be expected, and, if managed

appropriately, potentially helpful to the patient, in terms of understanding his/her difficulties.

Fine (1965) argues that the erotic transference may have almost any psychodynamic meaning, such as a bid for reassurance, a cover up of hostility, an expression of penis envy, or an oral-incorporative wish. Klopfer (1974) suggests that erotic transference may be understood in terms of a repetition of past frustrating situations in relationships, the desire to conquer the therapist and thereby prove s/he cannot be trusted, and a desire to confound the relationship with sex and love, so as to prevent the examination of other, more difficult issues. Further, a patient may become sexually seductive towards his/her therapist if s/he has been successful in winning approval and power over others in the past by sexual means. Sex is one of the few means of power open to women (Klopfer, 1974), and the female patient may thus exercise power over the powerful therapist by captivating him sexually and making a conquest of her captor.

Klopfer argues that in order to manage the erotic transference, three key principles apply: the patient's guilt about his/her sexual feelings should be reduced, the capacity for libidinal gratification should be increased via the exploration of the sexual feelings, and the meaning of love should be clarified, that is, the patient should be helped to shift from an infantile to an adult kind of love. In this way, the patient's erotic feelings for the therapist should be discussed and understood in terms of his/her intrapsychic difficulties, rather than acted upon.

Many psychoanalytic writers have, however, viewed the patient's love for his/her therapist as not so much a normal expression of transference neurosis, but as an unworkable resistance. It is argued (Blum, 1973) that erotic transferences tend to develop in patients with deficient reality testing, and that they are evidence of failure of development of the transference neurosis, and of the therapeutic alliance. Blum's contention that love for the therapist may signify early ego impairment on the part of the patient, possibly as a result of childhood sexual abuse, is useful in so far as it accords with empirical findings about the vulnerable personalities and life histories of patients who become sexually involved with their therapists (Pope and Bouhoutsos, 1986), but may inappropriately pathologise an essentially normal process within therapy.

Although Freud stated that patients' erotic feelings for their therapists are quite different from love as experienced outside of therapy, it has been suggested (Clements, 1987) that patients do "fall in love" with their therapists and that this phenomenon is identical to love which occurs outside the therapeutic situation. Further, Clements argues that "the therapeutic situation encourages, and then sets rather harsh limits to, emotional intimacy" (p 557). Clements goes on to reason that Freud made "an arbitrary value choice for abstinence and renunciation" from sexual contact between therapist and patient, and that if therapist and patient were to develop a love relationship, presumably incorporating a sexual component, this:

*"would not be incest, resistance, doing what should only be remembered, or perversity...(and) would not imply non-professional, psychotic or necessarily unethical behaviour and character"*

(Clements, 1987, p.557).

There are a number of inconsistencies, however, in Clements' position. First, she argues at the beginning of the article that Freud viewed the transference as "actual love" but later, quotes from Freud directly, indicating that he drew many distinctions between love outside of therapy and "love" within therapy, that is, he believed that transference love is provoked by the analytic situation, that it is greatly intensified by resistance, and it is highly lacking in reality. Secondly, Clements argues that to concentrate upon sex in therapy enables what she sees as the most important point about therapy to be missed. There are important questions about inequalities and distancing in the therapist-patient relationship, which need to be addressed, Clements suggests. These issues are not elaborated, however, or clearly articulated, and nor does Clements make a convincing argument about the link between focusing on sexual contact in therapy, and missing important issues about the therapeutic relationship. Moreover, by ignoring therapist-patient sexual contact she is able to disregard the overwhelming evidence that it is harmful to the patient (Brown, 1988) (cf. Section 1.15). Although Clements would no doubt dub this approach as being "duped by the fool's gold of identifying with the victim" (p 556) this very point of hers might be contested on the grounds that a central aspect of the role of a psychotherapist is exactly what she terms as "identifying with the victim", or understanding the client's difficulties and seeking to do no harm.

### **Erotic countertransference**

Within the psychoanalytic framework, the therapist's attraction to a patient was originally seen as a reaction to the patient's transference, rather than as a direct attraction to the patient him/herself (Pope and Bouhoutsos, 1986). Freud viewed transference as a

specific therapeutic phenomenon not identical to the experience of falling in love as it occurs outside the context of therapy. In the same way, the therapist's response, that of countertransference, was viewed not as a reaction to the qualities of the patient, but, rather, as a reaction to the transference, which may also produce feelings of hate and indifference towards the patient (Winnicott, 1949; Greenson, 1974). Freud held that erotic countertransference should never be acted out because both therapist's and patient's reactions are irrational or distorting and also because such acting out would overthrow the "cure" (Blum, 1973).

Therapists who fall in love with their patients or who desire sexual relationships with them have generally been regarded as suffering from countertransference *neuroses* (Greenson, 1974) which arise from therapists' instinctual and narcissistic needs as well as life events. Marmor (1972) argues that therapists are "beset by deeply rooted, often unconscious, needs that tend to foster or stimulate impulses toward physical closeness towards...patients" (p3). These needs include the biological, which vary with issues such as the state of the therapist's sexual relationship, and the psychological, that is the therapist's need to be a helping or parental figure. Thus, one of the ways in which therapists can act out their unconscious emotional needs with their patients is by becoming seductive (Greenson, 1974).

Thus the classical psychoanalytic view implies that a therapist's attraction to a patient is an *error*, and states that love for the therapist is blind, irrational, unrealistic and infantile, as well as defensive and resistant. It therefore poses a hindrance to therapeutic work and progress (Blum, 1973). Such a view of the process of therapy is exemplified by

Lerman's argument (cited in Tower, 1956) that no form of erotic reaction to a patient is to be tolerated.

There are a number of writers, however, who have suggested otherwise, arguing that countertransference in general, correctly managed, can be a valuable therapeutic resource and that sexual feelings towards the patient are entirely normal and to be expected (Lerman, 1960). Taylor and Wagner (1976) argue that therapists' sexual fantasies towards patients should be used as a therapeutic tool once the therapist has examined them and understood their meaning.

The view that erotic feelings towards patients are a normal part of the therapeutic relationship was proposed as early as 1959 by Harold Searles who suggested that successful psychoanalysis inevitably involves the therapist experiencing "reacting to, and eventually relinquishing, the patient as being his oedipal love-object" (p. 180). Searles suggests that just as the patient experiences oedipal love for the therapist as a parent, so the therapist experiences reciprocal responses, responses which were present in the patient's parent but which the parent was unable to recognise. Furthermore, the patient evokes transference feelings in the therapist, argues Searles, which are carried over from a significant individual from the therapist's own early life. Thus, the therapist responds unconsciously to the patient in these terms. Finally, Searles suggests that the patient who improves during therapy appeals to the narcissism of the therapist, and that in reality the patient close to the end of therapy becomes a more appealing person. The therapist may thus fall in love with the well patient whom s/he has "created" and in

relation to whom the therapist may be experiencing feelings of impending loss at the prospect of termination of therapy.

Another perspective on countertransference love as a parallel to transference love is offered by Celenza (1991) who suggests that just as transference love can be a defence for the patient against negative feelings, such as hate or rage, so countertransference love serves a similar function for the therapist, that of defending against difficult feelings so as to sustain a good, if not idealised, view of the transference.

It has been argued (Pope, Keith-Spiegel and Tabachnik, 1986) that failure to acknowledge and examine countertransference blocks its therapeutic potential and unleashes its destructive effects in that therapists may "act out" a sexual attraction to a patient. Indeed, Streaun (1993) suggests that,

*"in reality the puritanical, moralistic therapist is actively inhibiting what the therapist who has sex with patients is acting out. The differences between the two are not so great!" (p 21)*

Blum (1973) suggests that it is essential that when therapist-patient sexual contact occurs, it should not be rationalised in terms of a causal relationship between erotic transference and countertransference. He emphasizes that transference is not a necessary or sufficient cause of eroticised countertransference, and that there is no one to one relationship between eroticised countertransference and erotic transference. That is, to engage in sexual contact with a patient may not be conceptualised as the result of the

patient's erotic feelings towards the therapist. In this vein, Voth (1972) argues that a sexual relationship between a therapist and a patient "can be viewed as a massive symptom, a gigantic acting out of the patient's transference, the analyst's countertransference, and transferences of his (sic) own" (p398).

### **1.6.2. Behavioural approaches**

It is possible to extrapolate a behavioural perspective on sexual processes in the therapeutic relationship from the discussion by Schaap et al (1993) of the therapeutic relationship in behavioural psychotherapy, though no specific discussion of the problem of sexual contact in therapy has been offered from this perspective.

Schaap et al (1993) note that social psychological theories emphasise the social power and influence of therapists over their patients, since therapists' access to theoretical resources results in their exerting an influence over cognitive or behavioural processes in the patient.

This construct of social power is divided into five themes or power bases (Schaap et al (1993): first, expert power relates to knowledge and skills possessed by the therapist in relation to psychological processes, interpersonal relationships and therapeutic skills. Second, referent power relates to the patient's attempts to reduce psychological inconsistency between his/her behaviour and values or norms via therapy: thus the therapist is accorded referent power if s/he is viewed as attractive and empathic. This leads the patient to allow him/herself to be influenced in order to reduce this

inconsistency. Third, legitimate power results from an acceptance by the patient of the role division of the therapeutic relationship. Fourth, informational power differs from expert power in that the therapist is able to provide the patient with information or material which will influence his/her behaviour outside sessions. Finally, ecological power refers to the influence of the therapist by mediation of the patient's environment, for example by encouraging the patient to engage in social contacts.

This description of the therapist's social power suggests that therapists could exert sufficient power in a number of arenas over their patients to create a context in which sexual advances could occur, and to ensure that they do not oppose or disclose sexual contact. Once the patient comes to view the therapist as attractive and knowledgeable, any sexual advances may be viewed by the patient as consistent with the process of therapy in order to reduce psychological inconsistency. This, together with the ecological power exerted by the therapist, sets the scene for compliance and secrecy on the part of the patient.

Such a power analysis may also apply to the motivation of the therapist: in particular, gender socialisation may predispose male therapists to exploit the power which they experience as a therapist in the above ways. From the female patient's point of view, the "passive" role in the therapeutic relationship may also evoke dynamics as a consequence of gender roles and of the patient's past difficulties, which result in acceptance of exploitation.

### 1.6.3. Cognitive approaches

Whilst Safran and Segal (1990) do not address the question of sexual contact between patient and therapist in their book on interpersonal process in cognitive therapy, it is possible to develop a cognitive perspective on the issue from their work. Although Safran and Segal state that their perspective is of a cognitive nature, in fact their book draws on a cognitive-behavioural theoretical and empirical base, thus duplicating in part the behavioural perspective discussed above.

Safran and Segal (1990) argue that the therapeutic relationship may be employed to develop positive therapeutic expectancies, that is, that the therapist conveys a convincing rationale to the patient of the problem and of treatment strategies. The therapist's task as a coping, rather than mastery, role model is also seen as important, and the importance of collaborative empiricism is emphasised, that is, the need for therapist and patient to discover together the patient's irrational cognitions. Patients' in-session behaviour is a more controversial issue for cognitive therapists but Safran and Segal (1990) argue that problematic in-session behaviour might be regarded as a sample of the problem behaviour which originally occasioned the patient's therapy, and therapists can employ their own feelings for and reactions towards the patient as a means of identifying patients' behaviours which are likely to be interpersonally problematic.

From this perspective any seductive behaviour on the part of the patient may be understood by the therapist as an example of the kinds of interpersonally problematic behaviour which the patient may exhibit generally, and the therapist's response to such

behaviour (e.g. attraction towards the patient) may be useful therapeutic material as further evidence of the possible reaction of others to the patient's difficulties outside therapy. It is clear that were the therapist to engage in sexual contact with the patient, such opportunities for exploration and understanding of the patient's difficulties would be lost, and the therapist would be colluding with the patient's problems rather than assisting in their resolution. Furthermore, sexual contact would seriously impede the role modelling and collaborative empiricism aspects of therapy, providing a potentially exploitative role model and compromising the therapist's ability to behave and think neutrally in therapy.

#### **1.6.4. Systemic approaches**

Lobovits and Freeman (1993) offer a systemic approach to the issue of therapist-patient sexual contact, with the primary purpose of supporting an alternative discourse to the dominant use of psychoanalytic concepts. This is accomplished by employing emerging theoretical trends and methodologies currently developing in the field of narrative psychotherapy. They point out that the use of a single perspective for understanding sexual contact in therapy (that is, the psychoanalytic) does not encourage therapists to be accountable for their own conduct, rather, it encourages compliance with a particular therapeutic ideology. They challenge the view that clients are by necessity powerless and in some way incompetent, and that sexual contact in therapy can best be understood in terms of transference and countertransference. Rather, they assert that the problem should be located outside of the person, in the interactional context of the power relationship where the client is exploited.

Lobovits and Freeman argue that in some therapeutic approaches, and also in exploitative therapeutic relationships, the patient's problems are thought to be caused by pathological factors outside of the patient's awareness and beyond his/her competence to understand. Thus, such problems can only be solved by an expert who diagnoses, interprets and evaluates the patient and the problem, with minimal inclusion of the patient. In this way, patients' opposition to exploitative interactions is minimised and silenced. These writers thus largely offer a systemic critique of the psychoanalytic approach to therapy, and to the issue of sexual abuse in therapy, rather than a perspective which offers a systemic understanding of the problem.

#### **1.7. SEXUAL ATTRACTION IN THERAPY**

It is well-established in the literature that sexual attraction towards patients is very common. The research studies which have addressed this question have reported remarkably similar rates of such attraction, suggesting that only 12% - 15% of respondents never experience sexual attraction towards their patients.

Stake and Oliver (1991) found in their survey of licensed psychologists that 85% of respondents reported that they had felt sexually attracted to a patient. Pope, Keith-Spiegel and Tabachnik (1993) found that 86% of their psychologist respondents had experienced such attraction. In a survey of members of the American Psychological Association, Rodolfa, Hall, Holms, Davena, Komatz, Antunez and Hall (1994) found that only 12% of respondents reported never being attracted to any patient. Yet about half of those respondents who were attracted to patients reported that these feelings

caused them discomfort, anxiety or guilt. Similar frequencies of reported sexual attraction have been found among a population of Dutch male gynaecologists (85%) and ear, nose and throat specialists (81%) (Wilbers et al, 1992). In one study, a substantial proportion (68%) of respondents reported that if their patient was aware of their sexual attraction, they were more likely to view the therapy as harmed or impeded (Pope, Keith-Spiegel and Tabachnik, 1986).

Rodolfa et al (1994) report that almost half of their psychologist respondents who had been sexually attracted towards patients felt that the attraction had, at least in some cases, been beneficial to the therapy, in terms of increased empathy for patients, enhanced awareness of transference and countertransference reactions, and improved awareness of patients' nonverbal behaviours. Slightly fewer believed that there had been some negative effects as a result of the sexual attraction, including distraction from patient issues, problems in confronting patients, premature termination or feelings of over involvement with the patient.

Women psychologists may be more likely than men to report an absence of sexual attraction to patients (Stake and Oliver, 1991). Male respondents in the survey by Pope et al (1986) tended to report more beneficial effects of sexual attraction than did female respondents.

In sum, there is evidence to show that sexual attraction to patients is very common among a variety of health professionals. Of those who have not experienced such attraction, women may be more likely to be represented than men. Many psychologists

report the view that sexual attraction can be beneficial for the patient, but men are most likely to hold this view. Pope et al (1986) make the point that not only is sexual attraction towards patients extremely common, but therapists' training leaves them almost entirely unprepared for it.

### 1.8. EPIDEMIOLOGY

It is clear that sexual contact with patients is an issue across the different helping professions, both within and outside psychotherapy (Wilbers et al, 1992).

There is no systematic information available in the U.K. for any professional or lay group of psychotherapists in relation to their sexual contact with patients or attitudes towards it. Thus, North American research only is considered here.

Whilst the British Psychological Society provides broad information in its Annual Reports, in respect of the activities of its Investigatory Committee and Disciplinary Board, no specific information relating to sexual impropriety is provided. However, publicity has been increased, both by the Investigatory Committee's publication at quarterly intervals in "**The Psychologist**" of report columns, discussing issues arising from its work, and by the publication, both in the National Press and in "**The Psychologist**" of details of individuals who have been disciplined by the British Psychological Society often for sexual impropriety. For example in May 1995 and August 1996, "**The Psychologist**" carried details of members who had been expelled from membership of the British Psychological Society on the grounds that they had

contravened various sections of the Code of Conduct including those relating to "exploiting a relationship of influence or trust of a recipient of his services to further the gratification of his personal desires".

### **1.8.1. Prevalence of therapist-patient sexual involvement**

In considering the question of prevalence of therapist-patient sexual contact, it is essential to bear in mind a variety of methodological issues which have an impact upon the prevalence figures discussed below. It would be reasonable to suggest that the studies discussed below provide important information, in terms of broad upper (eg Pope, Levenson and Shover, 1979) or lower (eg Thoreson, Shaugnessy, Hepner and Cook, 1993) limits, about the problem of the sexual abuse of patients by psychotherapists, but that there are a number of methodological limitations in the research which must be considered when interpreting it (Pope, 1990c).

A number of biases may operate in respect of research in this area, including cultural bias, and volunteer bias. The most obvious issue is that of sampling bias, in terms of the motivation of those mailed in surveys, in particular their motives to participate or not to participate, a question for which no clear answers are available. It might be argued, for example, that only those therapists who perceive their sexual contact with patients as having exerted a harmful effect upon the patients, would be motivated to participate, or indeed that only those therapists who viewed such contact in positive terms would be prepared to respond, perhaps because of their consequent lack of concern in disclosing.

In addition, the demographic characteristics of the population of therapists who have sexual contact with their patients, particularly behaviour in relation to returning questionnaires, are unknown. Thus, it is problematic to draw inferences about the larger population of such therapists on the basis of such studies (Williams, 1992). In surveys, respondents may be prevented from responding at all, or from responding honestly by fear of lack of anonymity or confidentiality, even when these are assured by the researcher. Thus, the characteristics of those who do not respond to surveys are unknown, particularly in terms of the numbers who had sexual contact with patients. Further, it is not clear how many of those who respond but claim to have had no sexual contact with patients, may present a false picture in this respect. Those surveys which offer a definition of sexual contact may inadvertently exclude some forms of therapist-patient sexual contact, thus restricting the "cases" reported.

Generally speaking, the research has yielded no differences in any respect in the U.S.A. between the main statutory psychotherapy professions of psychology, psychiatry and social work (Borys and Pope, 1989) though there is a suggestion (Sonne and Pope, 1991) that the rate of sexual contact between marriage and family counsellors and their patients may be significantly higher than that reported for psychologists, psychiatrists and social workers. This research has not yet been published (Sonne and Pope, 1991). No information is as yet available to indicate the extent of sexual contact between other professionals, lay psychotherapists and counsellors, and their patients.

In North America at least, there have been approximately three times more malpractice cases involving psychiatrists than those involving psychologists (Perr, 1989) but this

finding may be accounted for by the larger number of psychiatrists in practice. It would therefore be reasonable to consider the surveys of different professions as a whole.

Most surveys have found that, overall, something under 10% of professional psychotherapists have had sexual contact with their patients. However, it is difficult to reach conclusions on the basis of these surveys because the authors do not always distinguish between patients who were current and those who were discharged at the time of the sexual contact, and because definitions of sexual contact differ from study to study, with some using sexual intercourse only as a definition (eg Holroyd and Brodsky, 1980), some offering less narrow definitions (eg Pope, Tabachnik and Keith-Spiegel, 1987), and some allowing respondents to make their own definition (eg Pope et al, 1979).

Permitting survey respondents to define sexual contact themselves may ensure that nothing of importance is excluded, as may be the case when such contact is defined in relatively narrow terms (eg intercourse only). However, it could be argued that self-definition allows respondents the potential to exclude aspects of sexual contact which they do not consider significant, but which others might.

Kardener, Fuller and Mensh (1973), in their study of psychiatrists, indicate a figure of 6-7% for all forms of erotic contact. Pope et al (1979), also in a study of psychiatrists found that 7% admitted to sexual contact with patients, a term that was undefined. Derosis et al (1987), found that 6.6% of the psychiatrist respondents to their survey had engaged in "sexual contact" with their patients. The term "sexual contact" is not defined.

Similarly, Gartrell, Herman, Olarte, Feldstein and Localio (1986) identify a figure of 6.4% of psychiatrists who reported engaging in "contact which was intended to arouse or satisfy sexual desire in the patient, therapist, or both". In a survey of psychologists, Pope et al (1986) report a rate of 6.5% for "sexual intimacies" on the part of psychologists with patients, though the researchers do not give the original wording of the question, or define sexual intimacy.

In Pope et al's (1987) study of psychologists, only 1.9% reported having "engaged in erotic activity with a client". Although Holroyd and Brodsky (1980) found that 3.2% of respondents to their survey had undergone sexual intercourse with a patient, another 4.6% engaged in other types of sexual behaviour. In a study of social workers, Gechtman (1989) found that 3.8% of respondents having "erotic" contact with clients. Rodolfa et al (1994) report a rate of 4% of psychologists who admitted to "sexual intimacies" with patients, and then only "rarely". Although Thoreson et al (1993) found that only 1.7% of their sample reported sexual intercourse or direct genital stimulation with current patients, a further 7% reported such contact with discharged patients. Presumably the figures would have been higher had a broader definition of sexual contact been adopted.

There is some suggestion that the rate of therapist-patient sexual involvement is declining in the U.S.A. (Pope, 1990c). However, this may depend upon the way in which sexual contact is defined, and whether post-termination contacts are included in the figures. Most studies have not provided their respondents with specific instructions

as to whether to include or exclude sexual contacts with patients where the patient was discharged when the sexual liaison began.

It is also problematic to draw inferences about actual changes in therapists' sexual behaviour because surveys do not specify when the sexual behaviour occurred (Williams, 1992). In addition, reporting practices, particularly by male psychotherapists, may have changed over recent years (Stake and Oliver, 1991) because of the increased publicity which has been accorded to the sanctions which have been applied to sexually abusive professionals. Thus, Schoener (1991b) concludes that there is no evidence to suggest that a decline is taking place in the incidence/prevalence of therapist-patient sexual contact.

Williams (1992) suggests that a number of sources of information should be used when attempting to establish the prevalence of sexual contact, including surveys of professionals, surveys of patients, and data from courts and professional ethics boards/state licensing boards (in the U.S.A.). There have been few published reports of the activities of state licensing boards, but one notable exception is a piece of research conducted by Gottlieb et al (1988) who found that over a period of three years (1982-1985), the total number of complaints against psychologists of sexual impropriety **within** therapeutic relationships rose dramatically, by over 480%.

In a recent survey of the records of a large U.S. State's psychology licensing and disciplinary board over 28 months, Pope (1993) found 22 cases in which sexual contact with a patient led to the therapist being disciplined. In a survey of therapy clients who

were also clinical psychologists, Pope and Feldman-Summers (1992) found that almost 7% had been sexually involved with their therapists.

Although these figures have proved a cause for concern among many in the psychotherapy and lay communities, there are those who would dispute such a view. In fact, Clements (1987) argues that even were the prevalence of sexual contact between psychiatrists and their patients as high as 13%, a figure suggested in some surveys, this would be "quite a low incidence that the profession did not need to feel ashamed about, but rather *proud of* " (p556) (my emphasis).

### **1.8.2. Nature of sexual acts**

Most researchers have included a definition of sexual contact in their surveys, which may limit the range of sexual acts which respondents describe. However, from the available information, the sexual acts which take place between therapists and their patients include suggestive behaviour, erotic kissing, fondling, massage, genital exposure, masturbation, oral-genital contact, anal intercourse and vaginal intercourse (Bouhoutsos, Holroyd, Lerman, Forer and Greenberg, 1983; D'Addario, 1977, cited in Pope and Bouhoutsos, 1986; Gartrell et al, 1986; Kuchan, 1989; Valiquette, 1989, cited in Jehu, 1994; Vinson, 1984).

Sexual intercourse occurs in anything between 41% (Holroyd and Brodsky, 1980) and 83% (D'Addario, 1977, cited in Pope and Bouhoutsos, 1986) of cases where sexual

contact has taken place with other studies suggesting figures somewhere in between, e.g. 58% (Bouhoutsos et al, 1983) and 75% (Vinson, 1984).

### **1.8.3. Serial sexual contact with patients**

From the limited evidence available there appears to be some discrepancy in the proportions of therapists reported to have had sexual relations with more than one patient. It is important to note, however, the finding that therapists who have sexual contact with one patient are at a high risk of repeating this behaviour (Gartrell et al, 1986).

In a study of psychiatrists conducted by Gartrell et al (1986) 33% of the psychiatrists who admitted having a sexual relationship with patients had done so with more than one patient. The number of patients abused by a single therapist ranged up to twelve.

Earlier studies suggest higher figures: Holroyd and Brodsky (1977) found that 80% of the clinical psychologists who had sexual contact with patients in their study had done so with more than one patient, and one therapist had victimised 10 patients. Such figures would accord with the 75% of psychiatrists who reported sexual contact, who stated that they had been sexually involved with more than one patient in a study conducted at around the same time (Butler and Zelen, 1977).

#### **1.8.4. When does sexual contact with patients occur?**

Sexual intimacy with discharged patients is little debated in the literature, and many of the epidemiological surveys do not differentiate between current and discharged patients. In around three-quarters of cases, therapists begin a sexual relationship with their patients after termination of therapy. Figures vary from 69% (Gartrell et al, 1986) to 77% (Pope and Vetter, 1991). Around 18% of sexual contacts occur in sessions, and 17% concurrent with therapy, but outside therapy sessions (Gartrell et al, 1986).

#### **1.8.5. Course of sexual involvement**

##### **Initiation**

Information on which participant in therapy initiated sexual contact is provided in a national survey of psychiatrists in the U.S.A. (Gartrell et al, 1986), an inquiry to Californian psychologists about their patients who had been sexually involved with previous therapists (Bouhoutsos et al, 1983), and a study in Montreal of voluntary workers who had engaged in sexual contact with their therapists (Valiquette, 1989, cited in Jehu, 1994). The results of these investigations are shown in Table 1.1.

**Table 1.1. Initiator of sexual contact (percentages)**

Source	Initiator			
	Therapist	Patient	Therapist and patient	Disputed/ mutual/ undetermined
Gartrell et al (1986)	11	32	57	-
Bouhoutsos et al (1983)	42	6	-	52
Valiquette (1989, cited in Jehu, 1994)	67	14	20	-

In the study whose respondents were therapists rather than patients, there was a higher reported rate of initiation of sexual contact by patients than therapists (Gartrell et al, 1986). In contrast, the studies requesting information of patients and of their current therapists' interpretations of the behaviour of previous therapists (e.g. Bouhoutsos et al, 1983) suggest a higher rate of therapist initiation of sexual contact. This suggests that there may be a bias in reporting, in that therapists may be likely to justify their sexual contact with patients by attributing the initiation of the contact to the patient.

The studies discussed above also provide data on when sexual contact commenced, again with varied results as shown in Table 1.2.

**Table 1.2. Commencement of sexual contact**

Source	Onset of sexual contact (%)		
	During therapy	After termination	During last session or immediately afterwards
Gartrell et al (1986)	27	63	-
Bouhoutsos et al (1983)	96	4	-
Thoreson et al (1993)	20	80	-
Valiquette (1989, cited in Jehu, 1994)	78	-	22

A similar theme emerges from these figures, that is that when therapists were asked to report on their own behaviour (e.g. Thoreson et al, 1993), they reported a higher rate of commencement of sexual contact after termination of therapy, whereas when patients or subsequent therapists were reporting (e.g. Bouhoutsos et al, 1983), the majority of cases appear to begin during therapy. This suggests that therapists may misrepresent their sexual contact with patients in order that it appears more acceptable, by reporting that the contact began after termination of therapy.

### **Duration**

In the only study to address the question of the duration of therapist-patient sexual contact, Gartrell et al (1986) report the length of therapist-patient sexual relationship as between one sexual encounter (19%) and over 5 years (17%) with other categories as follows: less than 3 months, 26%, 3-11 months, 17% and 1-5 years, 21%. It is clear from

this study that the largest group of therapists and patients were sexually involved for a relatively short period of three months.

#### **Termination of therapy in relation to sexual contact**

For those patients whose sexual contact with their therapist began whilst therapy was in process, the most detailed information available is derived from the patients described by Bouhoutsos et al (1983): therapy ended immediately after the first sexual contact in 34% of cases, while for the remainder it continued beyond this point. Both therapy and sexual contact ended simultaneously for 55% of these patients. Therapy was terminated by the patient in 67% of cases, by the therapist in 15%, mutually terminated in 17% of cases, and terminated by someone else in 1% of cases.

Among the 20 abusive therapists described by Butler and Zelen (1977), therapy was terminated immediately after the first sexual contact in 25% of cases, while in 30% it continued with sexual contact, and in 45% without such contact. In Valiquette's (1989, cited in Jehu, 1994) study of volunteers who had experienced sexual contact with their therapist, therapy ended after the first sexual contact in 36% of cases. It was terminated by the patient in 61% of cases, by the therapist in 27%, and by both parties in 12% of cases.

There is clear evidence from the studies discussed above that in a substantial number of cases, sexual contact and therapy occur simultaneously, with termination of therapy occurring immediately after the first sexual contact in a substantial minority of cases.

### 1.8.6. Gender of participants

The earliest information about the characteristics of therapists who become sexually involved with their patients was provided by Dahlberg (1970), based on cases of patients whom he had treated, who had sexual relationships with their therapists. These therapists were always male. There is some evidence to suggest that a greater number of the complaints made against women psychiatrists tend to be for homosexual involvement (Mogul, 1992).

To consider surveys conducted some time ago, when the overall figures are broken down by gender of therapist, the percentage of male therapists who engaged in sexual intercourse with patients rose to around 10% and women offenders formed only a tiny minority of the total number. However, this picture appears to be changing in surveys conducted more recently.

Gartrell et al (1986) surveyed North American psychiatrists, and found that 7.1% of male, and 3.1% of female psychiatrists had engaged in sexual contact with patients. Other surveys indicate figures of 3% and 12% for women and men respectively (Pope et al, 1979); 2.2% and 7.9% (Derosis et al, 1987), 2.5% and 9.4% (Pope et al, 1987) and 0.6% and 5.5% whilst therapy was ongoing (Holroyd and Brodsky, 1977). The latter study found that 8.1% of men and 1% of women had ever had sex with patients. Gechtman's (1989) study of social workers revealed no erotic contact between female social workers and their clients.

Bouhoutsos et al (1983) asked Californian clinical psychologists about their patients who had been sexually abused by previous therapists. The gender breakdown supports the preponderance of male therapist-female patient dyads: this was so for 92.4% of cases. In 2.5% of cases, a female therapist had been sexually involved with a male patient.

Some surveys have not, however, shown substantial gender differences in sexual contact with patients. These surveys have for the most part, but not exclusively, been conducted more recently (Stake and Oliver, 1991; Akamatsu, 1988; Pope et al, 1987). It has been suggested (Pope et al, 1987) that such an apparent decrease in the rate of sexual contact with patients by male practitioners may be accounted for by an actual decrease in abuse as a consequence of the increased attention which sexual misconduct has received in recent times. Of more concern is the possibility that those who have sexual contact with patients are less willing to disclose the contact even in anonymous surveys for fear that somehow it is becoming increasingly likely that sanctions will be applied (Stake and Oliver, 1991).

A small percentage of therapist-patient sexual relationships involve same sex pairs. Gartrell et al (1986) found that in 3.4% of the cases of sexual contact between psychiatrists and their patients the liaison involved a male therapist and male patient, and in 1.7%, female therapist and female patient. In Bouhoutsos et al's (1983) survey, which considered male and female therapists together, 5.1% of the liaisons were homosexual in nature.

Somewhat different findings on same sex relationships between psychiatrists and their patients are reported by Mogul (1992) who reviewed complaints to the American Psychiatric Association Ethics Committee. Only two (2%) of 85 complaints against male psychiatrists involved male patients, while six (75%) out of eight complaints against female psychiatrists involved female patients. The variations in the findings of these two studies may be due to sampling differences between psychiatrists responding to a national survey and those against whom ethical complaints have been made.

Gonsorick (1987) suggests that sexual contact with male patients may be under-reported, particularly if it was perpetrated by a male therapist. Possible reasons for this include the socialisation of men to exclude the perception of the self as powerless victim: thus self blame may occur when men are sexually abused by their therapists. Although sexual activity with a same sex partner does not necessarily mean that either person is homosexually oriented, if a male victim fears that he is homosexual because of such a sexual contact with his therapist, homophobia in society may mean that reporting is less likely to occur for fear of condemnation. Whilst this argument may not apply to surveys of therapists, it may account for some under-reporting by patients. In addition, those patients whose sexual orientation is homosexual may fail to complain about a sexually abusive psychotherapist because this might be viewed as disloyal to the homosexual community or could entail public revelation of the patient's sexual orientation.

It is perhaps somewhat premature to reach firm conclusions in relation to gender issues in therapist-patient sexual contact. It is clear that the picture has changed in recent years,

from one in which research studies found substantially more male than female therapists engaging in sexual contact with predominantly female patients, to a more recent suggestion that no major differences are evident between male and female therapists in respect of sexual contact with patients. Recent attention has been afforded to same sex liaisons, which appear to form a minority, approximately 5%, of all reported cases. Further research is clearly required to establish whether this pattern is sustained, and caution must be applied to interpretations of the data because of possible changes in reporting practices.

#### **1.8.7. Age of participants**

The research suggests that there is a considerable discrepancy between the age of therapists who become sexually involved with patients, and that of the patients. The therapists reported by Dahlberg's (1970) patients were typically over 40, with a range of 10 to 25 years older than the patient. Gartrell et al (1986) found that the average age of such therapists was 43, while the average age of the patients was 33. Similarly, Bouhoutsos et al (1983) describe average ages of 42 and 33 for therapists and patients respectively. However, Friedeman (1981, cited in Benowitz, 1994) suggests that the age differences reported between therapists and the patient with whom they are sexually involved are also true for therapists and patients generally.

### 1.8.8. Conclusion

A wide range of sexual acts are perpetrated with patients by therapists of all the main psychotherapy professions in the U.S.A., including intercourse in more than half the cases. Whilst it has in the past been assumed that the therapist is typically male and the patient female, recent studies have called this assumption into question. Almost half of such relationships appear to last for less than three months, although some last for more than five years. The limited and inconsistent evidence concerning serial sexual contact, the initiator of the sexual contact, and when it began, preclude any generalisation on these topics at the present time. From the findings on termination of therapy, in so far as they are comparable across studies, it appears that in about a quarter to a third of cases, therapy is terminated immediately after the initial sexual contact, while for the remainder therapy continues with or without further sexual contact. Whenever it occurs, termination of therapy is instigated by the patient in at least two thirds of cases.

Clearly, much research in this field remains to be undertaken, particularly in terms of attempting to establishing more precisely the extent and nature of therapist-patient sexual contact. Williams (1992) suggests that future research to complement existing data might target the naturalistic behaviour of populations, for example, complaints filed against therapists in professional, regulatory and legal settings could be integrated with information about numbers of therapists practising and patients being treated. In this way, estimates of minimum incidence and changing patterns of sexual contact between patients and their therapists could be obtained.

### 1.9. ATTITUDES AMONG PRACTITIONERS TOWARDS SEXUAL CONTACT WITH PATIENTS

The vast majority of North American therapists have indicated in surveys that they believe sexual contact with patients to be unacceptable. For example, Pope et al (1987) found that 95% of their psychologist respondents believed that sexual contact with a patient was unethical and about half believed that becoming sexually involved with a former patient was unethical. A similar result was achieved by Borys and Pope (1989). Herman et al (1987) report that 98% of their respondents said that therapist-patient sexual contact was always inappropriate and usually harmful to the patient.

There appears to be a gender difference in such attitudes: in a survey of psychologists, fewer female than male respondents expressed the belief that sexual contact was unethical and harmful (Holroyd and Brodsky, 1977) and the same applies to the belief that sexual contact may be appropriate with former clients (Akamatsu, 1988). Holroyd and Brodsky (1977) surveyed clinical psychologists' attitudes towards erotic and non erotic physical contact with patients and found that male therapists were more likely than female therapists to see benefits in non erotic contact for opposite sex patients. Male therapists are also more likely to consider sexual contact with a patient than are female therapists (Pope et al, 1986).

However, it is essential in considering these data to recall Folman's (1991) caution that surveys in this area have highlighted glaring discrepancies between therapists' ethical beliefs and their actual behaviours.

Some therapists do admit to believing that sexual contact with patients can be beneficial. In a survey by Holroyd and Brodsky (1977), for example, 4% of psychologists thought that erotic contact could be beneficial to opposite sex patients, and 2% thought the same in relation to same sex patients. In a survey of male members of the American Counselling Association by Thoreson et al (1993), those respondents who endorsed the view that erotic sexual conduct with patients may not constitute professional misconduct were more likely to report that they had practiced such behaviour than respondents who always considered sexual contact between patient and therapist to be misconduct.

#### **1.10. CHARACTERISTICS OF THERAPISTS WHO HAVE SEXUAL CONTACT WITH PATIENTS**

Little, if any, discussion is apparent in the literature in relation to the personal backgrounds, and in particular the childhood experiences, of those therapists who become sexually involved with their patients. One issue in this respect would be the possibility that some such therapists may have been the victims of childhood sexual abuse. However, no empirical data are available on this topic.

##### **Behavioural issues**

It appears that therapists do not differ on most demographic variables from therapists who do not have sexual contact with their patients (Holroyd and Brodsky, 1980). However, Thoreson et al (1993) suggest that in their survey there was some evidence to

show that those who engaged in sexual misconduct with clients or students were more likely to be single or divorced, and to be in private practice.

There appear to be some differences in attitudes towards, and use of, non erotic physical contact with patients between therapists who have sexual contact with their patients and those who do not (see Section 1.4.). At least a substantial minority of these therapists who report sexual involvement with their patients are repeat offenders (see Section 1.8.3.).

There is some evidence to suggest that therapists who have had personal therapy, or who had sexual contact with educators during professional training may be more likely to develop sexual liaisons with their patients. Gartrell et al (1986) surveyed U.S. psychiatrists, and found that those who reported sexual contact with their patients were more likely to have had personal therapy. This is the only study to investigate this issue, and the robustness of the association requires further testing. It would also be necessary to establish whether personal therapy occurred before or after sexual contact with patients, since different interpretations of such an association would be necessary depending on the timing of the therapy. This is a question which Gartrell et al (1986) do not address.

Pope et al (1979) argue that educator-student sexual contact models later therapist-patient sexual contact. For their female respondents, engaging in sexual contact as a student with educators was related to later sexual contact with clients, a figure of 23% as compared with 6% who had not had sexual contact with educators. For male

respondents, the number who had been sexually involved with educators was too small to test the relationship.

It has been argued that the pattern exhibited by those professionals who have sexual contact with their patients is similar to that of identified sex offenders (Burgess and Hartman, 1986) in terms of methods of controlling patients, means of self-defence and recidivism.

### **Personality issues**

The earliest information about the characteristics of therapists who become involved with their patients was provided by Dahlberg (1970), based on cases of patients who had had sexual relationships with their therapists, whom he had treated. In those cases where sufficient information was available, the therapist was having severe marital problems. Most male therapists practising at this time, Dahlberg points out, would be fairly unusual in their withdrawnness and introspection, studiousness and passivity, shyness and intellectualism. Having thus been unpopular with women, such therapists suddenly found themselves in the unusual position of having their female patients attracted to them, and thus, a fantasy of masculine omnipotence is fulfilled.

Such issues of job stress, poor self-concept, break-up or absence of a primary relationship and naïveté were cited by respondents who reported sexual contact with their patients in Rodolfa et al's (1994) survey of North American psychologists.

A number of variables were found by Thoreson et al (1993) to be significantly, though minimally, correlated with sexual contact with a patient (though in addition sexual contact with a student was also included in this survey and its conclusions must therefore be considered with some caution), that is, importance of intimacy in one's life, homosexuality of respondents, respondents' perceived femininity of self, emotional distress, substance abuse and the "overall attitude that sexual contact with a client, student under supervision, or student constitutes professional misconduct".

Butler and Zelen (1977) interviewed twenty volunteers, both psychologists and psychiatrists who admitted sexual involvement with their patients. Of these, 90% had been vulnerable, needy and lonely in relation to marital problems at the time of the contact. Some therapists saw themselves as domineering and controlling (15%) but most (60%) saw themselves as in a paternal relationship with a passive and submissive patient. Most experienced conflicts, fears and guilt. Strean (1993) suggests that the therapists whom he has treated are all "starved for love", thus strongly identifying with the love-starved patient and thereby, a narcissistic mutual attraction develops between patient and therapist.

In a study of an inpatient facility, Averill, Beale, Benfer, Collins, Kennedy, Myers, Pope, Rosen and Zoble (1989) found that there were two main groups of care staff who became sexually involved with patients. Firstly, a collection of younger, exploitative individuals, and secondly, a group of older, middle aged, isolated staff who were experiencing personal problems which triggered longings for nurturance. Both groups

appeared to have considered their own needs and issues at the expense of those of their patients.

Claman (1987) and Celenza (1995) suggest that the research evidence shows that many of these therapists fit a pattern of narcissistic disturbance of the self, that is, such therapists harbour from their childhood unfulfilled longings to be mirrored and needs to merge with others. When sexual contact occurs, these needs are mirrored by the patient, who functions as a "self-object". An example of such a therapist is given by Streaan (1993) who cites the case of "Roslyn Mason", a therapist who seemed to derive grandiose narcissistic satisfaction from her sexual contacts with patients by making statements such as:

*" I have felt that Doug's (name of patient with whom she had sexual contact) depression lifted because of me. He can cope with a sadistic wife with much more ease because of me. His self-esteem has risen because of me. He's a new man because of me." (p 95)*

On the basis of a review of the literature, Schoener and Gonsoriek (1988) suggest that therapists who have sexual contact with their patients are likely to display omnipotence and grandiosity, masochistic and sadistic tendencies, and even personality disorders. They offer a number of categories into which such sexually exploitative therapists may fall. This schema seems to be in accordance with the research cited above, and provide a useful summary of the personality issues involved in therapist-patient sexual contact.

Schoener and Gonsoriek argue that some such therapists are uninformed and naive, being inexperienced or poorly trained, particularly in terms of professional standards and boundary issues. An example of this would be the untrained 'hypnotherapist' who had sexually abused nine patients, described by Hoencamp (1990). A second group of healthy or mildly neurotic individuals seems to be the most common, and appears to comprise those cases where sexual contact is an isolated occurrence or relatively limited in scope. Here the therapist seems likely to be aware of the ethical problems with sexual contact with patients and is remorseful, frequently requesting help. There is a group of severely neurotic therapists who have long standing and substantial emotional problems, including depression, poor self concept and social isolation. Here, professional boundaries break down as the therapist becomes excessively socially and emotionally involved with the patient. Although guilt may be present this often does not lead to change. Such therapists may deny, distort or rationalise about the contact.

A number of therapists engaging in sexual contact with their patients, suggest Schoener and Gonsoriek, have character or personality disorders. The first group identified is one which demonstrates character disorders with impulse control problems, that is, individuals who have long standing impulse control problems (a history of sexual harassment, fraud, etc.) which may have led to encounters with the legal system. Remorse may be shown on discovery of the sexual abuse of patients but such individuals tend to have little appreciation of the consequences of their behaviour and may seek to minimise the harm they have caused. Those with sociopathic or narcissistic character disorders tend to premeditate their abuse of patients with cunning. Such therapists tend to be manipulative and calculating, usually multiply abusing their

patients. Finally there are a number of therapists who are psychotic or who have borderline personality disorders. Here, individuals display poor social judgment and impaired reality testing. Their level of understanding of the consequences of their behaviour, and the degree of remorse which they show are variable.

Levine, Risen and Althof (1994) suggest a diagnosis of paraphilia (excessive and "driven" sexual interest, fantasy, masturbation and partner-seeking behaviour) should be considered in cases of professional-client sexual contact, and that such a diagnosis was appropriate in just over 25% of the 31 professional "sex offenders" treated by their Programme for Professionals. In a similar percentage of their cases, compulsive sexual behaviours were diagnosed. In addition, personality disorder and clinical depression were in evidence among most of the remainder of the sample.

In terms of the motivation for initiating sexual contact with a patient, Sonne and Pope (1991), on the basis of a review of the literature, conclude that therapist-patient sexual intimacy usually involves anger (battering the patient, emotionally abusing the patient or recommending activities which will harm the patient, but are ostensibly intended for the patient's benefit), power (viewing the patient in almost exclusively sexual terms, substituting the patient for a significant figure in the therapist's life, attraction to pathology, authoritarian orientation, and being attracted to a physically immobilized patient) and sadism (pleasure in causing pain, and sexualized humiliation). Most studies concur that power needs motivate therapists who have sexual contact with their patients (Bouhoutsos, 1985).

Certainly some of the motivational factors discussed by Sonne and Pope (1991) are consistent with the personality variables described above. For example, power and anger as a motivating factor may feature for those with personality disorders and those who see themselves as domineering and controlling (Butler and Zelen, 1977). However, there is also a group of therapists whose sexual contact with patients arises out of their own vulnerabilities such as unhappiness and loneliness (e.g. Dahlberg, 1970; Butler and Zelen, 1977; Thoreson et al, 1993), as well as those who are ill- or uninformed (Gonsoriek, 1987).

#### **1.11. CHARACTERISTICS OF PATIENTS WHO BECOME SEXUALLY INVOLVED WITH THEIR THERAPISTS**

Whilst research has identified a number of characteristics of those patients who become sexually involved with their therapists, it may be argued that simply to be in the patient role renders any individual vulnerable. In a study apparently supportive of such a contention, Benowitz (1994), in a study of such patients, found that many were highly educated, and some were themselves mental health professionals.

Rutter (1989) suggests that there are four categories of women who are at risk for sexual boundary violations, that is, those who have been overtly sexually or psychologically invaded in childhood, those who experienced profound childhood aloneness, those whose compassion has been exploited by their families, and those whose outer potential has been devalued by both culture and family. He also suggests that therapeutic relationships, and indeed other relationships of trust reawaken childhood needs and

wounds and in this way women often lose the capability to exercise adult choice. They might desire connection in order somehow to restore a lost parent-child bond, these wishes originating in a time when nonsexual kisses and embraces were natural: thus, women may wish to touch or be touched by the therapist. Unfortunately, Rutter's analysis could be said to apply to many women in our culture, and thus may not be of assistance in distinguishing vulnerable from invulnerable women in relation to sexual contact in therapy.

Belote (1974) found female patients who had been sexually involved with their therapists to be vulnerable and high on traditional feminine attributes such as other-directedness, poor self-image, low self-actualization and to demonstrate little acceptance of their own aggression. Averill et al (1989) found that in their inpatient sample the typical patients who had become sexually involved with their therapists were those with borderline personality disorders, a history of childhood sexual abuse and/or rape, who were in long-term therapeutic relationships with maximum opportunities for transference. Some empirical evidence is available to support this finding: Pope and Vetter's (1991) survey of psychologists suggests that some 32% of patients becoming sexually involved with their therapists have a history of childhood sexual abuse and that an additional 10% have been raped. In DeYoung's (1981) case reports, all three of the patients who had been sexually involved with their therapists had been subject to childhood sexual trauma.

Cahill, Llewelyn and Pearson (1991a) suggest that those women with histories of sexual abuse may be at increased risk of developing a sexual relationship with their therapists

because of their tendency to sexualize relationships and to abdicate power to men. Such patients may also be prone to re-enacting early abusive relationships by casting the therapist in the role of abuser. In addition, the male therapist working with the female survivor of sexual abuse may be prone to identify with the offender and thus to eroticise the therapeutic relationship (Cahill, Llewelyn and Pearson, 1991b).

It has been argued that boundary violations, a feature of therapist-patient sexual contact, are most likely to be evoked by patients with borderline personality disorder (Gutheil, 1989) because of their rage towards the therapist, their neediness and dependency, their confusion of the self/other boundary, and their manipulateness and strong feelings of entitlement (see Appendix 5 for diagnostic criteria for borderline personality disorder). These dynamics evoke powerful counterdynamics in the therapist, which can easily lead to boundary violations.

Pope and Bouhoutsos (1986) suggest that three major categories of patients emerge from the literature, a low risk group who, although they are highly stressed, are essentially healthy; a middle risk group with a history of previous relationship problems and who may be personality disordered; and a high risk group with a history of hospitalization, suicide attempts, major psychiatric illness, including borderline personality disorder, and substance abuse problems. A high percentage of the women in the latter group had also experienced childhood sexual abuse.

A small minority of patients with whom therapists have had sexual contact are minors, 5% in a study by Pope and Vetter (1991). When Bajt and Pope (1989) looked at cases of

therapists' sexual contact with child patients by surveying 100 psychologists, some of whom worked with minors, and some of whom had published in the area of therapist-patient sexual intimacies, 81 examples emerged, reported by 24% of the 90 respondents. Of these, 56% were girls and 44% were boys, whose ages ranged from three to seventeen.

The patient who enters therapy after being sexually involved with one therapist is at considerable risk of sexual involvement with her new therapist (Folman, 1991; Gartrell et al, 1987). However, whether this is a result of patient or therapist variables remains unclear. It could be argued that those with borderline personality disorder are particularly prone to such multiple sexual contact, for reasons discussed above.

#### **1.12. REPORTING OF THERAPIST-PATIENT SEXUAL CONTACT, AND ITS CONSEQUENCES**

Most authors in the field concur that therapist-patient sexual contact is vastly under reported. In a study of psychologists who had treated patients who had been sexually involved with a previous therapist, Pope and Vetter (1991) found that only 12% of the patients filed complaints.

Levenson (1986) argues that professionals have an ethical obligation to intervene and to report their knowledge of unethical practice by a colleague, and indeed some ethical guidelines (e.g. British Psychological Society, 1991; General Medical Council, 1985) explicitly state this. However, when Gartrell et al (1987) looked at the reporting

practices of psychiatrists who knew of sexual misconduct by colleagues, only 8% of cases were reported, but the majority favoured mandatory reporting of such cases.

One recent report in the literature (Long, 1992) describes a case of sexual abuse of two 13 year old children by a nurse who had been convicted and sentenced through the criminal justice system. The case was referred to the United Kingdom Central Council (U.K.C.C.), a body which governs nurses, where judgment was first deferred (during which time the nurse committed further offences) and, following reprimands, he was subsequently allowed to remain on the register and practice as a nurse. Long (1992) criticizes the U.K.C.C. for its failure to protect the public.

A novel and interesting hypothesis about the failure of professionals to report their colleagues who engage in sexual contact with patients is proposed by Rutter (1989) who argues that a substantial proportion of men share the fantasy of sexual involvement with patients and thus envy others' forbidden sexual exploits in this respect. For these reasons they may "look the other way" when they encounter colleagues' sexually exploitative behaviour. This would imply that women may be more likely than men to report male colleagues, but no evidence is currently available to support or disconfirm this hypothesis.

**1.13. HOW MANY THERAPISTS WHO HAVE ENGAGED IN SEXUAL CONTACT WITH THEIR PATIENTS ADMIT THEIR BEHAVIOUR (OTHER THAN IN ANONYMOUS SURVEYS) OR SEEK HELP?**

In the two studies of the assistance-seeking behaviour of therapists who report sexual contact with patients, a relatively high percentage, 41%, sought "consultation" (Gartrell et al, 1986) and Butler and Zelen (1977) found a similar figure of 40% who had sought help from a colleague. This would suggest that many abusive therapists recognise the problematic nature of their sexual contact with their patients and the necessity to take some action in relation to it, but that more than half fail to do so.

**1.14. THE USE OF TOUCH IN PSYCHOTHERAPY**

Although during the early stages of the development of psychoanalysis, touch such as massage of the patient, and permitting the patient to touch the therapist, was used by Freud amongst others (Kertay and Reviere, 1993), over a period of time increasing emphasis was placed on less active strategies such as free association and the analysis of transference.

The psychoanalytic tradition has subsequently maintained a taboo on physical contact with patients on the grounds that touching introduces reality into the therapeutic relationship and consequently gratification and tension reduction which would render problematic the identification and understanding of transference material, diminish the range and depth of the material and reduce motivation to engage in therapy (Goodman

and Teicher, 1988). Other therapeutic approaches which concern themselves with the patient's reality may not consider touch to be problematic in certain circumstances.

Even within psychoanalysis, there is, however, disagreement. Touch is viewed by some as acceptable in the case of patients with certain presenting problems, such as delusions, or to provide a corrective emotional experience, dependent on the clinician's approach. Sponitz (1972, cited in Goodman and Teicher, 1988) captures the debate in asserting that the use of touch in therapy should be contingent on whether it would contribute a maturational quality to the therapeutic relationship.

Most of the literature concurs that if touch is used at all in therapy, it should be employed judiciously and with caution (Edwards, 1980) and that the decision to touch or not to touch patients must include a consideration of the perceptions, motives and interpretations of the touch (Holub and Lee, 1990). There are many different types of touch (Edwards, 1980) which can be anything from nurturant to aggressive, prompting to sexual. The use of some of these may be more problematic than others. Particularly for more damaged patients, touch may result in a loss of inhibition, or may be experienced as a sexual promise, which, when unfulfilled, can make the patient feel betrayed and abandoned.

It is also important to consider the power dynamics of therapy and consequently how the patient may perceive being touched by the (powerful) therapist (Holub and Lee, 1990). Furthermore, it is possible that whilst a therapist may not touch a patient with sexual intentions or implications, the client may either perceive it as such or have sexual

feelings towards the therapist. Even where a therapist makes a decision to use touch with some patients, it may be unsuitable for others (e.g. incest victims) (Holub and Lee, 1990). Perhaps in response to such considerations, the American Psychological Association (1982, cited in Goodman and Teicher, 1988) adopted the following statement regarding physical contact with patients:

*"permissible physical touching is defined as that conduct which is based upon the exercise of professional judgment, and which, implicitly, comports with accepted standards of professional conduct" (p492)*

The research evidence supports the use of caution regarding the effects of touch in therapy. Pattison's (1973) findings on the effects of touch on patients and the therapeutic relationship show that patients who were touched engaged in more self-exploration, and that touch had no effects on their perception of the relationship with the therapist. Although this suggests that touch in therapy may be extremely helpful to the therapeutic process, some research has demonstrated a relationship between touching patients and sexual contact with them.

For example, a survey by Kardener et al (1976) showed that the freer a physician is with non erotic physical contact, the more statistically likely s/he is also to engage in erotic practices with patients. Holroyd and Brodsky (1980) found that therapists who had sexual intercourse with patients advocated and used non erotic contact with opposite sex patients more often than those who did not. Those who had non intercourse sexual

contact, however, did not differ from other therapists in their use of non erotic touching.

So,

*"the differential application of non erotic hugging, kissing and touching to opposite sex patients but not to same sex patients is viewed as a sex-biased therapy practice at high risk for leading to sexual intercourse with patients"*

Holroyd and Brodsky (1980, p.807)

In a survey of psychologists' attitudes towards erotic and non erotic physical contact with patients, Holroyd and Brodsky (1977) found male therapists to be more likely than female therapists both to use and to see benefits in non erotic contact for opposite sex patients. There is also research evidence to suggest that women respond more positively to touch than men, and that touch is likely to be equated with sexual intent (Holub and Lee, 1990). However, studies have not addressed the possibility of same sex physical contact between therapists and patients, and its connection with sexual contact.

The use of physical contact with patients is a relatively common practice in psychotherapy. Results of a survey by Pope et al (1987) show that a quarter of psychologist respondents had kissed a patient and 44.5% hugged clients rarely, with 41.7% doing so more frequently, that is, a total of 86.2% of respondents had ever hugged a client. Most were prepared to shake their clients' hand and most did not consider this to be unethical. Holroyd and Brodsky (1977) found that 27% of their respondents engaged in non erotic physical contact, mostly humanistically oriented

therapists. Among general physicians, more female practitioners than male believe in and use non erotic touch with patients (Perry, 1976).

Unpublished data from the International Study of the Development of Psychotherapists (Davis, 1995, personal communication) shows that 54.8% of a sample of psychotherapists engaged in non sexual physical contact other than a handshake with their patients.

Kertay and Reviere (1993) suggest that a three level approach be adopted in relation to decision making about the use of touch in psychotherapy. First the issue of ethical violations should be considered: those therapists who recognise that they are likely to touch patients selectively on the basis of the patient's gender should avoid the use of touch. When touch leads to sexual arousal on the part of either therapist or patient, it should be discontinued. The second level of decision making relates to the "necessary qualities" of the therapeutic relationship. That is, various aspects of the therapeutic relationship should be considered. This suggests that touch should not be employed in the early stages of therapy, it must be congruent for the therapist, to the relationship between the patient and the therapist, and to the needs of the patient. Finally it is suggested that the therapist and patient should discuss the use of touch, and in particular, potential sexual feelings which may arise from the use of touch. This approach assumes, however, that the therapist is motivated to behave ethically, and to take steps to avoid sexual contact with patients. This applies to some, but not all, therapists.

**1.15. THE EFFECTS ON PATIENTS OF SEXUAL CONTACT WITH THEIR THERAPIST**

*"The disillusionment I experienced, necessary though it was, and too long in coming, also brought me grief. I was only beginning to realise the implications of my neediness. I had settled for an abusive form of contact rather than risking no contact at all. I was ashamed of myself ... he had methodically sabotaged my self-trust. He had disabled my sense of direction and my judgment. I had lost any chance of resolving the problems I brought to him initially. I had lost the opportunity to deal with the additional conflicts that had emerged in the course of therapy. And I had lost another father ... within a mere two months the combined effects of the sexual abuse and the unresolved problems that had originally prompted me to enter psychotherapy made life seem unbearable. I was burdened with an unending depression, and my thoughts progressed from occasional ideas about suicide to a studied contemplation of it. I experienced a pervasive sense of having no control over my life. I felt helpless to affect the world around me, helpless to affect my inner world. I was torn between caring for the once-trusted Dr X and hating the therapist who had used me sexually. My confusion emerged in the form of violent dreams that brought me screaming into wakefulness".*

(Patient's account of the effects of sexual contact with her therapist, Bates and Brodsky, 1989, p.40)

*"I've seen too many patients badly damaged by therapists using them sexually. It's always damaging to a patient"*

(Yalom, 1989, p.2) (original emphasis)

The above descriptions of the destructive effects of therapist-patient sexual contact are typical and illustrative of the accounts reported in the literature by patients and subsequent treating therapists.

Systematically gathered empirical data regarding the effects of therapist-patient sexual contact have only relatively recently become available. Traditionally, these relationships have been assumed to be harmful to patients (Marmor, 1972) but some writers have argued that such contact may be beneficial (e.g. McCartney, 1966). There is no evidence to suggest that sexual intercourse between a therapist and a patient is any more harmful than other forms of sexualized behaviour, such as provocative statements or fondling (Keith-Spiegel and Koocher, 1985). Thus, all forms of behaviour with sexual intent must be considered.

A review of every available case (34 in all) in the literature of therapist-patient sexual contact, some reported by therapists, carried out by Taylor and Wagner (1976) showed that the majority had negative or mixed effects on the patient, but 21% reportedly had positive effects<sup>1</sup>. However, this conclusion must be interpreted in the light of the empirical finding (Holroyd and Bouhoutsos, 1985) that psychologists who reported that

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<sup>1</sup> The effects of sexual contact upon the patient were established by Taylor and Wagner (1976) by rating "material presented in the case history, or by the patient's rating of the involvement" (p 594).

no harm occurred to patients as a result of sexual encounters with their therapists are twice as likely themselves to have had sexual contact with a patient as psychologists generally. Further, psychologists who have been sexually intimate with patients are less likely to report adverse effects of sexual intimacy, either for patients or for therapy (Holroyd and Bouhoutsos, 1985).

In a survey of psychologists who had treated patients who had been sexually intimate with a previous therapist, Pope and Vetter (1991) found that harm had occurred in 90% of cases overall. Butler and Zelen (1977) conclude on the basis of interviews with therapists who had had sexual contact with their patients, that "it was not a therapeutic experience for either patient or therapist" (p145). A similar conclusion was reached by Chesler (1972) who interviewed eleven women who had experienced sexual contact with their psychotherapist: "none of them was helped by their seductive therapists" (p144).

Feldman-Summers and Jones (1984) compared women who had had sexual contact with therapists, women who had had sexual contact with other health care practitioners and women who had not had sexual contact with a professional. The first group had a greater mistrust of and anger towards men and therapists, and a greater number of psychological and psychosomatic symptoms than the third group. The first two groups did not differ in terms of the psychological impact of the sexual contacts. The greater the reported prior sexual victimisation (e.g. childhood sexual abuse or adulthood sexual coercion), the greater the impact of sexual contact with the professional. Mistrust of and anger towards men in general were greater when the abusive professional was married than when he

was single. Finally, patients who reported the greatest number of psychological and somatic symptoms before treatment reported more symptoms after treatment with a professional with whom they had sexual contact, than those with fewer symptoms.

The effects of sexual contact which begins after termination of therapy have been little investigated, but there is some research evidence to suggest that this, too, is harmful to the patient. In Pope and Vetter's (1991) survey of psychologists, it was reported that harm occurred in 80% of the cases in which therapists engaged in sex with a patient after termination of therapy. Respondents were asked how many of the patients they had treated who had been sexually intimate with a former therapist, had "suffered harm as a result". This finding is supported by that of Grunebaum (1986) who interviewed patients whose sexual contact with their psychotherapist began after termination, and had been experienced as harmful. Brown (1988) suggests that the women she interviewed whose therapists had waited until after termination to become sexually involved with them, experienced similar levels and types of harm to those patients whose therapists had sexual contact with them during therapy.

As a result of their work with patients who had sexual contact with their therapists, and of growing anecdotal reports in the literature (e.g. Schoener, Milgrom and Gonsoriek, 1984) of the damaging effects of therapist-patient sexual contact, Pope and Bouhoutsos (1986) have developed the concept of the "Therapist-patient Sex Syndrome" which includes ambivalence (Schoener et al, 1984), guilt (Schoener et al, 1984), feelings of isolation and emptiness (Vinson, 1984, cited in Pope and Bouhoutsos, 1986), cognitive dysfunction (Vinson, 1984, cited in Pope and Bouhoutsos, 1986), identity/boundary

disturbance, and inability to trust (Schoener et al, 1984; Voth, 1972), sexual confusion, lability of mood, and suppressed rage (Schoener et al, 1984) and increased suicidal risk (D'Addario, 1977, cited in Pope and Bouhoutsos, 1986; Pope and Vetter, 1991). Patients' symptoms are increased (D'Addario, 1977, cited in Pope and Bouhoutsos, 1986; Voth, 1972) and hospitalization is frequently necessary (Pope and Vetter, 1991; Voth, 1972). Disturbances in patients' interpersonal relationships may also develop (Bouhoutsos et al, 1983; Forer and Greenberg, 1983; Voth, 1972).

There is a suggestion that sexual contact with health professionals, and thus possibly psychotherapists, may result in Post Traumatic Stress Disorder (Frederick, 1986), which shares many of the characteristics described by Therapist-patient Sex Syndrome (Pope and Bouhoutsos, 1986).

#### **1.16. TREATING PATIENTS WHO HAVE ENGAGED IN SEXUAL CONTACT WITH THEIR THERAPISTS**

Perhaps the most remarkable aspect of the research evidence on the treatment of patients who have had sexual contact with their therapists is that therapists who have themselves had sexual contact with their patients are more likely to be involved in treating patients who have been sexually involved with other therapists than those therapists who have not had sexual contact with their patients (Holroyd and Bouhoutsos, 1985). There are many possible explanations for this finding. One is that therapists who are interested in sexual contact with patients actively seek out therapeutic contact with vulnerable patients generally, including those who had sexual contact with a previous therapist. In

practice, however, many of these patients' histories of sexual contact with a previous therapist may be unknown at the point of assessment and there may be other reasons why the treating therapist is more likely to become sexually involved with these patients. For example, such patients may behave seductively in therapy because of their previous sexualized experience of therapy, or because of borderline personality disorder (Gutheil, 1989). A therapist inexperienced in treating such patients, or unfamiliar with the issues surrounding sexual feelings in therapy, may respond inappropriately to such behaviour on the part of the patient by becoming sexually involved with him/her.

North American research suggests that about half of all therapists will encounter in their practice a patient who has been sexually involved with a former therapist (Sonne and Pope, 1991). Thus, an issue which may initially seem of little relevance to the majority of clinicians is actually likely to become part of clinical practice for many of them.

Treating clinicians should be aware of the effect of their own values on therapy, as well as some common reactions in this situation. The most important consideration is the introduction of appropriate boundaries in this therapy (Schoener and Milgrom, 1987). It has been proposed that no assumptions should be made about the nature of the sexual contact which occurred between the patient and the ex-therapist, or how it affected the patient (Schoener and Milgrom, 1987). Instead, careful assessment of the nature of the relationship, residual issues for resolution and the patient's other difficulties, are essential.

The second therapist is likely at some point to find him/herself in the position of serving as an object of rage, neediness and ambivalence. There are a number of common pitfalls which a treating therapist may encounter (Schoener, 1990). The therapist may fail to forewarn the client of the limits of confidentiality, may focus unduly upon the client filing a complaint, or upon the client's anger. The therapist may make inaccurate statements about his/her legal involvement and could inappropriately, but with good intention, bend the rules of therapy for the victimised patient. It is all too easy for the therapist to fall victim to his/her own countertransference, for example to blame the victim or to experience sexual reactions to him/her (Sonne and Pope, 1991).

#### **1.17. REHABILITATION FOR THERAPISTS WHO HAVE ENGAGED IN SEXUAL CONTACT WITH PATIENTS**

The issue of rehabilitation of those therapists who have been sexually involved with their patients is a controversial one. Schoener (1991a) argues that punishment and rehabilitation should not be mutually exclusive. Rehabilitation may be advocated on the basis that therapists who lose their licences (in the U.S.A.) or their membership of a professional organisation, chartered status, etc. in Britain, may practice under another title without being subject to a professional code of conduct.

There is no empirically validated rehabilitation method for therapists who have engaged in sexual contact with their patients (Schoener, 1991a), and it may not therefore be possible to make accurate long term predictions about the likelihood of the therapist becoming sexually involved with other patients (Pope, 1991a). Those programmes

which have been set up in the U.S.A. have generally failed to employ an adequate assessment procedure (Schoener, 1991a). Moreover, there are a number of methodological difficulties inherent in the establishment of evidence about the success rates of rehabilitation initiatives, for example under-reporting of sexual contact between therapists and their patients. Rehabilitation programmes may fail for a number of reasons, including the dynamics of the therapists concerned, but most importantly, Sonne and Pope (1991) suggest, the methods of such programmes, psychotherapy and education/supervision, are not only unproven in this area, but are the very factors which have been positively associated with perpetration.

Pope (1991a) proposes that, in order to maximise the effectiveness of any rehabilitation programme, the professional competence of the treating psychologist should be established, the nature of the intervention should be clarified, and dual relationships and conflicts of interest should be avoided. Gonsoriek (1987) points out that therapists must exercise caution before agreeing to undertake this role, and consider issues such as his/her own personal and professional boundaries, and be prepared for intimidation and harassment as a result of the work.

Gonsoriek (1987) suggested that the first step is for an assessment to be made of the potential for rehabilitation. If this is appropriate, that is, if the violation is not too extreme and the therapist agrees to rehabilitation, a number of complex issues arise. The context of legal action, disciplinary hearings and media attention must be considered.

Treatment in this area bears some similarities to that undertaken with sex offenders, for example, the importance of "victim empathy" work (Beckett, 1994). It has been suggested that the first step is to confront any denial on the part of the therapist about his/her behaviour and its harmful effects (Gonsoriek, 1987). Subsequently the treating therapist must maintain a stance that the behaviour in question was unethical whilst developing and conveying an understanding of the stressful effects on the therapist of the events and of any legal action. It will be vital to create an understanding with the therapist of how his/her own difficulties may have created cognitive distortions in therapeutic work.

When making judgments about the question of further sexual contact with patients by the therapists in question, the "offending" therapist should be independently evaluated, it should be ensured that complete information about him/her has been gathered, that s/he has appropriately worked through issues related to the victim and the consequences of the sexual intimacy, and that the likelihood of reoffending is considered (Pope, 1991a).

Pope (1990a) found a substantial recidivism rate among those therapists who had engaged in sexual contact with one patient, about 80%, though this was without rehabilitation. Thus, Sonne and Pope (1991) argue on the basis of the experience of professional licensing boards that the prospects for the rehabilitation of therapists who have been sexually involved with patients are minimal.

In view of these findings, the appropriateness of allowing any such therapist to resume working with patients has been questioned (Pope, 1991a), because of the exposure of

patients to substantial risk, perhaps without their knowledge. Further, allowing therapists who have engaged in sexual contact with patients to continue to practice may well be inconsistent with the public trust placed in psychology and other similar professions (Pope, 1991b). Since there is a wide variety of non clinical activities such as research and management open to mental health professionals, it could be argued that in the absence of an empirically validated rehabilitation approach, those therapists who transgress the sexual boundary in therapy might be most appropriately redeployed in non clinical activities. There do not, however, appear to be any clear guidelines or policy available from professional bodies in respect of rehabilitative programmes or redeployment of their members who have engaged in sexual contact with their patients.

#### **1.18. PREVENTION OF THERAPIST-PATIENT SEXUAL CONTACT**

Very little has been written about the prevention of sexual contact between therapists and their patients. It has been suggested that psychoeducative and therapeutic approaches could be an appropriate means of achieving this aim where a therapist is identified as "at risk" (Pope, 1987) but Schoener (1991c) argues for the use of administrative safeguards, hiring practices, supervision, case consultation, dealing with sexual feelings in therapy and organisational consultation, as well as looking at sexual intimacy in clinical supervision, all as means of prevention.

Pope (1987) describes a fictional case involving the treatment of a therapist "at risk" of sexual contact with his patient. He raises difficulties which may be encountered in contracting in such cases, and outlines the components of treatment, which include

acceptance on the part of the therapist that inappropriate actions occurred, education/bibliotherapy, and cognitive-behavioural strategies. In particular, fantasies of sexual contact with the patient are addressed. Celenza (1995) suggests that discussion of countertransference material should be a central component of support for such vulnerable therapists. However, few such therapists are likely to put themselves forward for treatment, and the majority of preventative efforts are therefore perhaps most appropriately concentrated in other areas.

There is a strong case for the inclusion of the topic in clinical training programmes, which in general largely appear to neglect therapist-patient sexual attraction and contact. Rodolfa et al (1994) found that 40% of their respondents had never received any education during their training about sexual attraction in therapy. Perhaps, as Rutter (1989) suggests, merely supporting trainees and practitioners in recognising that psychotherapy both invites and forbids the expression of sexuality may be helpful.

The evaluation of preventative initiatives is a complex issue and there appear to be no reports in the literature to describe the outcome or effects of prevention in this area.

Gottlieb (1993) proposes a model aimed to assist therapists in avoiding dual relationships in psychotherapy, as well as other professional relationships in which they engage. The model assumes that at times, dual relationships cannot be avoided and thus require appropriate management, and that not all dual relationships are inherently exploitative, that is, they can sometimes be low risk and beneficial. The model attempts to view the issue of dual relationships from the consumer's perspective, rather than that

of the professional. The aim is to allow dual relationships in specific circumstances where appropriate, in the light of careful consideration.

The model is based on three dimensions shown in Table 1.3, power (which can vary depending on the type of relationship which the professional has with the consumer), duration of the relationship (which is seen as an aspect of power since it is assumed that power increases with time), and clarity of termination (that is, whether the professional and the consumer will have further professional contact), which are viewed as "basic and critical to the decision-making process" (Gottlieb, 1993).

**Table 1.3. Dimensions for ethical decision making (Gottlieb, 1993)**

<b>POWER</b>		
<b>Low</b>	<b>Mid-range</b>	<b>High</b>
Little or no personal relationship OR Persons consider each other peers	Clear power differential present but relationship is circumscribed	Clear power differential with profound personal influence possible
<b>DURATION</b>		
<b>Brief</b>	<b>Intermediate</b>	<b>Long</b>
Single or few contacts over short period of time	Regular contact over a limited period of time	Continuous or episodic contact over a long period of time
<b>TERMINATION</b>		
<b>Specific</b>	<b>Uncertain</b>	<b>Indefinite</b>
Relationship is limited by time externally imposed or by prior agreement of parties who are unlikely to see each other again	Professional function is completed but further contact is not ruled out	No agreement regarding when or if termination is to take place

When a relationship with a patient is being considered in addition to the therapeutic relationship, either during therapy or after termination, the model can be used to assess the current relationship. If the therapeutic relationship is assessed from the consumer's (or most conservative) perspective to involve low power, specific termination and to have been of brief duration, or if the therapeutic relationship falls at mid-range on the dimensions, the contemplated relationship should be considered in relation to the three dimensions. In the case of current relationships which fall at mid-level, some types of additional relationship may be appropriate. If both relationships involve high power, long duration and indefinite termination, the second relationship should be rejected. Where the first relationship falls to the left of Table 1.3, and the proposed relationship to the right, the new relationship may also be acceptable.

If the proposed relationship falls to the mid-range or to the left of the model, it may be appropriate and both relationships should then be considered for role incompatibility. In the case of low incompatibility the second relationship is likely to be permissible. In all cases a consultation should be obtained to consider the proposed relationship from the most conservative perspective possible. In addition, Gottlieb suggests, the situation, including relevant ethical issues, should then be discussed with the consumer, and if difficulties arise, the potential relationship should be rejected.

It seems that this model could serve as a training tool and be a useful aid to the decision-making process in relation to general aspects of the therapist-patient relationship, as well as therapist-patient sexual contact specifically.

Gonsoriek and Brown's (1989) notion of "type A" and "type B" therapy could be considered in terms of Gottlieb's (1993) model: "Type A" therapy is defined as long-term therapy in which transference is important and where the power difference between the therapist and the patient is substantial. "Type B" therapy is short-term, structured and transference is not emphasised. "Type A" therapy would probably be regarded in Gottlieb's terms as involving high power, long duration and, probably, of indefinite termination status. Secondary relationships, including sexual relationships, would therefore be regarded as inappropriate. It is likely that Gonsoriek and Brown's prohibition on sexual contact with severely disturbed patients would probably be supported in terms of Gottlieb's notion of high power, thus excluding sexual contact. Each approach includes its own safeguards: Gottlieb proposes the use of consultation as a safeguard, whereas Gonsoriek and Brown suggest a two year ban on any sexual contact between therapist and patient, regardless of the type of therapy. It is possible in Gottlieb's terms, that sexual contact between therapist and patient could be permissible where the therapist has offered, for example, a one or two session neuropsychological assessment but the situation would still require consideration in terms of the power differential, the viewpoint of the consumer and of a professional colleague, and of role incompatibility. In these terms, the risks might be considered too high and the proposed sexual relationship deemed inappropriate.

#### **1.19. UNDERSTANDING SEXUAL CONTACT IN THERAPY**

*"As clients, we are vulnerable because of needs that we cannot take care of ourselves. Professionals, because of their training and expertise, are*

*better equipped to meet these needs. The potential for boundary violations derives from the space that exists between the knowledgeable professional and the vulnerable client. The inequality between us, the power differential, creates the need for protection."*

(Peterson, 1992, p.34)

Peterson (1992) argues that boundary violations are characterised by four themes, a reversal of roles (the professional and the client switch places and the client becomes the caretaker), a secret (critical knowledge or behaviour is kept from the client), a double bind (the client is caught in a conflict of interest) and an indulgence of professional privilege.

By virtue of its long term nature and the emotional dependence of the patient on the therapist, the therapeutic relationship places both participants at considerable vulnerability for sexual intimacy (Plaut and Foster, 1986). It has been argued that an "intimacy continuum" may be identified (Plaut and Foster, 1986) where the therapeutic relationship moves towards erotic behaviour and thus exploitation, as non erotic touch, expression of caring, and emotional intimacy enter the therapist-patient interaction. In the opposite direction, however, social distance in the therapeutic relationship may serve the function of avoidance of intimacy.

There are a number of situations and circumstances which may be conducive to sexual intimacy in therapy. For example, therapists who see their patients in the evenings or at

weekends, in a building which is otherwise empty, perhaps with unusual furnishings (e.g. pillows on the floor) or in unusual settings such as coffee shops, are more likely to become sexually intimate with their clients (Brodsky, 1986). The jargon of therapists can also be conducive to sexual intimacy in the sense that the language of therapy can be seductive and can be used to encourage patients to acquiesce to sexual intimacy (Brodsky, 1986).

Most of the literature which addresses the question of therapist-patient sexual contact confines itself to that very question, viewing sexual contact as a specific form of inappropriate behaviour in therapy and thus implying that therapy without inappropriate or abusive practices can be benign or helpful to the patient. However, Masson (1988) calls into question the very heart of psychotherapy when he asks "is there ... something in the very nature of psychotherapy, that tends towards ... abuses ?" (p189). In the case of Dr John Rosen (see section 1.1), Masson suggests that Rosen, though his methods were widely known, was highly regarded by his peers and his methods imitated by them. Masson argues that:

*"many therapists, by the very nature of therapy, engage in activities that are not wholly unlike those of Dr John Rosen. Maybe it is in the very nature of therapy to encourage abuse. Maybe therapy is the very opposite of what it appears to be."*

(Masson, 1988, p.192)

He argues that the power of the therapist corrupts him/her and that abuse can be perpetrated in psychotherapy because therapists largely escape scrutiny of their practice. Moreover, they encourage secrecy in their patients. Although, he argues, cases of abuse and misconduct can be represented as exceptions, there is so much abuse in the name of therapy that "there must be something about psychotherapy itself that creates the conditions that make such abuse possible" (p228).

To support this view, Masson critically examines those therapists (such as Carl Rogers) who are commonly viewed as benevolent, and concludes that even in such cases, aspects of such therapists' practice are open to criticism and that all therapeutic approaches "distort" the patients' reality. He argues that every therapist is drawn into corruption because the profession is so corrupt, and that because therapy depends for its existence (and for its' practitioners' profit) on other peoples' misery, it will never be in the forefront of the struggle for social change because "it is not in the interest of the profession to create conditions that would lead to the dissolution of psychotherapy" (p297). Thus, Masson argues for the abandonment of the endeavour of psychotherapy: "psychotherapy cannot be reformed in its parts, because the activity, by its nature, is harmful" (p299).

Masson suggests that the reason that sexual misconduct with patients has generally been recognised and condemned is that it is easy to acknowledge and can then serve to cover up the many great abuses that go on in daily practice which have so readily been accepted among the professional communities, and have even been openly advocated by some. However, Masson does not discuss relatively recent attempts by the professional

community to suppress debate, research and publicity about therapist-patient sexual contact (Pope and Bouhoutsos, 1986).

For example, when Dahlberg tried to have his paper (1971) on therapist-patient sexual contact published, it was extremely difficult for him to do so, since it was viewed as too controversial by journal editors, and Forer (1984, cited in Pope and Bouhoutsos, 1986), whilst receiving permission to conduct a survey of the members of the Los Angeles County Psychological Association, was advised not only to avoid publicising his findings which showed a high rate of therapist-patient sexual contact, but was only permitted to disclose very restricted aspects of the results even at general meetings of the Association.

Masson's argument also fails to consider or to discuss the reports of many patients of positive outcomes from therapy, which is not consequently experienced by them as abusive (Garfield, 1978). Masson's central argument, however, remains relevant: in order fully to understand sexual contact in psychotherapy, therapy itself must be examined, not just one of its possible aspects.

There is clearly a combination of individual, organisational, social, and therapeutic factors which must be taken into account in developing an understanding of therapist-patient sexual contact.

### 1.19.1. Training Issues

Pope et al (1986) argue that educator-student sexual contact models later therapist-patient sexual involvement. For female respondents in their study, engaging in sexual contact as a student with educators was related to later sexual contact as professionals with patients: 23% as compared with 6% who had not had sexual contact with educators. For male respondents, the sample was too small to test the relationship. Thus, there is a suggestion from North American research that many therapists who have sexual relationships with their patients were themselves sexually involved with their own teachers, supervisors or therapists (Folman, 1991; Pope, 1989). No comparable research would appear to be available in Britain.

Pope also suggests (Pope and Bouhoutsos, 1986) that psychotherapists' training affords too little attention to the matter of sexual attraction to patients in general, and sexual countertransference, in particular. It may be negative transference and countertransference which is particularly neglected in clinical training (Celenza, 1995). In fact, Celenza suggests, the notion of countertransference love can be used inappropriately by therapists at an unconscious level, leading the therapist to assume that his/her feelings of love for the patient are in some way therapeutic. Tansey (1994) goes one step further, and argues that the psychoanalytic profession (and presumably other psychotherapy professions) is: "paralysed by phobic dread of countertransference that is sexual or desirous in nature". (Tansey, 1994, p.140)

He goes on to suggest that this dread paradoxically contributes to the occurrence of sexual contact between therapists and patients. In a paper which courageously discusses directly the author's own sexual attraction to his patients, Tansey (1994) suggests that it is only by such open discussion that psychotherapists can hope to prevent their feelings from becoming out of control, and prevent themselves from acting upon them.

A theoretical perspective on the matter of sexual contact between therapist and patient is offered by Streaan (1993) who argues that the therapist's "psychotherapy family", that is the personnel of training programmes, is central to the understanding of therapist-patient sexual contact. Streaan argues that the culture present in many psychotherapy training programmes in which traditional therapeutic barriers are crossed and candidates are infantilised, predisposes many therapists to "cross barriers with their own psychological sons and daughters" (p 31) by giving their patients what they themselves desired, a love affair with their own therapist. Alternatively the therapist may, like a child in a family, rebel against the family's values, displaying contempt by transgressing codes of conduct and having sexual contact with patients. Thus:

*"when boundaries are constantly crossed, when sadism and masochism are constantly being expressed, when strong wishes for narcissistic satisfaction are frequently being stimulated, the possibilities for sexual acting out by therapists are increased ... (and) therapists are not trained in any formal way not to act out sexually. It is something that is just assumed"*

(Streaan, 1993, p.32)

### 1.19.2. Power issues in therapy

Peterson (1992) argues that boundary violations are the result of:

*"the professional's attempts to equalise the power differential or discount the relationship. Such attempts alter the boundaries that protect the primacy of the client's needs"*

(Peterson, 1992, p.4)

Society ascribes professional privilege and advantage to a variety of professionals, including therapists, doctors, lawyers, pastors and teachers. The authority and status of the professionals are thereby increased and become societal norms. In addition, our society has, according to Peterson (1992), "secularised" these professions, thus denying the spiritual aspects of their role and thereby minimising the significance of the connection between professional and patient. The likelihood of boundary violations is increased when the professional fails to restrain him/herself sexually, becoming concerned primarily with his/her own needs rather than those of the patient who has come to the professional in need.

Peterson (1992) argues that the power differential between professionals and patients affects the ability of the latter to decide freely. Patients' self-determination is limited because of professional power and ability, often, to shape patients' destiny. This leaves patients vulnerable to the influence of professionals. The way in which boundaries operate is to protect the space between professional and patient by controlling the power

differential in the relationship. Boundaries allow for a safe connection based on the needs of the patient rather than the professional, in that they produce the consistency and predictability in behaviour that lowers the risk to patients. It is essential that the professional acknowledges and uses appropriately, his/her power (Peterson, 1992).

However, many professionals attempt to deny their authority or own their power and this struggle with power is the primary psychological gateway through which boundary violations are created, argues Peterson. Without the direction or leadership of the professional, the unreality of the client's expectations is not moderated. Consequently the client may fill this void with his/her own agenda, thus paving the way for inappropriate behaviour, as a direct result of the refusal by the professional to accept the authority which is inherent in the role. If we eschew our authority as professionals, we falsely position ourselves and our clients as equal, thus no one is in charge or responsible.

### **1.19.3. Gender issues in the therapeutic relationship**

Whilst research findings do not support the position that therapist-patient sexual contact is exclusively a problem of male therapists and female patients (see Section 1.8.6), there are nevertheless gender issues which may be relevant. Such issues have usually been considered in the literature in relation to male therapists and female patients, but other gender combinations do occur, and require explanation. Some writers have begun to address same sex therapist-patient sexual contact, and female therapist-male patient pairings, but further research and theoretical attention are necessary.

Brooks (1990) argues that those male therapists who have sexual contact with their female patients may be overattached to traditional male gender roles. Thus, rather than viewing such therapists as aberrant, this perspective would regard them as an "unacceptable endpoint(s) on a psychological continuum, upon which all male psychologists have a place" (p345). In view of male socialisation to inhibit emotional expression, Brooks argues, men might be more vulnerable to have difficulty in managing feelings arising as a result of the transference, and thus may potentially be more likely to mishandle the power and control imbalance in therapy.

Rutter (1989) extends this argument, suggesting that psychological wounds from early childhood might contribute to inappropriate sexual contact with patients. Such wounds, suggests Rutter, derive from the loss of intimacy between father and son, as a result of which the male child fills the void with cultural myths about maleness and male sexuality, which includes the view that men should act on their sexual tensions and that women will always be available as sources of physical, emotional and sexual intimacy.

Additionally, the adult male may harbour anger at the lost intimacy between him and his mother, or because she made him feel powerless. What Rutter terms "merged" mothers may predispose their sons to believe that there is no boundary between their feelings, those of their sons, and those of other people. Conversely "depriving" mothers who require their sons to take care of them, yet simultaneously remain distant, can raise men who need to retaliate against women who are vulnerable.

Few attempts have been made in the literature to understand the female therapist who becomes sexually involved with a male patient, or even sexual contact between the same sex therapist and patient. Recent research suggests that more female therapists appear to be engaging in sexual contact with their patients (see Section 1.8.6). Stienstra (1988) argues that many of the issues which pertain to male offenders are also relevant in a consideration of female perpetrators. For example, women are no less subject to sexism than men, and are also in a position of power vis-à-vis patients (of both genders) in the therapeutic setting. Women therapists may be equally vulnerable on an emotional level to distress or personality difficulties which may predispose them to transgress the sexual boundary in therapy.

Marmor (1976) argues that there are strong social and psychological disincentives to women to take the initiative sexually, and that it is ego-syntonic for women to reject men's sexual advances. However, argues Marmor, the incest taboo in respect of mothers and sons is more powerful than that between fathers and daughters: thus in the symbolism of the therapeutic relationship, the barriers against sexual acting out between the female therapist and the male patient are significant. Such an argument fails to consider female therapist-female patient sexual contact, and no discussion is available in the literature of male therapist-male patient pairings.

In an attempt to begin to understand the phenomenon of female therapist-female patient sexual relationships, Stienstra (1988) notes that the age difference found between male therapist and the female patients with whom they become sexually involved, tends to be absent in female therapist-female patient pairings. Female therapists are more likely,

suggests Stienstra, to terminate therapy before commencing a sexual relationship with a patient, often anticipating that the relationship will be long-term.

Benowitz (1994) suggests that those patients explore their sexual orientation, particularly the possibility of bisexuality or lesbianism, and discuss this openly in therapy may be at risk in relation to those therapists who are prone to becoming sexually involved with their patients. Whilst this argument was developed in relation to female therapist-female patient pairings, it may also apply to sexual contact between male therapists and male patients. She further suggests that although a female therapist may have a primary heterosexual orientation, she may still engage in sexual contact with female patients, indeed that some such female therapists have their first same-sex encounter with a patient.

Benowitz (1994) also suggests that those female therapists who experience discomfort with their homosexual feelings may be at high risk of sexual inappropriateness with their female patients, or even that heterosexism may result in some therapists mislabelling nurturing feelings and behaviour in sexual terms. Perhaps this is also true for male therapists who become sexually involved with their male patients. It would appear that the onset of female therapist-female patient sexual contact may occur at an earlier stage in therapy than heterosexual contact and that there is more socialisation in such pairings (Benowitz, 1994). However, Stienstra (1988) argues the opposite and clearly further research is required in relation to the topic of homosexual sexual contact between patients and their therapists, and to consider the particular issue of onset of sexual contact.

It has been suggested (Gabbard, 1994) that the female professional who acts out sexually with her patients frequently believes that love is curative, and (unconsciously) that she can provide to the patient the nurturance which s/he failed to receive from his/her mother. Thus, an over identification with the patient occurs. However, the extent to which this is also true of male therapists who have sexual contact with their patients, and whether there is any significant difference in this respect is not clear. Data reported by Benowitz (1994) suggest that male and female therapists who report sexual contact with patients are very similar in their belief that sexual contact is less harmful and more beneficial to the patient, by comparison with therapists who do not become sexually involved with their patients.

A gender perspective is therefore an important one in developing an understanding of the processes of therapist-patient sexual contact. Such a gender perspective should not focus exclusively upon the explanation of male therapist-female patient sexual contact, but needs to contribute to an understanding of the reasons for sexual contact between same sex therapists and patients and between female therapists and their male patients. Little research has, however, been undertaken in this area, and the current understanding of gender issues is, at best, imperfect. Perhaps the best that can be said at present is that gender is likely to be an issue, but that the way in which it operates is not fully understood.

#### **1.19.4. Supervision issues**

The notion that sexual contact with patients may occur as a failure of supervision or as a consequence of lack of supervision has some face validity. Such an argument would be based on the function of supervision as an opportunity to explore emotional issues in the therapeutic relationship, in particular countertransference reactions which, if neglected may lead to the sexualisation of the therapeutic relationship. However no research study has considered this question.

#### **1.19.5. The persecutory therapist**

There is a plethora of mechanisms, not merely that of sexual contact with a patient, by means of which therapists can be experienced as persecutory. However, it is possible that some patients who have sexual contact with their therapists may not experience the therapist as persecutory but may, at least initially, view the sexual contact in positive terms

Intrusion on the part of the therapist may occur by means of the kind of questioning techniques employed. Derogation of the patient may result from confronting the patient or attempting to provide insight. Invalidation of experience can arise when there is a suggestion of alternative or covert meanings in the patient's discourse. Therapists may be "opaque" by denying their personal involvement in the therapy encounter. Therapy may become an "untenable situation", where the patient is unable to establish how to behave in sessions, and finally, the "persecutory spiral" may develop, an escalating

destructive situation in which both participants in psychotherapy come to feel increasingly persecuted, perhaps as a consequence of rigidity, authoritarianism or supposed omniscience on the part of the therapist about the theory and technique of psychotherapy (Meares and Hobson, 1977).

The therapist who has sexual contact with patients may have erred in several of these domains, in particular, intrusion, derogation, invalidation of experience and the untenable situation. The opaque therapist, in his/her anxiety to maintain neutrality, might fail to take account of natural feelings of sexual attraction towards the patient and thus, paradoxically, be disposed to act upon them. Many of these persecutory processes may also be present where sexual contact occurs, in those therapists for whom sadistic and/or power motives are present.

#### **1.19.6. Why do most therapists refrain from sexual contact with their patients?**

Pope et al (1986) asked their survey respondents for their reasons for refraining from sexual contact with patients. The reasons were usually related to ethics, values and professionalism, and to the belief that such contact would be countertherapeutic. Other motives, however, touched on issues such as therapists' existing relationships, fear of damage to oneself as a therapist, fears concerning one's reputation, or of censure or retaliation on the patient's part. That is, there are some therapists who refrain from sexual contact with their patients not for ethical reasons, but because of self-interest, and who would therefore possibly sexually abuse their patients if it were certain that there would be no negative consequences.

### **1.19.7. Why do some therapists engage in sexual contact with their patients?**

The responses given in surveys by those who state that sexual contact between therapists and their patients can be beneficial, may assist the development of an understanding of the phenomenon. Herman et al (1987) reported that 2% of their psychiatrist respondents believed that sexual contact with a patient can enhance self-esteem, provide a corrective emotional experience, treat a grief reaction, or change a patient's sexual orientation. Slightly more, 4.5%, believed that it could be useful in treating a sexual difficulty, and 4% believed that it could be appropriate if the patient and therapist were in love. Gechtman (1989) reports that 10% of social worker respondents believed that sex with a therapist may be beneficial to the patient. Some surveys report respondents' rationales for and evaluations of, their own sexual involvement with patients, for example, Gartrell et al (1986) found that most psychiatrists in their survey who reported sexual contact with their patients thought that the experience of therapist-patient sex by the patient was positive. Pope and Bajt (1988) found that in 9% of such cases, psychologists argued that they had engaged in sexual relations with a patient for the treatment and welfare of that patient.

Of Butler and Zelen's (1977) 20 therapists, both psychologists and psychiatrists, who had had sexual contact with their patients and who volunteered to be interviewed, 90% reported that when the sexual contact occurred they were feeling vulnerable, needy and/or lonely as a result of relationship difficulties. Some saw themselves as domineering and controlling (15%) but most (60%) saw themselves as in a paternal relationship with the passive and submissive patient. 45% admitted to rationalising in

order to permit otherwise unacceptable behaviour during therapy. Most experienced conflicts, fears and guilt.

Celenza (1991) suggests that it is overly simplistic to assume that those therapists who become sexually involved with their patients do so intentionally, and that such contact is frequently motivated by unconscious factors and determined by a variety of factors. Clearly there is a substantial proportion of cases where the therapist is suffering from a psychiatric or personality disorder, often showing no signs of remorse (Schoener, Milgrom, Gonsoriek, Luepeker and Conroe, 1989), but in many cases no such difficulties are apparent. Frequently, Celenza (1991) argues, these therapists are aware that their actions are unethical, but are beset by powerful feelings which they cannot ignore, feelings which may be related to the therapist's personal conflicts, or to a wish to avoid negative aspects of the therapeutic relationship in order to make the transference "easier for both parties to bear" (Celenza, 1991, p.508). In addition, many of the reasons for engaging in sexual contact described above, suggest the need for enhanced education in respect of the harmful effects of such contact upon the patients.

#### **1.19.8. The relationship between sexual attraction towards, and sexual contact with, patients**

Freud's prohibition on kissing, other preliminaries to, and actual sexual contact with patients has, Pope and Bouhoutsos (1986) argue, had the unintended consequence of therapists becoming suspicious of any warm feelings towards their patients, thus

intensifying anxiety about therapist-patient sex and inhibiting full recognition of the problem and the development of attempts to address it.

Sexual attraction towards patients is very common among health professionals (see Section 1.7), yet there is considerable anxiety amongst psychologists about their own sexual attraction to patients (Pope et al, 1986), and a substantial minority (49.4%) believe it to be unethical (Pope et al, 1987). This, together with the historical reluctance of professionals to acknowledge and discuss the issue, has contributed to the difficulty in confronting the reality of therapist-patient sexual contact (Pope, 1990a), especially in the U.K.

Professional training courses may thus be reluctant to address sexual feelings for patients, and may thereby miss the opportunity to prevent therapist-patient sexual contact from developing (Pope, 1989). It is arguable that by enabling trainees to understand that they are likely to be sexually attracted to their patients, and vice versa, training programmes could begin to "normalise" the phenomenon and so prevent some therapists from acting upon what they see as an unusual situation.

#### **1.19.9. Psychological models of relevance**

It has been suggested that the pattern observed in therapists who engage in sexual contact with their patients is similar in many ways to that of identified sex offenders (Burgess and Hartman, 1986) in relation to methods of controlling victims, manners of self-defence when confronted, and the pursuit of further exploitation. It may be argued,

however, that few differences exist between sexual offenders and those who do not engage in such behaviour, for example, many men have the attitudes and beliefs necessary to behave in a sexually aggressive manner towards women (Scully and Marolla, 1985) and sexual aggression is common in romantic relationships. Indeed, Malamuth, Haber and Feshback (1980) report that over half of their sample were willing to rape if they were certain of not being discovered.

Similarly, it may be argued that there are few differences between those therapists who have sexual contact with their patients, and those who do not do so. Furthermore, many cases of sexual contact between therapists and their patients are not characterised by sexual aggression and conceptualising such contact in relation to sexual offending may not always be relevant. In this respect, a consideration of one influential psychological model of sexual offending which does not assume aggression towards the victim (Finkelhor, 1984) may shed some light on the problem. In addition in this section, a general psychological theory of human motivation, reversal theory (Apter, 1989), is considered in terms of what it can offer to the development of an understanding of sexual contact in therapy.

#### **Finkelhor's Four Precondition Model**

Finkelhor's (1984) four precondition model was originally developed in relation to child sexual abuse, but it does draw upon some research evidence relating to non child abusing sex offenders. It has the advantage of integrating social and psychological notions about the causes of sexual abuse in children. Finkelhor argues that potential

offenders first have to be motivated to abuse a child sexually. They must then overcome internal inhibitions to offending, external constraints on behaviour and the child's resistance to sexual abuse.

To examine the first precondition, that of motivation, there are three components described by Finkelhor. First, the notion of "emotional congruence" incorporates the idea that sexual activity with children serves some emotional need, perhaps to do with lack of dominance in other situations, low self esteem, arrested emotional development, or the behaviour being designed to master traumatic memories of the self as a victim. This is supported by Streaun's (1993) view that sexually abusive therapists usually feel like "deprived children with depriving adults" and thus their patients, who seemed to the therapists to be similar to children, were the least threatening sexual partners available. A second component of the motivation to offend is that of sexual arousal to children. The third element which Finkelhor includes in this first precondition is that of "blockage". This refers to those variables which are obstacles to developing socially acceptable sexual relationships.

Finkelhor's second precondition, that of overcoming internal inhibitions, partially addresses the fact that some people who offend who appear not to have blockages to forming unacceptable relationships. It is unlikely that there is a simple hydraulic relationship between one sexual outlet and another, and it is also important to distinguish between those factors which block the development of relationships and those which create the conditions in which offences are more likely.

Even when one is oriented towards a particular type of sexual activity, there are often internal barriers to progressing towards acting on that interest. For example, fantasies about coercive sex are common among "normal" men (McLeod Petty and Dawson, 1989) but the majority do not act upon these. Likewise, therapists may fantasise about sexual contact with their patients, or other forms of unethical behaviour (Pope et al, 1986), and it is certainly true that many therapists report that they are frequently sexually attracted to patients, but something must inhibit the majority from acting upon these fantasies.

Finkelhor proposes that the concept of disinhibition is helpful in understanding the circumstances under which an individual is likely to transgress. However, there are people who never develop internal moral constraints about sexual behaviour, who might be described as sexually uninhibited rather than disinhibited, and there are others who develop unusual constraints which nevertheless permit sexual offences (Thomas-Peter, 1989).

The third and fourth preconditions address factors outside the individual. Finkelhor's third precondition, in focusing upon environmental factors, suggests that the individual must overcome external inhibitors to offending, such as adult supervision of children and the absence of physical opportunity for the abuser and the child to be alone together.

Finally, the fourth precondition is that of overcoming the resistance of the child. This means more than the child simply saying "no": rather, the model emphasises children who are recognised by abusers as "good targets" because of factors such as emotional

insecurity, neediness or lack of support. Some children's ability to avoid abuse may be reduced because they lack information or because they have a special, trusting relationship with the offender. Finkelhor also recognises that in some instances, the contribution of the child is irrelevant, for example where force is used.

This model has much to offer in understanding sexual contact with patients in psychotherapy. In terms of the first precondition, that of motivation, research suggests that many psychotherapists who sexually abuse patients report that they feel dominant and controlling, or were experiencing marital problems or personal difficulties at the time of the sexual contact (Butler and Zelen, 1977). Thus, sexual contact with patients can serve an emotional need for the therapist. Although Finkelhor had to explain why adults become sexually aroused to children, in a consideration of sexual contact between therapists and their *adult* patients (which forms the vast majority of cases) it is necessary only to explain why an individual should become sexually aroused to one in a less powerful position than him or her. Dahlberg (1970) suggests that many therapists may be shy individuals who have difficulty in forming sexual relationships and may therefore seek to exploit their professional position in order to do so with their patients.

Finkelhor's second precondition, that of overcoming internal inhibitions relates in part to the means by which the therapist may reinterpret internalised aspects of ethical codes in order to engage in sexual contact with patients. This is not difficult for therapists belonging to professional organisations whose ethical codes do not explicitly forbid sexual contact with patients, or who have received no ethical training in relation to sexual abuse in therapy. It is also possible that stressors might contribute to

disinhibition. For example, many therapists who become sexually involved with their patients are subject to personal and possibly occupational stress in their lives (Rodolfa et al, 1994). A number of rationalisations may be used by therapists to justify their actions, for example the notion that patients may actually benefit from sexual contact, as a "corrective emotional experience" (Herman et al, 1987).

To consider the third precondition, it is known that in order to overcome external constraints to sexual contact with patients many therapists will see patients at unusual times, or in unusual settings (Brodsky, 1986). Isolated practice of therapy may also occur in the absence of supervision, something which is all too common, at least in clinical psychology. Even under the most favourable conditions, psychotherapy is a relatively physically isolated pursuit which provides ample opportunity for abuse of the patient.

Finally, it may not be too difficult to overcome the patient's resistance if the patient has little initial resistance because of his/her presenting problems, or is a "good target" because of emotional damage in the past (Pope and Vetter, 1991), or if the therapist sets the conditions for therapy from the onset to facilitate sexual contact, for example by forbidding patients to discuss therapy experiences outside of sessions (McCartney, 1966). Certainly the therapist is a person whom the patient trusts and thus the patient may comply with requests made by the therapist which would be considered unacceptable from other individuals. Further, the therapist may use information gained from this special relationship to frame a proposal of sexual intimacy in such a way that the patient will agree.

### Reversal Theory

Reversal theory is primarily a theory of human motivation, but also encompasses issues of cognition, emotion and personality (Apter, 1989). It suggests that human beings frequently switch or **reverse** between two stable states on certain phenomenological dimensions. Reversal theory has identified a number of metamotivational states which display polarity; thus metamotivational states are paired with one another, representing alternative frames of mind or modes available to the individual with which to view his/her motives and behaviour.

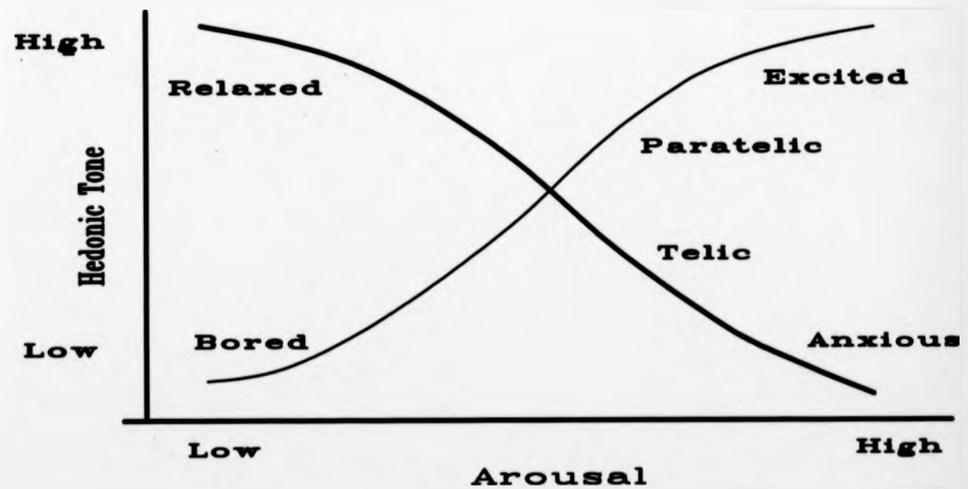
One of the phenomenological dimensions which reversal theory regards as particularly relevant is that of arousal. The experience of means and ends is also considered to be important. It is suggested that arousal encompasses two variables, intensity (high or low) and "hedonic tone" (pleasant or unpleasant). The theory holds that these two variables are related in a non linear way, that is, both high and low arousal can be both pleasant and unpleasant. The four motivational states to which this refers are anxiety (unpleasant high arousal), excitement (pleasant high arousal), relaxation (pleasant low arousal) and boredom (unpleasant low arousal).

Excitement and boredom are related to each other by being opposites as are anxiety and relaxation. Thus there are two diametrically opposed ways of experiencing arousal:

*"one in which arousal becomes increasingly pleasant as it increases, and one in which it becomes increasingly unpleasant as it increases"*

(Apter, 1989, p.16)

Thus there are what Apter terms two "modes", the arousal-avoidance and arousal-seeking modes, which, since they are opposite to each other, involve reversals when a switch occurs from one to the other. This is illustrated in figure 1.



**Figure 1: The relationship between arousal and hedonic tone for telic and paratelic states**

Reversal theory would suggest that an instantaneous switch can occur from one curve to another, that is, from one mode to another by way, as seen on the graph in figure 1, of a vertical switch upwards or downwards. So, for example reversal theory explains that people undertake dangerous sports because they aim to raise their arousal levels as high as possible. So, following a relatively short period of anxiety, a switch occurs, resulting in a relatively long period of excitement. Reversals may occur as a result of contingent events or particular conditions, because of frustration, or because of satiation in one mode. They are held to be involuntary, to occur after a period of time. So, for example, where an individual is in a state which is other-focused, sooner or later a reversal will occur and the person will begin to focus on him or herself.

Apter further suggests that there are two metamotivational modes relating to the primacy either of the means (or activity) or of the end (or goal), which may be termed, respectively, paratelic and telic modes. The rewards of the telic mode result from progress towards the goal as well as the attainment of the goal itself, whereas the pleasure of the paratelic mode derives primarily from the activity itself, its sensual gratification, the skill of the performance, and the sensations which accompany it. Telic mode is associated with the arousal-avoidance mode and the paratelic mode with the arousal-seeking mode (Apter, 1989). Apter suggests that the metamotivational system which exerts the greatest influence on behaviour is the telic-paratelic system.

Other metamotivational pairs are identified by reversal theory, and comprise the conformist/negativistic pair, the mastery/sympathy pair and the autocentric/allocentric pair. In the case of the conformist/negativistic pair, the conformist state is that in which

the individual wishes to conform to rules, and feels compliant, co-operative and agreeable. By contrast, the negativistic state is one in which people wish to break rules, often feeling rebellious, defiant and angry. Hedonic tone is relevant to this pair in respect of the extent to which the individual feels that he or she is breaking a rule (felt negativism) (Potocky and Murgatroyd, 1993).

To consider the mastery/sympathy pair, when people are in the mastery state they are interested in control and value strength, viewing the situation as competitive or as a struggle. In the sympathy state, by contrast, the focus is upon caring. Tenderness and sensitivity are valued and situations are viewed in terms of harmony or unification. This has some parallels with the allocentric/autocentric pair: when in the autocentric state, individuals are self-focused in interactions, but when in the allocentric state, they are concerned with the outcome of the interaction for other people. The person's level of satisfaction with the outcome of an interaction, then, is dependent upon which state they find themselves in (O'Connell and Apter, 1993).

Reversal theory suggests that the four pairs of states always co-exist and that at any one time a person is in a combination of states. For example, when in the allocentric and sympathy states, people are focused on the other, wishing themselves to lose and the other to gain. To gain in such a state would result in an unpleasant feeling of guilt, but to lose would result in the pleasant feeling of virtue.

Reversal theory suggests that those individuals for whom reversal is difficult will experience psychological problems. Murgatroyd (1993) suggests that sex offenders may have a need for high levels of paratelic satisfaction to be associated with mastery.

Thus, reversal theory may enable the generation of hypotheses through which the complex cognitive state of the therapist engaging in sexual contact with patients may be understood, both on a broad level and specifically at the time of the sexual contact. Further, it may provide an explanation of the mechanisms by which the sexually abusive therapist switches from one motivational state to another, thus enabling sexual contact to occur.

The behaviour of therapists who become sexually involved with their patients, and who have severe personality pathology may be explained in reversal theory terms in a similar way to sexual offenders with such pathology. For example, they may demonstrate paratelic meta-motivational state at times of sexual contact with patients, with aversive telic experience in day to day life (Thomas-Peter, 1989).

It is perhaps, however, the question of explaining the behaviour of those therapists who function within normal limits, which is most interesting from the perspective of reversal theory. It is reasonable to suppose that most therapists function, whilst conducting therapy at least, mainly in the sympathy and allocentric states. Thus, the therapist intends the patient to gain from the transaction. This will result in the therapist experiencing the pleasant feeling of virtue. Given that all four pairs of states are always present, it is also necessary to identify which states of the other two pairs the therapist would typically

function in whilst conducting therapy. It is likely that the telic and conformist modes would be most appropriate to the therapeutic situation, and that the combination of these four states would comprise appropriate therapeutic conduct.

Therefore, to consider the therapist's experience during an interaction with a patient which becomes sexualized, one would need to identify when and why reversals would occur. Reversals may occur as a contingency (perhaps following the discussion of sexual material in therapy, because of the therapist's experience of sexual attraction towards the patient, or because of the intimate nature of the therapeutic situation). They may happen as a result of frustration, perhaps in relation to difficulties occurring in the therapist's personal relationship or where the therapist feels that s/he is not successful in helping the patient, or, finally following satiation which may occur because of the dominance of one mode in the personality of the therapist.

Thus, in order to engage in sexual behaviour with a patient, a number of changes in the therapist's affective experience would be required. Reversals would need to occur so that the therapist would become more arousal-seeking, sensation-oriented and playful. This is represented by the paratelic mode, the system with the greatest influence on behaviour (Apter, 1989). It would probably also be necessary for a reversal to occur from the conformist to the negativistic state, at least in the sense that the latter involves rule-breaking behaviour. However, it could be argued that a therapist who engages in sexual contact with a patient could do so in the conformist state since it is the **experience** of acting against expectation which is important. Sexual intimacy could be experienced as acceptable, understandable, a mutual progression or therapeutic. As far as the

mastery/sympathy and allocentric/autocentric pairs are concerned, a number of possibilities present themselves. It could be argued that a therapist who has sexual contact with a patient is likely to be focused on control (mastery) and concern with self (autocentric) but one can imagine that such therapists might report feeling harmony and caring in relation to the patient (sympathy) and, perhaps, maintain that their sexual involvement was not incompatible with concern for the patient (allocentric). In all of the above scenarios, however, the therapist would not experience negative feelings about the sexual contact, until in a different state.

Presumably there may be occasions when such reversals do not occur when sexual activity takes place, and this may lead to a different outcome for the therapist in terms of affective reaction. For example, if the therapist remains in the allocentric and sympathy states when sexual contact occurs, s/he may feel unpleasant guilt because of having taken something for him/herself (sexual gratification) rather than focusing on the patient's needs.

### **Psychodynamic explanations**

In the same way that psychoanalytic approaches alone have been offered to explain sexual feelings in therapy, only psychodynamic explanations have specifically been put forward for understanding the therapist who has sexual contact with his/her patients.

Strean (1993) offers such a psychodynamic model which is based on his own treatment of a number of therapists who had sexual contact with their patients, some of whom are

described in detail in his book **"Therapists who have sex with their patients: Treatment and recovery"**. He proposes that therapists who engage in sexual contact with their patients are unable to receive love from anyone in their lives because of their own family backgrounds and their emotional distance from others. Thus, they seek emotional and sexual gratification from their patients as a result of their strong identification with, and narcissistic attraction towards, the love-starved patient. The "love" which such therapists give to their patients is the love which they themselves desire from significant others in their lives.

This explanation suggests that therapists engaging in sexual contact with patients "felt like deprived children with depriving adults in most interpersonal situations" (Strean, 1993, p.169) and thus the seemingly child-like patient presents little threat as a sexual partner.

Strean (1993) suggests that such therapists have unstable sexual identities and, for the male therapist who has sexual contact with female patients, the process enables him to achieve gratification by identification with the "female in himself". Perhaps not unrelated to this is a hostility toward the opposite sex, as well as a hostility towards the therapist's own profession and the practice of therapy. The extent to which this process also applies to female therapists who have sexual contact with patients is not discussed by Strean, and nor is the issue of same sex pairings.

Strean (1993) employs the concept of "acting out" to consider those emotions which the sexually abusive therapist is unable to manage: thus he identifies revenge and greed as

motivations for sexual acting out with patients. Thus, such therapists are seeking, according to Strean, revenge against their own therapist, and others for disappointments. They also tend to have short sexual liaisons with patients, thus abandoning them or otherwise treating them sadistically in the same way that they have been abandoned or treated sadistically themselves. Lengthy therapist-patient liaisons are not discussed or explicable in terms of this aspect of the model.

Strean's account fails to take into consideration a number of other factors. First, if one of the reasons for sexual contact with patients is that of seeking revenge against one's own therapist, what of those therapists, such as clinical psychologists in Britain, for whom personal therapy is not a requisite part of training? Although Strean's population of sexually abusive therapists had experienced personal therapy, this aspect of his explanation does not readily transfer to populations of therapists who have not. Whilst highlighting some important and salient issues which may be relevant in understanding the phenomenon of therapist-patient sex, Strean's explanation lacks internal cohesion and, like many psychodynamic theories, fails to take account of issues other than the intrapsychic, for example, gender issues.

Rutter's (1989) discussion of therapist-patient sexual contact may also be considered broadly psychodynamic in approach. He makes the important point that:

*"there is a tremendous potential for people to involve themselves in sexually exploitative sexual acts because of the confusion between sexual intercourse as act and sexual intercourse as symbol" (p 55)*

That is, Rutter argues, any relationship which moves an individual deeply can stimulate sexual fantasy, and sexual fantasy can be a way of expressing central nonsexual issues about our internal needs. He holds that in general men's' destructive sexual behaviour is the result of a search to "heal a wounded sense of self" and that male healers are no exception to this rule in that they too are often as much in need of healing as are their patients. In particular, it is Rutter's thesis that such men repress or ignore their innate feminine feelings, yet these reappear in men's' sexual fantasies. This process explains why fantasies of "forbidden" women have such special power. There are some parallels with Streaan's position that male therapists have an ambivalent relationship with the feminine aspects of their personalities, as well as women in general. However, like Streaan, Rutter fails to explain therapist-patient sexual contact other than that occurring between male therapists and female patients.

Rutter also provides a useful explanation of the processes which may occur in both parties when sexual contact is likely. He suggests that in therapy, a woman may:

*"lose her sense of boundaries because she is touched to the core...(and) the man's own fantasy life is likely to be stimulated by his involvement with a woman who has revealed her psychological core" (p 127)*

The man may then wish to cast aside his professional identity and participate instead as "the wounded one". Women, socialised to heal men's' wounds, may feel that they must comply because of the help they have received from the man. Thus there occurs a

"mutually dissolving quality of deep connection" which may be assisted by cultural messages which allow men to ignore boundaries against sexual intimacy.

Gabbard (1994) suggests a psychodynamic classification system to explain the psychopathology of therapists who become sexually involved with their patients. Most, he suggests, fall into four categories, lovesickness, psychotic disorders, predatory psychopathy and paraphilias.

Lovesickness includes the loss of judgment so that it becomes difficult to recognise the harm caused to the patient. There are a number of themes identified by Gabbard where lovesickness is an issue, including the unconscious re-enactment of incestuous longings, misperception of the patient's wish for maternal nurturance as a sexual overture, and interlocking enactments of rescue fantasies on the part of both the therapists and the patient. The patient may be seen as an idealised version of the self, there may be confusion of the therapist's needs with those of the patient, and the therapist may hold the fantasy that love is in itself curative. There may be a repression or disavowal of rage at the patient's persistent thwarting of therapeutic efforts, there may be anger at the organisation, institute or personal therapist, or the sexual contact may represent a manic defence against mourning and grief at termination. The therapist may fantasise that s/he is an exception to accepted ethical guidelines, the therapist may be insecure about his/her gender identity, or view the patient as a "transformational object", an agent of magical change. Female therapists may be prone to the social image of the need for a woman to "settle down the rowdy man" (Gabbard, 1994), and some therapists may

experience conflict in relation to their sexual orientation. In the case of masochistic surrender, the therapist allows him/herself to be controlled or intimidated by the patient.

Psychotic disorders, predatory psychopathy and paraphilia are, Gabbard suggests, less frequently-occurring problems in therapists who become sexually involved with their patients.

In sum, a number of psychodynamic explanations have been proposed to account for sexual contact between therapists and patients. The main themes include a focus on historical factors in both the therapist and the patient, but most notably the therapist, whose family background may render it difficult for him/her to receive love, and who thus seeks emotional and sexual gratification from patients. Hostility, the tendency to act out emotions which are difficult to manage, and to ignore feminine feelings are all suggested to be part of a "wounded sense of self" (Rutter, 1989). However, such theories are at present based on small samples of therapists treated or interviewed by a small number of writers, and further research is clearly required to test them out on larger samples. In addition, existing psychodynamic theories largely fail to account for sexual contact between female therapists and their male patients, and same sex liaisons.

### **Summary**

Marmor (1976) offers a useful framework within which one may consider some of the above variables. He suggests that contributory factors consist mainly of the situational and the characterological. In terms of the situational, the most constant element is the

intimate, isolated and highly emotionally charged nature of the therapeutic relationship itself. Therapists may feel frustrated at their inability to help the patient with conventional therapeutic methods, leading to the "illusion of a magically curative copulation" (Searles, 1959, p.431). In this sense there are few external constraints to overcome in Finkelhor's terms.

In terms of characterological factors, it is dangerous when a therapist begins to respond to the patient as if s/he were a parent with an emotionally deprived child. Some male therapists may be hostile to women for a variety of reasons and may therefore need to exploit, humiliate or even reject them. Marmor (1976) also mentions personality disorders in this respect. Muse and Chase (1993) suggest that this dimension might be separated into intrapsychic (e.g. omnipotence and psychosexual difficulties) and circumstantial factors (e.g. personal crisis, grief or depression). Such issues would fulfil Finkelhor's first precondition, in terms of emotional congruence.

However, whilst there are a number of characterological factors which may have an influence in bringing about sexual contact between therapists and their patients, it is essential to bear in mind that, as may be observed in the case of child sexual abuse, not all children who are sexually abused go on to become abusers, and not all abusers have characterological defects (Fisher, 1994). In the same way, not all therapists who become sexually involved with their patients have had sexual contact with their educators, and not all are suffering marital difficulties, for example. Whilst these variables may serve as part of the explanation, motivational issues are also important and it is here that reversal

theory makes a unique contribution to the understanding of sexual contact between therapists and their patients.

#### 1.20. SUMMARY

Sexual contact between therapists and their patients is an increasing area of concern in many countries. It is prohibited by the codes of conduct of the main therapy professions, because of its negative effects upon patients, though sexual contact between therapists and their discharged patients is permitted under certain circumstances by some professional bodies. Sexual issues in therapy can be understood in terms of a number of theoretical frameworks, but psychoanalysis has provided the main explanatory attempts thus far. Whilst sexual attraction towards patients is very common amongst therapists, actual sexual contact occurs in only a minority of cases, though precise figures are difficult to establish because of methodological difficulties with the research to date.

It appears that therapists may offer a distorted picture of the nature of their sexual contact with patients, in order to make it appear more acceptable, for example by inaccurately suggesting that the contact was initiated by the patient and began after termination of therapy. Therapists who engage in sexual contact with their patients may exhibit some problematic personality variables and may be motivated by power, anger or vulnerability. The patients are likely to have a variety of vulnerabilities, such as borderline personality disorder, or a history of rape or childhood sexual abuse. The literature suggests that sexual contact with a therapist usually has an extremely negative effect upon the patient, and can result in suicide. Whilst treatment both for the therapist

and patient is important, there are many potential problems and pitfalls involved in undertaking this task, for example, lack of an empirically validated rehabilitative methodology in respect of therapists who have been sexually involved with their patients. There are similar problems with preventing therapist-patient sex, but training may be one solution.

A number of factors should be taken into consideration in attempting to understand the phenomenon of sexual contact between patient and therapist, including situational variables, abusive factors inherent in therapy itself, the lack of attention afforded to the topic in professional training courses, and lack of supervision. Gender may play a complex part in therapist-patient sexual contact. There are three main psychological models which are considered in terms of understanding sexual contact between therapist and patient. Finkelhor's (1984) model addresses both psychological and situational factors, whereas reversal theory (Apter, 1989) concentrates on motivational and emotional issues. The psychodynamic approaches of Streat (1993) and Rutter (1989) concentrate on historical and identity factors and consider the meaning of the sexualisation of the therapeutic relationship.



**CHAPTER TWO**

**RESEARCH AIMS AND  
QUESTIONNAIRE DESIGN**



The research had three main aims, to identify predictive variables in relation to sexual contact between clinical psychologists and their patients, to provide descriptive information about the prevalence and nature of sexual contacts between clinical psychologists and their patients, and to begin develop an understanding of the phenomenon of sexual contact between therapists and their patients. Lifetime prevalence was examined, that is, retrospective information was requested from respondents about their previous experiences.

This was the first national empirical survey of British professionals in respect of therapist-patient sexual contact (Sinclair, 1991). It was anticipated, therefore, that the present research would be a starting point, with future studies covering other professional and non-professional therapists in Britain. Since North American studies have demonstrated no difference between the therapy professions, such as psychology, psychiatry, and social work (Borys and Pope, 1989) in the rate of therapist-patient sexual contact, it was thought to be reasonable to suggest that the results from the present survey would indicate the approximate prevalence of sexual contact between professionals of other disciplines and their patients.

A principled mixture of qualitative and quantitative methods was used in that the questionnaire was designed so that some questions were open-ended where it was necessary to explore complex issues which had been afforded little consideration in previous research. This approach aimed to assist the development of an understanding of the meanings which inform the behaviour of respondents in certain areas (Gillett, 1995) such as the decision to refrain from sexual contact with patients. In this way, it was

anticipated that qualitative data would be material in the generation of theory which would be grounded in textual material (Henwood and Pidgeon, 1995). This approach fitted well with research which was not primarily aimed at testing a theory. Other questions were less complex and conformed to quantitative methodology.

As a means of addressing the aims, a five page questionnaire (Appendix 1) was developed and was informed by previous research in the U.S.A., in terms of the domains covered. Some of the questions related to variables which have been associated with sexual contact between therapists and their patients in North American research (cf. chapter one). Specifically, the therapist's age, gender, experience of personal therapy, use of physical contact with patients, and experience of sexual contact with educators during training were addressed.

Additional biographical information was requested in relation to respondents' marital status and sexual orientation. Professional information requested included total number of years of practice as a clinical psychologist, therapeutic orientation, and main area or specialty of clinical work. Respondents were also asked to specify their main work setting.

In an early study, Dahlberg (1970) found that those therapists who engaged in sexual intimacies with their patients were likely to be older than their colleagues, a finding replicated by Bouhoutsos et al (1983). Many surveys have found that male therapists are more likely to engage in sexual intimacies than female therapists (Gartrell et al, 1986; Pope et al, 1986). One study has found that those therapists who become sexually

intimate with their patients are more likely to have undergone personal psychotherapy or psychoanalysis (Gartrell et al, 1986).

There is a suggestion that differential use of physical contact with male and female patients is more common among those therapists who engage in sexual contact with patients (Holroyd and Brodsky, 1980). Finally there is some evidence to suggest that experience of sexual contact with an educator during training may predispose therapists to become sexually involved with patients (Pope et al, 1979).

The research also aimed to examine in a British sample variables which had not emerged from the North American research as significantly associated with sexual contact with patients, or which had not been considered in previous research efforts. Respondents were therefore asked to give their marital status and sexual orientation, as well as the length of time since they qualified. They were asked to state their therapeutic orientation and clinical specialty, and whether they had treated patients who had been sexually involved with previous therapists.

It was thought to be important to ask about therapists' experience of sexual attraction to patients, on the basis that this is an essentially normal process in therapy and that denial of attraction may dispose therapists to act it out (Pope and Bouhoutsos, 1986). Respondents were asked to specify why they had not felt such an attraction, as well as to specify why they had not engaged in sexual relations with a patient, in order to attempt to extract meaningful information in these areas.

It was decided to explore further Pope et al's (1979) suggestion of a relationship between sexual contact as a trainee with an educator and later sexual exploitation of patients. Therefore a number of questions in this area were asked, to address respondents' attitudes to the issue of educator-student/trainee sexual contact, to establish any sexual contact with educators which respondents had experienced as undergraduates and as postgraduates, to enquire about sexual contact between respondents who had experienced personal therapy and their therapists, and about respondents' experiences of sexual contact with their own students/trainees, if they were in such a training role.

The questionnaire included questions about respondents' direct patient contact, that is, the average number of hours per week of face to face contact, and the proportions of patients in long and short term therapy. Long term therapy was defined as more than 50 sessions and short term therapy as less than 20 sessions. It was decided to define long term therapy as more than 50 sessions rather than as more than, say, 20 sessions, so that the difference between short and long term therapy as defined in the questionnaire was an appreciable one. It was hypothesised that those respondents and patients in long term therapy may be most likely to experience intense transference and countertransference in their therapeutic relationships, which may increase the risk of sexual contact.

Respondents' use of physical contact with patients was requested by gender of the patient and by various categories of physical contact, that is, handshakes, arm patting, holding hands, touching arms or shoulders, hugging or "other" forms of physical contact.

Respondents' experience of and attitudes towards, sexual attraction to their patients were accessed by questions designed to gain information from those who had, and had not, experienced such attraction. Respondents were asked whether they had ever been sexually attracted to one of their patients and if not, to give reasons for this. Those who had experienced sexual attraction were asked to recall the last occasion when they had such feelings, and to give their current view of the attraction, as well as to state the effect, if any, they believed the attraction had on therapy.

A series of questions were asked about respondents' views about, and experience of, sexual contact with their own patients. Two broad questions were asked about whether respondents believed that patients could ever benefit from sexual contact with a therapist, and whether respondents themselves had experienced what they regarded as sexual contact with a patient. It was left to respondents to define sexual contact for themselves, so that nothing of possible importance was excluded. However, there are problems with this approach; see Section 1.8.1. The question was worded to encompass all sexual contact which respondents had ever experienced in their career, that is, lifetime prevalence. Thus, this study does not attempt to estimate the proportion of therapeutic relationships in which sexual contact occurs. Similarly, the term "benefit" was used above, to allow respondents to define for themselves any possible positive consequences for patients of sexual contact with their therapist. Those respondents who did not report to sexual contact with a patient were asked to describe what prevented them from engaging in such behaviour. This question was designed to identify variables which prevent clinical psychologists from engaging in sexual contact with their patients.

Questions were formulated for those respondents who had engaged in sexual relations with a patient to assess the severity of abuse: they were asked to specify the approximate number of patients with whom they had engaged in sexual contact, and, for all of those patients, the number of occasions on which sexual contact had occurred over the therapist's lifetime. Respondents were asked to give the number of current and discharged patients with whom they had had sexual contact, and to detail any previous disclosures of such contacts. Additionally there were questions about the location of the sexual contacts with current patients in order to establish the extent to which attempts were made to separate the sexual contact from therapy.

In order to gain some meaningful information about the nature of the sexual contacts which had occurred between therapists and their patients, detailed questions were included about the most recent sexual contact with a patient, if there had been more than one. Here, a particular area of interest was the degree of physical intimacy of the contact (from kissing to penetration), and any coercion involved. Details relating to that contact were requested, that is, the patient's gender, age, and the types of sexual contact which occurred. Questions followed relating to whether the patient consented to the sexual contact, whether there was an aim of inflicting pain on the patient, and the duration of the sexual contact.

Respondents were requested to give the current status of their involvement with the patient in terms of therapeutic, sexual and social contact, and to indicate how they came to be sexually involved with the patient. Respondents' views of the effects of the contact on the patient, and respondents' current feelings about the involvement were requested.

Respondents were asked to give their view of who initiated the sexual contact, and to state whether they took any steps to dissuade the patient from disclosing the sexual contact.

Questions about the way in which the sexual involvement came about, who initiated the contact, and the perceived degree of consent on the part of the patient, were designed to establish respondents' perceptions of the issue of consent. It was hypothesised that those therapists who become sexually involved with patients may be likely to rationalise such contact by viewing it as consensual, disregarding the differences in power which are present in the therapy relationship. In relation to this issue, it was felt to be useful to ascertain respondents' views of the effects which the sexual contact may have exerted upon the patient.

A series of questions was asked to assess respondents' views of student-educator sexual contact and their experience of sexual contact with educators as students, distinguishing between undergraduate and postgraduate circumstances, and with students/trainees, as educators. Respondents were asked to state whether they had experienced sexual contact with their personal therapist, if applicable.

It was recognised that to simply ask about respondents' own experiences of sexual involvement with patients might create a highly selective picture since only one profession would be targeted, and such information would rely exclusively upon self disclosure, which may understate the prevalence of sexual contact. Thus respondents were asked to specify whether they had treated patients who had been sexually involved

with a previous therapist of any profession, and to indicate whether they knew through sources other than their own patients of clinical psychologists who had sexual contact with patients.

Questions were included about respondents' experience of treating patients who had had sexual contact with previous therapists. They were asked to specify the professional background of the treating therapist, to rate the effects of the contact on the patients, and to provide information about whether the therapists' sexual misconduct had been reported to their employer or professional organisation.

Respondents were asked if they knew through sources other than their own patients, of clinical psychologists who had become sexually involved with patients, and to specify their number, whether they were reported, how many patients they were involved with, and any action taken by the respondent in respect of the sexual contact. These questions were aimed at examining in a British sample the North American finding (Gartrell et al, 1987) that although therapists may know of colleagues who breach the sexual boundaries of therapy, they rarely take action in relation to such boundary violations. Additionally, the questions aimed to identify some of the reasons for such lack of action.

Finally, space was provided for respondents to make further comments.



CHAPTER THREE

METHOD



### 3.1. THE MEASURES

A questionnaire (Appendix 1), covering letter (Appendix 2) and self addressed envelope were sent to the sample selected for the research. The covering letter informed subjects of the context and aims of the research. They were requested to complete the questionnaire and to return it in the addressed envelope provided as soon as possible. Attempts were made to reassure subjects about confidentiality: they were informed that no specific identifying information was requested in the questionnaire and that the author did not intend to attempt to identify any respondent personally. It was suggested that if they were at all concerned about being identified, however, they should not respond to any questions which they felt might identify them. Further, although the questionnaires would be opened by a secretary and the envelopes discarded, if they were concerned about the postmark on the envelope providing a means of identification, they should post the questionnaire from another town.

Individuals were asked to respond even if they were not in current clinical practice, in order that the opportunity was taken to gather information about all possible sexual contacts which had ever occurred between clinical psychologists and their patients.

### 3.2. THE SAMPLE

The covering letter, questionnaire and envelope were sent to a random sample of 1000 members of the Division of Clinical Psychology of the British Psychological Society whose total membership at the time was 2421. The sample was generated from the British Psychological Society computer which holds the names and addresses of all

members of the British Psychological Society. When these details are inputted to the computer, they are stored on disk space in a random manner. When the mailing was requested, the first 1000 members were mailed from the disk. It was intended that members would be directly mailed by the British Psychological Society, excluding corresponding, affiliate and overseas members. These exclusions were designed to achieve an exclusively British sample of qualified psychologists with some professional experience, so as to enhance comparability with North American studies, and to exclude trainee and pre-training grades of membership, who would have at most minimal clinical experience, and thus be unlikely to have any experience of sexual contact with patients.

Unfortunately, however, due to an error at the British Psychological Society offices, the population included trainee, as well as qualified, clinical psychologists, though overseas and corresponding members were excluded. Thus, the sample was taken from a population of 2238, the total Division of Clinical Psychology membership minus overseas and corresponding members, but including affiliate members. The questionnaire and covering letter were considered by a member of British Psychological Society staff before the British Psychological Society agreed to undertake the mailing. No amendments were required.

Clinical psychologists were targeted for reasons discussed in chapter two, and because they are a readily accessible population, the majority of which is engaged in therapeutic work. Further, it was expected that clinical psychologists would be least threatened by such enquiries, given that the author is herself a clinical psychologist.

### 3.3. MEANS OF MAXIMISING THE SAMPLE SIZE

No stamped addressed envelopes were sent with the questionnaires in the belief that the larger sample size which this allowed in terms of reduced cost would more than compensate for the loss of replies due to lack of a stamp. As many questions as possible were formatted so that respondents could simply tick a box and the questionnaire was printed in a small font in order that it appeared as short as possible.

### 3.4. DATA ANALYSIS

The data were analysed using *SPSS PC+*. Questions fall into two classes, those where the respondent was asked to give a categorical or quantitative response, and those where the response was open-ended and unstructured. Categorical or quantitative responses included checking a box, e.g. male or female, or giving a figure, e.g. age in years. Open-ended or unstructured responses included, for example, reasons given by respondents for not becoming sexually involved with patients.

#### 3.4.1. Quantitative data

A number of questions were included in the questionnaire in relation to respondents' use of physical contact of various kinds with patients (question 2.1.). The issue of interest here is that of differential touching of clients according to their gender (Holroyd and Bouhoutsos, 1980). In order to be able to analyse these data in a meaningful manner, a transformation was undertaken so that a score was recorded for equal physical contact

with male and female clients, versus differential touching. That is, a score of 1 was recorded for each form of physical contact if the respondent indicated that s/he used the form of physical contact with both male and female patients, and a score of 0 was recorded if the respondent indicated that s/he used the form of physical contact with one gender of patients, but not the other. The disadvantage of this method of data analysis was that those respondents for whom there is no difference in their use of touch according to gender of the client, and those who touch neither male nor female clients, are not differentiated. However, since the principal area of interest was that of **differential** touch, it was not considered that this issue was of great significance.

When giving their marital status (question 1.3), respondents were permitted to check more than one category. However, it was decided to select the most recent marital status for ease of recording: for example, where a respondent described him/herself as divorced and in a stable relationship, s/he was coded in the latter category. Therapeutic orientation (question 1.6.) was coded on a four point scale for each orientation where 0 = no influence, 1 = least influence, 2 = moderate influence and 3 = most influence.

Respondents were required to give one sexual orientation (question 1.4), selecting from heterosexual, homosexual and bisexual. When coding these data for the purposes of the logistic regression analyses, two variables were created, heterosexual or bisexual/homosexual, and homosexual or heterosexual/bisexual.

Where respondents were asked to specify the profession of therapists who had been sexually involved with their patients (where applicable) (question 5.2) each profession

mentioned on the questionnaire was coded separately and where a respondent checked that profession, a score of 1 was recorded. Where the respondent did not check that profession, a score of 0 was recorded. A score of 2 was recorded where the respondent had not treated patients who reported sexual involvement with a previous therapist. Respondents' answers to the quantitative questions were coded and entered into *SPSS PC+* data entry. Subsequently these data were analysed descriptively in order to explore relationships within the data.

Logistic regression was used in order to identify predictor variables for sexual contact with patients. The dependent variable for the logistic regression analyses was that of sexual contact between the respondent and at least one of his/her patients, either current or discharged. All possible predictor variables were included in the logistic regression analyses, that is, gender, age, marital status, sexual orientation, total years of post-qualification practice, therapeutic orientation, clinical specialty, weekly hours of face to face patient contact, proportion of patients in long and short-term therapy, main work setting, experience of personal therapy, use of physical contact with male and female patients, experience of sexual attraction to patients, current feelings about such attraction, effect of the attraction on the therapy process, experience of sexual contact with patients, view of whether such contact could benefit patients, experience of undergraduate and postgraduate sexual contact with an educator, view of whether such contact could benefit students/trainees, experience of sexual contact with personal therapist, where relevant, experience of sexual contact as an educator, with students/trainees, and experience of treating patients who were sexually involved with previous therapists.

The logistic regression method of data analysis was chosen because the dependent variable is binary in nature, that is, there were only two possible responses to the question "have you ever had what you regard as sexual contact with one of your patients, no matter whether current or discharged?", that is, yes and no. Logistic regression is the statistical method of choice when the dependent variable can have only two values. The logistic regression model predicts the binary dependent variable from a set of independent variables.

Since the number of respondents in the sample who had engaged in sexual contact with their patients was rather small (20), instead of checking the stability of the analyses using a split-half approach, repeated logistic regression analyses were performed, each time omitting one of the "abuser" cases. Thus, with 20 "abusers", in addition to an analysis of the whole sample, there are 20 analyses on the whole sample minus an "abuser" case.

The "forward stepwise" method was used to search for the best set of predictor variables. For stepwise logistic regression, the first variable is selected on the basis that it is the one with the largest positive or negative correlation with the dependent variable. If the variable passes the removal criterion, the second variable is selected based on the highest partial correlation and so forth. After each step, variables already in the equation are examined to see whether they should be removed according to a removal criterion (either a minimum F value a variable must have (2.71) or a maximum probability of the minimum F value a variable can have (0.10)). Variables are removed until none remain that meet the removal criterion.

In addition, for each analysis, a subsequent "forced entry" logistic regression analysis was performed, where all variables in the stepwise equation were entered in a single step. There were two main reasons for this approach. Firstly, one variable entered into the analyses was logically related to another. One question asked of respondents was whether or not they had been sexually attracted to their patients. This was coded as one variable, "attract". The next question asked those respondents who **had** been sexually attracted to their patients what effect they believed this to have had on therapy. Responses to this subsequent question were also coded as a variable, "affect". Thus, in order accurately to interpret the results of the logistic regression analyses, it was necessary to enter into the forced entry analyses the variable "affect" in order that any significant result involving the variable "attract" could be interpreted accurately. This was necessary since *SPSS PC+* does not have a built-in method for ensuring that logically related variables are entered into the analysis simultaneously. Secondly, the robustness of any significant results emerging from the initial stepwise analysis would be tested via the forced entry analyses. That is, only those variables which were significant in the stepwise logistic regression analyses were entered into the forced entry analyses.

In addition, an attempt was made to address the inadvertent inclusion of trainee clinical psychologists in the sample, by performing a parallel set of identical analyses on a subset of the data from which trainees had been removed.

In considering the results of the above analyses, the conventional significance level of  $p < 0.05$  was used. However, a small number of results were slightly out of this range and

these are considered in the thesis where such results assist in the interpretation of the data. This may be justified on the basis of the clinical nature of this research, but caution must be employed in interpreting the results as even a significance level of  $p < 0.05$  may suggest some associations which may prove to be spurious.

Many of the variables were crosstabulated and chi square analyses were undertaken as well as a small number of Mann-Whitney U tests for those variables where respondents ranked their answers. First, respondents' reporting of sexual contact with their patients was considered in relation to most other relevant variables, and second, other issues such as respondents' gender, marital status, main work setting, etc., were considered in relation to relevant variables. These statistical analyses aimed to identify variables which might be instrumental in explaining why clinical psychologists become sexually involved with their patients.

#### **3.4.2. Qualitative data**

There were four questions whose responses were defined as "qualitative", where respondents who had not experienced sexual attraction towards a patient were asked to give reasons for this, and where respondents who had not become sexually involved with patient were asked why such contact had not occurred. Respondents who knew of clinical psychologists who had engaged in sexual contact with a patient, but had not taken action to address this problem were asked to give their reasons for their lack of action, and, finally, respondents were invited to make "any other comments" at the end of the questionnaire.

The first step in analysing these data was that of **basic taxonomy development** (Henwood and Pidgeon, 1995). Respondents' answers to these questions were entered verbatim into *Wordperfect*. For each of the four questions where such a response was required, responses were examined and a definitions manual derived from the data in order to develop categories which described the responses (Appendix 4).

The first question, "Have you ever felt sexually attracted to one of your patients? If no, why not?" contained categories as follows, ethical concerns, features of patient population, respondent experiences feelings for patients which preclude the sexual, traumatic experience, self-management, don't know, nature of the relationship, fortuitous, existing relationship, and taboo/repression.

The second question, "Have you ever had what you regard as sexual contact with one of your patients, no matter whether current or discharged? If no, what has stopped you?" contained categories as follows, boundary issues, personal values/ethics in relation to therapeutic practice, professional values/ethics, supervision, don't know, negative professional consequences for self, lack of opportunity, avoidance of sexual contact, negative personal consequences for self, not having experienced any desire to engage in sexual contact, traumatic experience, fear of potential negative consequences within the therapy relationship, and impact upon the patient.

For the third question "do you know through sources other than your own patients, of clinical psychologists who have been sexually involved with their patients? Have you taken any action to prevent the continuation of such contacts? If no, why not?" the

categories were as follows, suspicion only, hearsay only, the sexual contact was not considered to be harmful to the patient, the sexual contact was not current, the sexual contact occurred after termination of therapy, action had already been taken, no risk of reoffending, patient was to blame for the sexual contact, the respondent did not believe it to be his/her responsibility to take action, the respondent was a friend of the offending psychologist, lack of realisation of the importance of taking action, fear of retribution/retaliation.

The fourth question, "any further comments" contained categories as follows: suggestions for further research, questioning whether respondents would answer the questionnaire truthfully, power issues in therapy, I had not thought about or experienced this before or tend not to consider patients in a sexual way, comments about theoretical orientation, ethical issues, disclosure of personal experience of sexual abuse or sexual dilemmas, some allegations of sexual abuse by therapists are false, comments about the research methodology, negative comments about the research, I have felt tempted but I keep myself under control, sexual contact with ex-patients or ex-trainees is acceptable, comments about dealing with sexual impropriety, comments supporting the research, detail of colleagues who have had sexual contact/behaved sexually inappropriately with patients, gender issues, organisational/professional responsibility, therapist-patient sexual contact can be damaging, preventative suggestions, comments on sexual relationships between educators and trainees, sexual contact with patients can be acceptable under some circumstances, comments on sexual attraction in therapy, and hearsay only.

A four point rating scale of 1 to 4 was used for each answer, where 1 = definitely applies; 2 = probably applies; 3 = possibly applies; 4 = does not apply. Each question had a "miscellaneous or uncodeable" and "other" category. The responses categorised here did not receive a rating. The fourth question, "any further comments" did not receive reliability ratings because of its non-specific nature.

An Assistant Psychologist with a B.Sc. in psychology, a P.G.C.E., an M.A. in child psychology, and six months' experience as an Assistant Psychologist in the N.H.S., was then trained to rerate some of these data. The training consisted largely of an explanation by the author of the category system and the rating system. Specifically, the second rater was made aware that some responses could be coded in more than one category, and regular discussions took place between the author and the second rater in relation to the progress of the second rater and any difficulties which had arisen. The second rater rerated every response to two of the open-ended questions, allocating the response to a category and rating it. The two ratings for each response were then compared, using Cohen's Kappa..



CHAPTER FOUR

QUANTITATIVE DATA: RESULTS I



Chapters four and five describe the quantitative results derived from the questionnaire.

This chapter describes the main results from the questionnaire, for those questions where respondents were asked to provide numerical responses or to check one or more categories. The chapter is arranged so that information is first presented for the sample as a whole, as single variables. These data are, where possible, compared with other data available on Division of Clinical Psychology membership. Salient crosstabulations are then presented to describe further the whole sample. Subsequently, respondents' reporting of their experiences of sexual contact with their patients is discussed, and most variables are then described in relation to this.

Three main methods of presenting the data are used. Frequencies are reported where appropriate, and crosstabulations were used to describe the data in more detail. Chi square analyses were undertaken where variables had been crosstabulated to establish whether there were significant differences between various groups described.

In most tables, column percentages have been adjusted to sum to 100%, for reasons of comparability across columns. This has usually involved the exclusion of missing data.

Chapter five presents the results of logistic regression analyses (stepwise and forced entry) which were performed on the data set in an attempt to establish variables which predicted sexual contact with patients.

#### 4.1. RELIABILITY CHECK (DATA ENTRY)

The large bank of data collected for this study raises questions about the accuracy of the data entry. It was therefore decided to check the accuracy of the data inputting to *SPSS PC+* by having a random subset of responses inputted twice.

The author was the sole data inputter for the questionnaire data. *SPSS PC+ Data entry* was used. A second data inputter was used to input the same data from 30 questionnaires randomly selected from the data set. This individual was an Assistant Psychologist with a B.Sc. in psychology and eighteen months' experience as an Assistant Psychologist in the N.H.S. The data from each inputter were then compared for differences. For each variable, a score out of 30 was calculated, to represent the number of cases agreed upon by the two raters.

For the majority of variables (46), there was only one case out of 30 where the two raters disagreed. For 28 variables, there was no disagreement between raters. For nine variables, the raters disagreed in two cases, and for four variables the raters disagreed in three cases.

The majority of the disagreements between the raters were due to differences in interpretation of the raw data, rather than inputting errors. For example, a small number of respondents checked two, rather than one, responses to the question on marital status. In such cases it was necessary to select one response for the purposes of data inputting. This resulted in some disagreement, for example, the author's approach was to select the

category which bore most resemblance to the **current** marital status of the respondent. For example, where both *in a stable relationship* and *divorced/separated* were checked, the author selected the former as the category to record. Whilst this is clearly a matter for interpretation, the author's ratings were consistent over time in such respects.

Similarly, where respondents were asked to specify the proportion of their patients in long term therapy, some gave a range (e.g. 2-5%) rather than a precise proportion, or gave 0.5% which, for the purposes of the data entry, could either be entered as 0% or 1%. Thus, it may be argued that the main differences between the two data inputters were relatively minor in nature, or due to differences in interpretation of the data, which would not have a significant impact on the data because of the consistency of the author, who was the sole data inputter.

#### 4.2. RESPONSE RATE

A total of 588 of the 1000 questionnaires were returned, of which 581 were completed, and 6 were returned blank either because the recipient had never practised or because s/he was a trainee and did not feel that it was appropriate to complete the questionnaire. One questionnaire was returned with comments from the recipient which indicated that s/he did not wish to complete the questions, and one individual who completed the questionnaire wrote back expressing doubts about the validity of the study, and of the appropriateness of requesting intimate information of this nature.

For all descriptions of data, where percentages do not total 100% or where the total number of respondents does not add up to 581, this is due to respondents having failed to answer particular questions.

### 4.3. RESPONDENT SAMPLE

#### 4.3.1. Gender

60.7% of respondents were female and 37.6% were male. Whilst comparative information is not available for the whole Division of Clinical Psychology for the time at which the questionnaires were mailed, it is possible to offer a comparison of the respondents to this survey, with current data on Division of Clinical Psychology members. Data on age and gender of all current Division of Clinical Psychology members residing in the U.K. were recently made available to the author (Bull, 1995, personal communication). In making such comparisons it should be noted that the present sample was not taken from all U.K. resident Division of Clinical Psychology members but excluded certain grades of membership, and that the present data was gathered approximately four years before information was available on the Division of Clinical Psychology as a whole (Bull, 1995, personal communication). However, some comparison is possible. Of current Division of Clinical Psychology members (total membership 2823), 63.9% are female and 36.7% are male. Chi square analysis of data from the present study and of Bull's (1995) data showed no significant difference ( $\chi^2 = 0.99$ ;  $df = 1$ ;  $p > 0.2$ ) between the two samples and this suggests that the sample of

respondents is broadly representative of the Division of Clinical Psychology in terms of gender.

A survey of Division of Clinical Psychology members conducted at around the same time as this survey (Norcross, Brust and Dryden, 1992) found that 55% of its respondents were female and 45% were male. Although chi square analysis of the present data and that of Norcross et al (1992a) showed a significant difference between the two samples ( $\chi^2 = 6.72$ ;  $df = 1$ ;  $p < 0.01$ ), it is suggested that it is most appropriate to compare the present data with the total Division of Clinical Psychology membership, even if the latter data were collected some years after this survey was carried out.

#### 4.3.2. Age

The mean age of the sample was 39 years (range 24-78; S.D. 9.14). Whilst some data are available (Bull, 1995, personal communication) on the ages of current Division of Clinical Psychology members, such data are only available in age "bands" of 10 years, e.g. 20 - 29, 30 - 39, etc. The present data, therefore, were converted into the same form for comparison, and are shown in table 4.1.

**Table 4.1. Comparison of ages of respondents with those of current total British resident Division of Clinical Psychology membership four years later (Percentages: frequencies are given in parentheses)**

Age	Present data	Whole D.C.P.
20-29	12.4% (72)	11.0% (309)
30-39	42.5% (246)	31.2% (881)
40-49	33.1% (191)	37.4% (1057)
50-59	8.1% (47)	14.5% (410)
60-69	2.9% (17)	3.5% (100)
>70	0.3% (2)	1.6% (45)
No age given	0.7% (4)	0.8% (21)
Total	100% (579)	100% (2823)

Whilst any comparisons between the two data sets must be made with caution for reasons given above (4.3.1.), it is possible to draw some tentative conclusions. A chi square test performed on the two data sets shows that there is a significant difference between the present data set and the Division of Clinical Psychology as a whole ( $\chi^2 = 1794.109$ ;  $df = 6$ ;  $p < 0.00005$ ). The present sample has a slightly heavier balance of younger people than the Division of Clinical Psychology membership data, specifically, the present sample appears to over-represent under 40's and to under-represent over 40's. Perhaps younger practitioners are more willing to give time to respond to a study such as this, possibly because of increasing emphasis in recent times upon ethical issues. However, the effect is also likely to be a consequence of the large numbers of subjects in these data sets, and it appears that the two distributions do not have major differences. Whilst some caution must therefore be applied to interpreting the present data as in

respect of age, at least, this sample may not be representative of the Division of Clinical Psychology as a whole, there is some evidence to suggest that there are not marked differences between these two samples.

The mean age of Norcross et al's (1992a) sample was 39.5 years (S.D. 8.1; range 24-75). Similarly, the mean age of this sample was 39 years with a very similar range in which the bottom of the range is 24 for both samples and the top of the range is 78 in this survey.

#### **4.3.3. Length of practice**

The mean length of postqualification practice as a clinical psychologist was 11 years (range 0-40; S.D. 8). There were 35 respondents (6% of the sample) who were currently in clinical psychology training at the time of responding to the questionnaire. No data are available to compare this aspect of the data with the Division of Clinical Psychology as a whole, but Norcross et al (1992a) report data on 1096 Division of Clinical Psychology members, obtained from a survey mailed to all those Division of Clinical Psychology members who received Clinical Psychology Forum (2117). They found that the mean length of postqualification practice of their respondents was 11 years, precisely the same result as in the present study. The range was 0-45 years (S.D. 8.4), again, remarkably similar to the present data.

#### **4.3.4. Marital status**

Most respondents were married (60.5%) or in a stable relationship (20.8%). A minority (12.5%) were single and 4.3% were separated or divorced, only 0.9% describing themselves as widowed. No comparative data are available for marital status.

#### **4.3.5. Sexual orientation**

The majority of respondents described themselves as heterosexual (96.4%), with 1.5% stating that they were bisexual and 1.7% homosexual. No comparative data are available for sexual orientation.

#### **4.3.6. Specialty**

The majority of respondents identified their main specialty as adult mental health. The next two most common specialties were children and learning difficulties, with only small percentages of respondents (5% and under for each category) working in other specialties such as neuropsychology and with the elderly. These results are shown in table 4.2.

**Table 4.2. Respondents' main area of clinical work (percentages)**

<b>Name of specialty</b>	<b>Percentage of respondents</b>
Adults	54.0
Children	13.9
Learning difficulties	12.9
Elderly	5.2
Physical Health	3.6
Neuropsychology	3.8
Other	4.5
Total	97.9%

#### **4.3.7. Main work setting**

The overwhelming majority of respondents worked primarily in the N.H.S. (90%) with 4% working mainly private practice, just over 4% mainly in "other" settings, (such as universities and business settings) and very few working mainly in Social Services or the Voluntary Sector (less than 1% apiece). These results are detailed in table 4.3, where a comparison is also offered with Norcross et al's (1992a) sample (the original categories used by the authors have been collapsed where necessary to allow appropriate comparisons with the data from this study).

**Table 4.3. Work setting: A comparison with Norcross et al (1992a)** (frequencies are given in parentheses)

Work setting	This study	Norcross et al (1992a)
N.H.S.	90.0 (513)	65.5 (643)
Private Practice	4.0 (23)	4.0 (39)
Social Services	0.9 (5)	1.6 (16)
Voluntary Agency	0.7 (4)	Not specified
Other	4.4 (25)	28.9 (284) (includes University employment)
Total	100 (570)	100 (982)

Norcross et al (1992a) provided a wider choice of categories to respondents but nevertheless, some comparisons are possible here. Chi square analysis of the data in table 4.3 shows that there is a significant difference ( $\chi^2 = 140.3$ ;  $df = 3$ ,  $p < 0.01$ ) between the two samples in respect of main work setting. Fewer of Norcross et al's (1992a) sample were primarily employed in the NHS, a difference of over 24%. Since the percentages in the other categories are broadly similar, it may be concluded that the other main difference lies in the 29% of Norcross et al's (1992a) sample falling into the "other" category. Of this, 21% is described by the authors as "other" and only 8% are categorised as in University employment. However, Norcross et al (1992a) do not provide a generic "N.H.S." category, but specify N.H.S. settings, which excludes a general community clinical psychology base, a relatively common accommodation arrangement for clinical psychologists. It may be that a large proportion of the 21% mentioned above are employed in such a setting, and that some of this percentage are employed in the voluntary sector, another category not provided by Norcross et al

(1992a). Some caution must therefore be exercised in interpreting the results of the present study in the light of the differences in respect of main work setting between this sample and a larger Division of Clinical Psychology sample.

#### **4.3.8. Patient contact per week**

Respondents spent a mean 14 hours per week in face to face patient contact (range 0-60; S.D. 7.57). They had a mean 12.9% of patients in long term (defined as 50 sessions or more) therapy (range 0-100; S.D. 21.1) and 67% of subjects' patients were in short term (defined as 20 sessions or fewer) therapy (range 0-100; S.D. 30.25). As can be seen from the large standard deviations, there is considerable variability across psychologists in the distributions of long-term and short-term clientele.

#### **4.3.9. Experience of personal therapy**

Forty-four percent of subjects had undertaken personal therapy. This figure is significantly higher ( $\chi^2 = 24.65$ ;  $df = 1$ ;  $p < 0.001$ ) than that reported by Norcross, Dryden and DeMichele (1992), who, in a larger survey of Division of Clinical Psychology members, found that approximately 38% reported at least one episode of personal therapy. However, the magnitude of the difference is modest.

#### 4.3.10. Therapeutic orientation

Respondents were asked to indicate the three therapeutic orientations which most influenced their practice. The results of this question are given in table 4.4.

**Table 4.4. Respondents' therapeutic orientations** (Percentages: frequencies are given in parentheses. In any given column each cell shows the percentage of the total number of respondents giving the specified influence)<sup>1</sup>

Orientation	Little or no influence	First influence	Second influence	Third influence
Behavioural	9.3 (170)	27.0 (171)	29.7 (159)	16.3 (77)
Cognitive	7.7 (140)	30.0 (190)	33.5 (179)	14.4 (68)
Psychodynamic	15.6 (284)	18.6 (118)	11.8 (63)	23.8 (112)
Systemic	18.8 (342)	10.9 (69)	11.8 (63)	21.9 (103)
Humanistic	20.1 (367)	8.5 (54)	11.8 (63)	19.7 (93)
Other	28.5 (520)	4.9 (31)	1.5 (8)	3.8 (18)
Total	100 (1823)	100 (633)	100 (535)	100 (471)

Almost 95% of respondents chose one of the specified orientations as their primary influence, rather than citing "other", then specifying an orientation which was not given in the questionnaire as first influence. Relatively few (11.9%) respondents accord "little or no influence" to both behavioural and cognitive orientations. "Other" therapeutic orientations cited included Rogerian and feminist.

<sup>1</sup> The number of respondents citing first influences on their practice (633) exceeds the total number of respondents in the sample (581) because some respondents checked more than one orientation as their first influence.

A comparison of the primary theoretical orientation given by the present sample, and that reported by Norcross et al's (1992a) sample is given below (the original categories used by the authors have been collapsed where indicated to allow appropriate comparisons with the data from this study).

**Table 4.5. Primary theoretical orientation: A comparison with Norcross et al (1992a)** (frequencies are given in parentheses)

Primary theoretical orientation	This study (percentages of total sample)	Norcross et al (1992a) (percentages of total sample)
Behavioural	16.3 (77)	26.9 (268)
Cognitive	14.4 (68)	21 (209)
Psychodynamic	23.8 (112)	11.9 (119) (includes Kleinian)
Systemic	21.9 (103)	6 (60)
Humanistic	19.7 (93)	4 (40) (includes Rogerian)
Other	3.8 (18)	29.9 (298) (includes Eclectic/integrative)
Total	100 (728)	100 (994)

Chi square analysis of the data in table 4.5 showed that the two groups are significantly different ( $\chi^2 = 311.39$ ;  $df = 5$ ;  $p < 0.001$ ) but this effect is likely to be due to the large numbers of subjects in the studies. The two data sets are not markedly different. Whilst there is one broad similarity between the figures for the two studies, there are also some differences. The proportion of respondents citing their main influence as behavioural was similar but in this study, more respondents regarded themselves as primarily cognitive, psychodynamic, humanistic and systemic than in Norcross et al's (1992) survey. By contrast, in Norcross et al's (1992a) sample, almost a third of respondents fell

into the "other" category including those who gave their primary orientation as eclectic/integrative. This was not a category offered in the present questionnaire and thus respondents may have been "forced" to choose a specific orientation. This renders problematic the drawing of conclusions in relation to absolute differences between the two samples. Over 60% of respondents cited their first theoretical influence as cognitive or behavioural, whereas only 48% of a larger sample of Division of Clinical Psychology members did so (Norcross et al, 1992b).

#### **4.3.11. Summary**

In summary, whilst it is difficult to draw conclusions in relation to similarities and differences between this sample and that of Norcross et al (1992a and b) for worksetting and theoretical orientation, the following conclusions may be drawn. The most commonly cited therapeutic orientations in both samples were cognitive and behavioural. A similar proportion in both groups reported this as the most significant influence on them. Whilst the length of postqualification practice in both samples was similar, there were many more women respondents in this sample than in that of Norcross et al (1992a). However, the present sample is similar in terms of gender to the current Division of Clinical Psychology membership. In respect of age, for mean and mode there were similarities between this sample and the Division of Clinical Psychology as a whole (Bull, 1995, personal communication) but in terms of distribution, the two samples were significantly different.

In this sample, there were 6% more respondents who had experienced personal therapy than Norcross et al's (1992b) sample. Thus, those who had experienced personal therapy were somewhat over-represented in this sample. One possible explanation for this difference is that those who received the questionnaire and who had experienced personal therapy were more ready to respond because of greater sympathy to the subject, or greater sensitivity to the question of boundaries in therapy.

There may be a number of possible explanations for these differences, but it may be assumed that Norcross et al's (1992a and b) sample is more likely to be representative of Division of Clinical Psychology members since no controversial questions were asked of respondents in that survey.

The following tables convey further detail about the sample.

**Table 4.6. Relationship between marital status and experience of personal therapy**

(Percentages: frequencies are given in parentheses)

	Single	Stable relationship	Married	Separated/divorced	Widowed
No personal therapy	37.5 (27)	48.8 (59)	62.1 (216)	41.7 (10)	40 (2)
Personal therapy	62.5 (45)	51.2 (62)	37.9 (132)	58.3 (14)	60 (3)
Total	100 (72)	100 (121)	100 (348)	100 (24)	100 (5)

A chi square analysis was performed on the data in table 4.6 ( $\chi^2 = 504.4$ ;  $df = 1$ ;  $p < 0.005$ ) which showed that those respondents who had experienced personal therapy were

significantly different from those who had not experienced personal therapy. Specifically, those who had not experienced personal therapy were more likely to be married than those who had been in personal therapy.

**Table 4.7. Relationship between gender and sexual orientation** (Percentages: frequencies are given in parentheses)

Sex	Heterosexual	Homosexual	Bisexual
Female	61.7 (341)	60 (6)	66.7 (6)
Male	38.3 (212)	40 (4)	33.3 (3)
Total	100 (553)	100 (10)	100 (9)

A chi square test on the data in table 4.7 showed no significant difference ( $\chi^2 = 0.35$ ;  $df = 4$ ;  $p > 0.9864$  in respect of sexual orientation between male and female respondents.

**Table 4.8. Relationship between clinical specialty and gender** (Percentages: frequencies are given in parentheses)

Clinical specialty	Male	Female
Adults	57.3 (125)	53.6 (184)
Children	11 (24)	16.3 (56)
Learning difficulties	13.3 (29)	13.1 (45)
Elderly	4.1 (9)	6.1 (21)
Physical health	4.1 (9)	3.5 (12)
Neuropsychology	4.6 (10)	3.2 (11)
Other	5.5 (12)	4.1 (14)
Total	99.9 (218)	99.9 (343)

Chi square analysis of the data in table 4.8 showed that there is no significant difference ( $\chi^2 = 8.38$ ;  $df = 8$ ;  $p > 0.397153$ ) in respect of specialty between male and female respondents.

**Table 4.9. Relationship between gender and experience of personal therapy**

(Percentages: frequencies are given in parentheses)

Sex	Personal therapy	No personal therapy
Male	31.5 (80)	43.9 (137)
Female	68.5 (174)	56.1 (175)
Total	100 (254)	100 (312)

A chi square test on the data in table 4.9 showed that there was no significant difference ( $\chi^2 = 9.28$ ;  $df = 4$ ;  $p > 0.0545$ ) between male and female respondents in their experience of personal therapy.

**Table 4.10. Relationship between sexual orientation and marital status**

(Percentages: frequencies are given in parentheses)

Marital status	Heterosexual	Homosexual	Bisexual
Single	12.0 (67)	30 (3)	33.3 (3)
Stable relationship	19.7 (110)	70 (7)	44.4 (4)
Separated/ divorced	4.5 (25)	0	0
Widowed	0.9 (5)	0	0
Married	62.8 (350)	0	22.2 (2)
Total	100 (557)	100 (10)	100 (9)

A chi square test on the data in table 4.10 showed that there is a significant difference in marital status according to sexual orientation ( $\chi^2 = 29.41$ ;  $df = 8$ ;  $p < 0.00005$ ). However this chi square analysis should be interpreted with caution since some cell frequencies are less than 10 and statistical corrections for small cell frequencies are not available for tables which are larger than  $2 \times 2$ . As one might expect, few of those respondents who were married identified themselves as homosexual or bisexual, and heterosexuals were more likely to be married than homosexuals or bisexuals. None of those who were separated/divorced or in the widowed group, identified themselves as homosexual or bisexual. Those who viewed themselves as homosexual and bisexual were more likely to be single and in a stable relationship.

#### **4.4. USE OF PHYSICAL CONTACT WITH PATIENTS**

Respondents were asked to describe their use of physical contact with male and female patients. These findings are shown in table 4.11.

**Table 4.11. Respondents' use of physical contact with patients: both sexes collapsed**  
(each cell indicates percentage of total sample who have ever engaged in the specified type of contact with a patient of the specified gender)

Type of contact	Male patients	Female patients	$\chi^2$	df	p=
Handshake	97.3	95.4	191.82	1	<0.000005
Patting on arm	52.6	58.4	318.14	1	<0.000005
Holding hand(s)	18.6	30.6	246.29	1	<0.00005
Touching arm/shoulder etc.	52.6	60.7	249.89	1	<0.00005
Hugging	14.6	32.8	149.91	1	<0.00005
Other	4.0	5.0	239.01	1	<0.00005

The majority of respondents, both male and female, have shaken hands with their patients, and just over half have patted patients on the arm or touched their shoulder. However, holding hands, hugging and other forms of physical contact are less common. Chi square analyses of the data in table 4.11 show that all of the types of physical contact vary significantly with patients' gender.

Table 4.12 shows the use of different forms of physical contact with patients of each sex, by gender of respondent.

**Table 4.12. Respondents' use of physical contact with patients: by sex of therapist**  
(each cell indicates percentage of specified respondent subsample who have ever engaged in the specified type of contact with a patient of the given gender)

	Male therapist	Female therapist	Male therapist	Female therapist
Type of contact	Male patient	Male patient	Female patient	Female patient
Handshake	99.1	96.9	97.7	94.6
Patting on arm	63.9	45.3	56.6	59.4
Holding hands	21	16.9	29.2	31.7
Touching arm/ shoulder etc.	63.9	45.3	57.5	63.1
Hugging	18.3	12.2	25.6	37.4
Other	3.2	4.5	4.1	5.7

For the majority of types of physical contact, chi square analysis shows no significant differences between men and women in respect of their use of physical contact with male versus female patients. However, in the case of touching the arm/shoulder of patients ( $\chi^2 = 5.07$ ;  $df = 1$ ;  $p < 0.0243$ ), and hugging patients ( $\chi^2 = 11.83$ ;  $df = 1$ ;  $p < 0.0006$ ) there was a significant difference between male and female respondents in their differential use of such contact according to the sex of the patient. Therefore, whilst male and female respondents usually used most forms of physical contact equally with male and female patients, female respondents were more likely to touch the arm/shoulder of, and to hug, female patients than male patients.

#### 4.5. EXPERIENCE OF SEXUAL ATTRACTION TOWARDS PATIENTS

Of all respondents, 61% reported having been sexually attracted to a patient but 38.3% said that this had never happened to them. 89.3% of those respondents who had been sexually attracted to a patient subjects expressed current unconcern about the attraction, whereas 10.7% were concerned. The majority (60.9%) of those who reported sexual attraction to one or more of their patients believed that the attraction had little or no effect on therapy. Only a minority (10.6%) believed that the attraction had a negative effect. Under a third (28.5%) reported that they believed that their sexual attraction towards patients had made a positive impact on therapy.

The tables below set out the results in relation to sexual attraction in therapy in more depth, with particular attention to gender differences, marital status and respondents' experience of personal therapy.

**Table 4.13. Relationship between marital status and experience of sexual attraction to patients** (Percentages: frequencies are given in parentheses)

Marital status	No sexual attraction to patients	Sexual attraction to patients
Single	12.2 (27)	13.0 (46)
Stable relationship	19.9 (44)	21.5 (76)
Married	63.3 (140)	59.8 (211)
Separated/divorced	3.6 (8)	4.8 (17)
Widowed	0.9 (2)	0.8 (3)
Total	100 (221)	100 (353)

Chi square analysis of the data in table 4.13 showed that there was no significant difference ( $\chi^2 = 2.18031$ ;  $df = 8$ ;  $p > 0.974974$ ) between those who were sexually attracted to patients, and those who were not, in respect of marital status. Married respondents were most likely both to experience sexual attraction to patients, and to report not experiencing such attraction.

**Table 4.14. Relationship between gender and experience of sexual attraction to patients** (Percentages: frequencies are given in parentheses) (n= 570)

Sex of respondent	Sexually attracted to patients	Not sexually attracted to patients
Male	52.3 (183)	16.4 (36)
Female	47.7 (167)	83.6 (184)
Total	100 (350)	100 (220)

Chi square analysis of the data in table 4.14 shows that men are more likely to report attraction to their patients than women ( $\chi^2 = 73.6779$ ;  $df = 1$ ;  $p < 0.0000005$ ). Women more frequently report that they are not sexually attracted to patients, than that they have experienced such attraction. The opposite is true for men.

**Table 4.15. Relationship between experience of personal therapy and experience of sexual attraction to patients** (Percentages: frequencies are given in parentheses) (n=572)

	<b>Sexually attracted</b>	<b>Not sexually attracted</b>
Personal therapy	50 (175)	36.5 (81)
No personal therapy	50 (175)	63.5 (141)
Total	100 (350)	100 (222)

Chi square analysis of the data in table 4.15 shows that there is a significant difference between the group which reported sexual attraction to patients and the group which did not, in respect of experience of personal therapy ( $\chi^2 = 12.93$ ;  $df = 2$ ;  $p < 0.0015$ ). Those who were sexually attracted to their patients were more likely to have experienced personal therapy than those who did not report such attraction.

This would suggest that engaging in personal therapy may be one of the factors which helps clinical psychologists (and perhaps other therapists) to understand that sexual attraction between therapist and patient can frequently be a natural part of the therapeutic process. However, since personal therapy is not compulsory for clinical psychologists, it may simply be that those who opt for such therapy are more inclined to think in terms of the therapeutic process and that the awareness of sexual attraction as part of the therapeutic process is a part of the understanding of those individuals before they undertake personal therapy. Alternatively those who experience sexual attraction

towards patients might be more likely to seek therapy than those who do not experience such attraction.

**Table 4.16. Relationship between gender and respondents' view of the effect upon the patient of sexual attraction towards a patient** (Percentages: frequencies are given in parentheses) (n=330)

Effect of attraction	Male	Female
Mainly adverse	8.0 (14)	14.8 (23)
Little or none	70.9 (24)	68.4 (106)
Mainly positive	21.1 (37)	16.8 (26)
Total	100 (75)	100 (155)

Chi square analysis of the data in table 4.16 showed that there is no significant difference ( $\chi^2 = 4.32$ ;  $df = 2$ ;  $p > 0.1152$ ) between men and women in respect of the effect which they perceive their sexual attraction towards patients to have exerted on the process of therapy. Most men and women believed that their sexual attraction towards patients had exerted little or no influence on therapy.

#### **4.6. ATTITUDES TOWARDS AND REPORTED PREVALENCE OF, SEXUAL CONTACT WITH PATIENTS**

The majority of respondents (93.6%) felt that patients could not benefit from sexual contact with a psychotherapist. A small percentage (3.6%) stated that they believed that such benefit was possible. This percentage was similar, but not identical, to the

percentage of respondents who admitted sexual contact with at least one of their patients: twenty individuals (3.4% of the sample) admitted to having engaged in what they regarded as sexual contact with current or discharged patients. Of these, thirteen were male, and seven were female. Three individuals did not respond to this question.

The majority (80%) of those who had sexual contact with patients did not believe at the time of completing the questionnaire that patients could benefit from such contact. There may be a number of possible explanations for this apparent contradiction. For example, the experience of sexual contact with a patient or patients may have resulted in some individuals experiencing at first hand some of the problematic aspects of therapist-patient sexual contact, including possible negative effects upon both the patient and the respondent him/herself. For some of the respondents, the sexual contact with the patient did not appear to be a planned, or even in one case, desired, event, and such respondents may have held the view for some time, perhaps even before the sexual contact, that such contacts are unlikely to be beneficial to the patient.

A small minority (3%) of those who did not disclose sexual contact with patients held the view that such contact may be beneficial to patients. Such individuals may include those who gave as a reason for refraining from sexual contact, lack of opportunity, and other similar reasons.

Perhaps most interesting are the four respondents (20%) who held the belief that sexual contact with a therapist could benefit patients, despite their experience of such contact. One of these individuals had engaged in sexual contact with six of his patients, usually

during therapy sessions, and who describes deriving sexual pleasure from such contacts, whilst understanding their abusive nature. Another of these respondents began sexual contact with one patient after her discharge, which he saw as initiated mutually. He did not express concern at the time of completing the questionnaire about the contact.

The third case involved a respondent who was trapped by the patient's dog whilst the patient made suggestive comments to her: even given this experience, this respondent, perhaps surprisingly, expressed the view that very rarely patients could benefit from sexual contact with their therapist. This respondent also described sexual contact with educators, both as a postgraduate and as an undergraduate. Such experience may have influenced her view of sexual contact with a therapist as potentially beneficial. Finally one respondent who reported sexual contact with three patients which began whilst the patients were in therapy, stated that he believed that therapist-patient sexual contact could be beneficial to the patient. This respondent gave very little detail about his experiences, but did express concern about the effects of the sexual contact upon the most recent patient.

In summary, it is difficult to detect a pattern among the four respondents who reported sexual contact with a patient or patients, and who believed that such contact could be beneficial to patients. Certainly half of these individuals (half of the total number who reported sexual contact with more than one patient) report multiple sexual contacts with their patients, contacts which commenced when the patient was in therapy, and which only occurred during therapy sessions. It is therefore reasonable to conclude that those with experience of multiple sexual contacts with their patients are likely to maintain the

belief that such contacts can be beneficial to the patient, perhaps primarily as a dissonance-reduction strategy (Festinger, 1957).

Sixteen of the clinical psychologists who had engaged in sexual contact with their patients had had sexual contact with one patient, one with two patients, one with four patients and one with six patients.

The most frequent total number of occasions on which respondents had engaged in sexual contact with patients was one (six respondents). Three individuals reported two occasions, one reported three occasions, one reported four, one reported six and one reported ten occasions. Two respondents described multiple sexual contacts with patients. One reported 800+ occasions of sexual contact and one reported 1000. Five respondents who had had sexual contact with patients did not respond to this question.

The majority (13) of those respondents who reported sexual contact with their patients had sexual contact with discharged patients only. Twelve respondents reported sexual contact with one discharged patient, and one with three discharged patients. Six respondents had engaged in sexual contact with current patients only. Four respondents had sexual contact with one current patient, one respondent with two current patients, and one with three current patients. One respondent admitted to sexual contact with five current and one discharged patients. In summary, 65% of these respondents had been sexually involved only with discharged patients, and 30% only with current patients.

When those psychologists who had engaged in sexual contact with current patients were asked the circumstances in which this occurred, one did not respond, four stated that the contact had happened only during therapy sessions, and one respondent reported that sexual contact occurred only outside therapy sessions. Two respondents reported sexual contact both within and outside therapy sessions.

Table 4.17 summarises the frequency with which respondents disclosed their sexual involvement with their patients to various others. The total for this table exceeds 20 because respondents were able to check more than one individual to whom they disclosed.

**Table 4.17. Previous disclosures made by respondents concerning sexual contact with patients (n=20) (Frequencies are given)**

<b>To whom disclosure made</b>	<b>Number of respondents</b>
<b>Colleague</b>	13
<b>Friend/partner</b>	12
<b>Manager</b>	5
<b>Personal therapist</b>	4
<b>Supervisor</b>	3
<b>Other, unspecified</b>	1
<b>No previous disclosure</b>	2
<b>Did not respond</b>	1

Thus, only two and possibly three respondents (since one did not respond) who had sexual contact with patients had not disclosed this contact prior to completing the questionnaire for this survey.

#### **4.6.1. The most recent sexual contact with a patient (if more than one)**

Just over half (11) of those respondents reporting sexual contact with one or more of their patients reported that the patient with whom they had had their most recent sexual contact (if more than one had occurred) had been female, six reported that the patient had been male and three individuals did not provide detail about the gender of the patient. The patient's age was given by all but four respondents. The mean age of patients was 30 years (range 18-41; S.D. 7.86). Fifteen of these contacts were heterosexual in nature. There were two homosexual pairs, one male and one female. Three respondents did not give this detail.

Types of sexual contact occurring between respondents and the most recent patient with whom sexual contact occurred are given in table 4.18.

**Table 4.18. Type of sexual contact with most recent patient (n=17) (Frequencies are given)**

Type of sexual contact	Number of respondents engaging in behaviour
Kissing	12
Non-genital touching/holding/fondling	11
Hand-genital contact	8
Vaginal intercourse	7
Oral-genital contact	1
Anal penetration	2
Other	0

In the above question, respondents were able to check more than one category if they wished. Most contact defined by respondents as sexual was of a non-genital nature, and a substantial minority of the contact was non-penetrative.

All respondents (16/20) who answered the question concerning the degree of consent given by the patient to the sexual contact, and the extent to which pain had been inflicted on the patient stated that their sexual contact with the patient had been consenting and did not involve the infliction of pain on the patient. Eleven considered the sexual involvement to have been mutually initiated and six stated that the patient had initiated it. One of the subjects stated that he had initiated the sexual contact. One individual did not respond to this question.

Of the eighteen respondents who reported the duration of the sexual contact, almost half (44%) reported that the sexual contacts had been once-only encounters. Four had lasted

for less than three months, and two had lasted for between three and eleven months. Four had endured for more than five years. Two individuals did not respond to this question.

Over half of those who responded (10/19) to the question relating to current contact with the last patient with whom sexual involvement had occurred, reported that they had no current contact whatsoever with the patient. Three had continued social contact with the patient, but no sexual or therapeutic contact. Two had continued therapeutic contact with the patient, but no sexual contact, one had continued therapeutic and sexual contact with the patient and three were married to or in a committed relationship with the patient. Almost half of those who responded (8/18) to the question concerning their current feelings about the sexual contact expressed concerns about it at the time of completing the questionnaire. Ten out of 18 of those who had sexual contact with patients were unconcerned about it at the time of responding. Two respondents did not state whether or not they were now concerned about the matter.

In sum, 60% of the respondents who reported sexual contact with their patients were male, thirty five percent were female, and five percent did not specify their gender. Eighty five percent of this group had been sexually involved with more than one patient, while the rest acknowledged involvement with two or more patients. Fifty five percent of these sexual contacts occurred between a male clinical psychologist and a female patient. Among those respondents who reported multiple sexual involvements with their patients, half were male and half were female. This picture is somewhat different to that obtained in a recent North American survey (Gartrell et al, 1986), mainly in respect of

gender differences. Gartrell et al (1986) report that their sample included more male respondents reporting sexual contact with their patients (89% compared with 60% in this sample). In the present study there were fewer male therapist-female patient pairs than in Gartrell et al's sample (55% and 88% respectively). In Gartrell et al's (1986) survey, all of the respondents reporting multiple sexual contacts were male: in the present study, half were male and half were female. Rather more of the present sample had been sexually involved with more than one patient (85% compared with 66% in Gartrell et al's study).

It is difficult to draw any firm conclusions about differences between the present British sample of clinical psychologists who report sexual contact with their patients, and the samples drawn from North American populations. There are a variety of reasons for this, including the paucity of surveys in the U.K., lack of knowledge about the behaviour of a variety of British mental health professions in respect of sexual contact with patients, and possible changes over time in reporting practices by men and women. Further research is required in Britain to identify any differences which there may be between different countries in respect of therapist-patient sexual contact, and, in particular, to pinpoint whether the assumptions made on the basis of research carried out in North America are applicable to mental health professions in the U.K. The data from this study suggest that there may be some grounds to suspect that there may be some differences between the experience of the two countries.

#### 4.7. ATTITUDES TOWARDS, AND PREVALENCE OF, EDUCATOR-STUDENT SEXUAL CONTACT

Twenty per cent of respondents believed that trainees could benefit from sexual contact with a lecturer or supervisor. This is a high proportion and this may be accounted for by respondents' interpretation of the question; for example, some mentioned receiving high marks as a benefit for trainees. 5.6% did not respond to this question. Considerably fewer of those in an educative role (2.9%) reported actually engaging in sexual contact with trainees/students than the 20% of the sample which believed that such contact could be beneficial. This contrasts with Pope et al's (1979) finding that five times as many psychologists reported sexual contact with their students, as believed that such contact could be beneficial to students.

Overall, 6.9% of the sample reported sexual contact as an undergraduate with a lecturer or tutor and 6.7% had engaged in sexual contact with a lecturer/tutor or supervisor, as a trainee clinical psychologist. There is little overlap between those respondents in each group. Those who reported sexual contact as an undergraduate comprised 39 out of 581, and those who reported sexual contact with an educator as a postgraduate numbered 40 out of 581. Of these, only eight reported such sexual contact both as an undergraduate and as a postgraduate. Lower rates of educator-student sexual contact were found by Thoreson et al (1993) who report that 1.7% of their respondents had sexual contact with a teacher and 1.6% with a supervisor. However, there is reason to suspect that female students are more likely to experience sexual contact with educators (Pope et al, 1979) than are male students and this may explain the discrepancy between the present study

and that of Thoreson et al (1993) in this respect, since Thoreson et al's (1993) sample consisted entirely of male counsellors.

These findings are shown in table 4.19 with detail relating to gender of the respondents. The table suggests that a greater proportion of women had sexual contact as students, both undergraduate and postgraduate, with their educators than men, but rather more male than female educators had sexual contact with their students.

**Table 4.19. Relationship between educator-trainee sexual contact and gender of respondent (Percentages: frequencies are given in parentheses)**

Gender of respondent	Undergraduate sexual contact	Postgraduate sexual contact	Sexual contact as educator
Male	38.2 (218)	38.3 (219)	59.6 (273)
Female	61.8 (353)	61.7 (353)	40.4 (185)
Total	100 (571)	100 (572)	100 (458)

For all of the categories of sexual contact with educators shown in table 4.19, there were statistically significant differences between male and female respondents in their experience of such contact. Chi square analyses showed that female respondents were more likely than male respondents to report sexual contact with an educator as undergraduates ( $\chi^2 = 17.152$ ;  $df = 1$ ;  $p < 0.00004$ ), and as postgraduates ( $\chi^2 = 5.11668$ ;  $df = 1$ ;  $p < 0.0237$ ). Male respondents were more likely than female respondents ( $\chi^2 = 12.1596$ ;  $df = 2$ ;  $p < 0.0023$ ) to report sexual contact as educators, with students/trainees. 2.9% of lecturers/supervisors in the present sample had had sexual contact with their trainees/undergraduates. In Thoreson et al's (1993) sample, by contrast, 16% reported

sexual contact with one or more of their students or supervisees. The latter finding is likely, however, to have been influenced by Thoreson et al's (1993) exclusively male sample and perhaps by the different professions targeted in the present in the present study (clinical psychologists) and that of Thoreson et al (1993) (counsellors).

Only 0.7% of those respondents who had undertaken personal therapy had experienced sexual contact with their personal therapist. This finding is broadly similar to that reported by Thoreson et al (1993) in their sample of male counsellors (0.9%).

#### **4.8. TREATMENT OF PATIENTS SEXUALLY INVOLVED WITH PREVIOUS THERAPISTS**

Almost a quarter (22.7%) of respondents had treated patients who had been sexually involved with previous therapists. This figure is not dissimilar to that reported by Kuchan (1989) who found that in a survey of therapists in Wisconsin, 19.9% reported such knowledge. Only one of these psychologists rated the effects of the sexual involvement as positive, whereas 91% believed that it had negative effects on the patient. 8.2% viewed the effects as "mixed". It is likely that these figures represent an under-estimate of the number of actual cases of therapist-patient sexual contact since it is unlikely that therapists would always be aware of their patients' sexual contact with former therapists.

Respondents were asked to identify the professional background of the previous therapists who had been sexually involved with their patients and this information is given in table 4.20.

**Table 4.20. Professional background of therapists who had been sexually involved with respondents' patients** (Percentages in this table do not total 100% as respondents could report in more than one category)

<b>Profession of therapist alleged to have been sexually involved with patients</b>	<b>Percentage of respondents reporting this profession</b>
Psychiatrists	28
Private sector psychotherapists	28
"Other" therapists	28
Nurses	25
Social workers	20.5
Clinical psychologists	18.9
Counsellors	11.4
Voluntary agency therapists	7.7
Unknown therapists	4.5

Psychiatrists, private sector psychotherapists and "other" therapists were equally the groups most frequently reported by respondents to have been sexually involved with respondents' patients. It is likely, however, that the categories "other" and private sector psychotherapists cover a wide variety of professionals and non-professionals and these results are therefore difficult to interpret. In addition, counsellors and voluntary sectors therapists are likely to be relatively less common than some of the other categories in this question. Psychiatrists, nurses and social workers, however, are numerous and this may account for their frequency in this category.

Of these previous therapists who had been sexually involved with the patients seen by respondents, 45.3% had not been reported to an appropriate authority. Respondents were

uncertain in this respect about 27.7% of the previous therapists. 27% had been reported in some way. However, some of these patients may have been seen by more than one respondent, and therefore the same sexual dyad may be represented more than once. The above figures on reporting, therefore, should be interpreted with this in mind.

#### **4.9. RESPONDENTS' KNOWLEDGE THROUGH SOURCES OTHER THAN PATIENTS, OF CLINICAL PSYCHOLOGISTS WHO HAD BEEN SEXUALLY INVOLVED WITH PATIENTS**

Over 38% of respondents knew through sources other than their own patients, of clinical psychologists who had been sexually involved with patients. Of these, 63% knew of one such psychologist, 27% knew of two, 5% knew of three, 1.8% knew of four, and 0.5% knew of five. A further 0.5% reported knowledge of six clinical psychologists who had been sexually involved with their patients, and 0.5% of seven.

Just over half (59.5%) of these clinical psychologists known to respondents had been sexually involved with only one patient, and 40.4% had been involved with more than one. 12.9% of respondents who knew of such psychologists had taken action to prevent the continuation of such contacts (e.g. to report the contact or to discuss the matter with the psychologist concerned).

It is likely that a number of psychologists who have transgressed the sexual boundary in therapy are known to more than one respondent, especially those who have been reported to their employer or the British Psychological Society. This is likely to have influenced the percentage of respondents reporting knowledge of colleagues in this

category and thus the high proportion of respondents reporting in this category is likely to over-estimate the true prevalence of sexual contact between clinical psychologists and their patients.

Respondents' knowledge of the reporting status of these sexual contacts to appropriate authorities are given in table 4.21.

**Table 4.21. Reporting status: Clinical psychologists who had been sexually involved with patients** (Each cell denotes percentage of the 221 respondents who knew of clinical psychologists through sources other than their own patients, who had been sexually involved with at least one patient)

Reporting status	Percentage of clinical psychologists
Reported	54.6
Not reported	26.7
Uncertain whether or not reported	18.7
Total	100

The data in table 4.21 show that whilst the majority of clinical psychologists known in this way to respondents had been reported to an appropriate authority, over a quarter had not been reported and in over 18% of cases, respondents were uncertain whether reporting had occurred. Since sexual contact with patients is a clear breach of the British Psychological Society Code of Conduct (1991), it is of concern that so many cases had not been reported, particularly as this suggests that many psychologists are unaware of their professional duty in this respect.

#### 4.10. RELATIONSHIP BETWEEN SEXUAL CONTACT WITH PATIENTS AND OTHER VARIABLES

Since there were only 20 respondents who admitted sexual contact with at least one of their patients, the statistical tests used to establish differences between that subgroup and the sample will lack discriminatory power, and the results must therefore be interpreted with caution.

Table 4.22 below shows, for the whole sample, a breakdown by gender category of whether or not respondents had ever engaged in sexual contact with a patient.

**Table 4.22. Relationship between gender and sexual contact with patients**

(Percentages: frequencies are given in parentheses)

Gender of respondent	Sexual contact with patients	No sexual contact with patients
Male	68.4 (13)	37.5 (206)
Female	36.8 (7)	62.5 (344)
Combined	100% (20)	100% (550)

Chi square analysis of the data in table 4.22 showed a significant difference ( $\chi^2 = 5.13$ ;  $df = 1$ ;  $p < 0.0235$ ) in respect of gender between those who were sexually involved with their patients, and those who were not. Whilst approximately three quarters of the group who did not engage in sexual contact were female and a quarter were male, the reverse is true for those who did engage in sexual contact with their patients

The modal and median age of those respondents who had engaged in sexual contact with patients was 42 (range 35 - 66). This compares with a figure for both statistics of 37 for those who had not done so (range 24 - 78). These data were analysed using a Mann-Whitney U test since the data for respondents' ages are not normally distributed ( $\chi^2 = 117.9622$ ;  $df = 21$ ;  $p < 0.01$ ),  $U = 3525.500$ ;  $p = 0.014$ . This shows that the respondents who reported sexual contact with their patients were significantly older than those who did not report such contact.

Eight of the respondents who had engaged in sexual contact with their patients were married, six were in a stable relationship, five were single and one was separated/divorced. Table 4.23 shows these figures in percentage terms and compares this group with those respondents who did not engage in sexual contact with their patients.

**Table 4.23. Relationship between marital status and sexual contact with patients**

(Percentages: frequencies are given in parentheses)

Marital status	Sexual contact with patients	No sexual contact with patients
Single	25 (5)	12.3 (68)
Married	40 (8)	62 (343)
In a stable relationship	30 (6)	20.6 (114)
Separated/divorced	5 (1)	4.3 (24)
Widowed	0	0.7 (0.7)
Total	100% (20)	100% (553)

Chi square analysis of the data in table 4.23 showed that there was a significant difference in respect of marital status between those who had engaged in sexual contact with their patients, and those who had not ( $\chi^2 = 42.66$ ;  $df = 8$ ;  $p < 0.00005$ ). There is a much more even distribution of respondents between the three main categories, of single, married and "in a stable relationship", in the group of respondents who had sexual contact with their patients than in the group which had not. The largest group of those who had had sexual contact with patients were married, but substantial proportions were either in a stable relationship or were single.

Most of the group reporting sexual contact with their patients identified their sexual orientation as heterosexual (15), with four categorising themselves as homosexual and one as bisexual. The table below expresses these figures in percentages and offers a comparison with the rest of the sample.

**Table 4.24. Relationship between sexual orientation and sexual contact with patients** (Percentages: frequencies are given in parentheses)

Sexual orientation	Sexual contact with patients	No sexual contact with patients
Heterosexual	75 (15)	97.5 (543)
Bisexual	5 (1)	1.4 (8)
Homosexual	20 (4)	1.1 (6)
Total	100% (20)	100% (557)

Chi square analysis of the data in table 4.24 suggests that there is a significant difference ( $\chi^2 = 42.79$ ;  $df = 4$ ;  $p < 0.00005$ ) in respect of sexual orientation between those respondents who had had sexual contact with their patients and those who had not. Whilst the majority of respondents in each of the groups were heterosexual, 20% of those who had sexual contact with patients were homosexual, whereas only 1.1% of those who had not had sexual contact with patients were homosexual.

Table 4.25 below shows the sexual orientation and gender of those respondents who had engaged in sexual contact with their patients.

**Table 4.25. Relationship between gender and sexual orientation of respondents who had engaged in sexual contact with their patients (n=20=100%)** (Each cell denotes a percentage of the group which reported sexual contact with patients: frequencies are given in parentheses)

Gender of respondent	Sexual orientation of respondent		
	Homosexual	Heterosexual	Bisexual
Male	10 (2)	55 (11)	0
Female	10 (2)	20 (4)	5 (1)

The data in table 4.25 show that heterosexual men are the largest group among those who had engaged in sexual contact with their patients and that there were no bisexual men in this category. Men and women are equally represented in the homosexual category and 35% of the respondents who had sexual relations with their patients were female. When homosexual and bisexual orientations are considered together as one

category, and compared with heterosexual orientation, chi square analysis shows that there is no significant difference in sexual orientation in respect of gender (Yates' corrected  $\chi^2 = 0.66$ ;  $df = 1$ ; Fisher's exact  $p < 0.2068$ ).

The majority of those respondents reporting sexual contact with their patients had not engaged in personal therapy (55%) but a substantial minority had done so (40%). Only 44% of the whole sample reported experience of personal therapy. Chi square analysis of these data showed that those who reported sexual contact with their patients were more likely to have experienced personal therapy ( $\chi^2 = 223.8195$ ;  $df = 1$ ;  $p < 0.0000005$ ) than those who did not report such contact. This would support the finding of Gartrell et al (1986) that those who reported sexual contact with their patients were more likely to have had personal therapy but it is unclear when such personal therapy took place, that is, before or after the commencement of sexual contact.

The median number of hours per week spent in face to face patient contact by the group having sexual contact with patients was 12 (range 1 - 25). For the sample as a whole, this figure was 14 (range 0 - 60). Mann-Whitney analysis of these data ( $U = 5400.0$ ;  $p = 0.9776$ ) showed that there was no significant difference between the two groups in this respect.

All but one of the psychologists reporting sexual contact with their patients were mainly employed in the N.H.S. One was mainly in private practice and one did not respond to this question. These data are shown in table 4.26.

**Table 4.26. Relationship between respondents' main worksetting and sexual contact with patients (Percentages: frequencies are given in parentheses)**

Main worksetting	Sexual contact with patients	No sexual contact with patients
N.H.S.	94.7 (18)	89.9 (494)
Private practice	5.3 (1)	3.8 (21)
Social Services	0	0.9 (5)
Voluntary Agency	0	0.7 (4)
Other	0	4.5 (25)
Total	100% (19)	100% (549)

Chi square analysis of the data in table 4.26 showed no significant difference ( $\chi^2 = 8.12$ ;  $df = 8$ ;  $p > 0.4223$ ) in respect of work setting between those who reported sexual contact with their patients, and those who did not. Those who had sexual contact with their patients were all employed mainly in the NHS or private practice and none in other settings, whereas more variety was evident in respect of main work setting in the respondents who had not engaged in sexual intimacy with patients.

Table 4.27 below shows the distribution of respondents in the two groups according to clinical specialty.

**Table 4.27. Relationship between respondents' main area of clinical work and sexual contact with patients (Percentages: frequencies are given in parentheses)**

Main area of clinical work	Sexual contact with patients	No sexual contact with patients
Adult mental health	70 (14)	54.8 (299)
Children	0	14.8 (81)
Learning difficulties	10 (2)	13 (71)
Elderly	10 (2)	5.1 (28)
Physical health	5 (1)	3.7 (20)
Neuropsychology	0	4 (22)
Other	5 (1)	4.6 (25)
Total	100% (20)	100% (546)

The data in table 4.27 show that none of the those reporting sexual contact with their patients worked mainly with children or in neuropsychology. A number of possible explanations for this finding suggest themselves. For example, as a consequence of its emphasis on psychometric testing, neuropsychology practice may not lend itself to the physical or therapeutic intimacy which is frequently present during therapeutic work. To seek sexual contact with a child patient would involve the transgression of numerous taboos, and is therefore less likely to be less frequent than sexual contact with adult patients, or simply not reported. Whilst those therapists engaging in sexual contact with adults may not always view their actions as inappropriate in any way, it is likely that any therapist engaging in sexual contact with a child would be aware of the unequivocally abusive quality of such a contact (Finkelhor, 1984).

By contrast, broadly similar percentages of the two groups worked in adult mental health, (though this specialty is somewhat over-represented among those who had sexual contact with their patients), and in learning difficulties, physical health and with "other" patient groups. Chi square analysis of these data showed no significant difference ( $\chi^2 = 8.12$ ;  $df = 8$ ;  $p > 0.4223$ ) between the two groups in respect of clinical specialty.

The median length of postqualification practice as a clinical psychologist for those who reported sexual involvement with a patient or patients was 16 years. For the sample as a whole, the median length of postqualification practice was 10 years. Chi square analysis of these data shows a significant difference ( $\chi^2 = 47.64$ ;  $df = 36$ ;  $p < 0.0929$ ) between those respondents reporting sexual contact with their patients and those who did not, in that those respondents reporting sexual contact with their patients were more likely to have practiced for a longer period of time than those who did not report such contact. A box and whisker plot of these two variables is given in Appendix 3. This illustrates that the group reporting sexual contact with patients had been qualified for longer than the group which did not report such contact.

The following tables give details for those who were sexually involved with their patients and those who were not, of the importance of a variety of therapeutic orientations to respondents. These tables suggest that behavioural and cognitive interventions are reported as less important as a primary influence on therapeutic practice, by those respondents who have been sexually involved with their patients. By contrast, systemic approaches are considered more important by this group as a primary influence than for those respondents who were not sexually involved with their patients.

None of these differences were, however, statistically significant. Humanistic approaches are almost twice as important as the primary therapeutic influence for those respondents who were sexually involved with their patients. This difference was statistically significant. Psychodynamic approaches were cited as almost equally important as a primary influence, for both groups. In the following tables, Mann-Whitney analyses were computed since the raw variables form an ordinal scale.

**Table 4.28. Relationship between the importance of psychodynamic therapeutic orientation and sexual contact with patients** (Percentages: frequencies are given in parentheses)

<b>Importance of psychodynamic orientation</b>	<b>Sexual contact with patients</b>	<b>No sexual contact with patients</b>
None	60 (12)	48.5 (269)
Primary	20 (4)	19.5 (108)
Secondary	5 (1)	11.2 (62)
Tertiary	15 (3)	20.7 (115)
Total	100% (20)	100% (555)

Mann Whitney analysis of the data in table 4.28 ( $U = 5008.5$ ;  $p < 0.465737$ ) showed no significant difference between those respondents who reported sexual contact with their patients, and those who did not, in respect of the importance of psychodynamic therapeutic orientation.

**Table 4.29. Relationship between the importance of behavioural therapeutic orientation and sexual contact with patients (Percentages: frequencies are given in parentheses)**

<b>Importance of behavioural orientation</b>	<b>Sexual contact with patients</b>	<b>No sexual contact with patients</b>
None	35 (7)	29.4 (163)
Primary	5 (1)	13.7 (76)
Secondary	40 (8)	26.8 (149)
Tertiary	20 (4)	29.9 (166)
Total	100% (20)	100% (555)

Mann Whitney analysis of the data in table 4.29 ( $U = 5298.5$ ;  $p < 0.740315$ ) shows no significant difference between those respondents who reported sexual contact with their patients, and those who did not, in respect of the importance of behavioural therapeutic orientation.

**Table 4.30. Relationship between the importance of cognitive therapeutic orientation and sexual contact with patients (Percentages: frequencies are given in parentheses)**

<b>Importance of cognitive orientation</b>	<b>Sexual contact with patients</b>	<b>No sexual contact with patients</b>
None	30 (6)	24.0 (133)
Primary	5 (1)	11.9 (66)
Secondary	20 (4)	31.4 (174)
Tertiary	45 (9)	32.6 (181)
Total	100% (20)	100% (555)

Mann Whitney analysis of the data in table 4.30 ( $U = 4535.5$ ;  $p < 0.168029$ ) shows no significant difference between those respondents who reported sexual contact with their patients, and those who did not, in respect of the importance of cognitive therapeutic orientation.

**Table 4.31. Relationship between the importance of systemic therapeutic orientation and sexual contact with patients (Percentages: frequencies are given in parentheses)**

<b>Importance of systemic orientation</b>	<b>Sexual contact with patients</b>	<b>No sexual contact with patients</b>
None	75 (15)	58.7 (326)
Primary	15 (3)	17.8 (99)
Secondary	5 (1)	11 (61)
Tertiary	5 (1)	12.2 (68)
Total	100% (20)	100% (555)

Mann Whitney analysis of the data in table 4.31 ( $U = 4743.0$ ;  $p < 0.274043$ ) shows no significant difference between those respondents who reported sexual contact with their patients, and those who did not, in respect of the importance of systemic therapeutic orientation.

**Table 4.32. Relationship between the importance of humanistic therapeutic orientation and sexual contact with patients** (Percentages: frequencies are given in parentheses)

<b>Importance of humanistic orientation</b>	<b>Sexual contact with patients</b>	<b>No sexual contact with patients</b>
None	40 (8)	64.3 (357)
Primary	30 (6)	15.7 (87)
Secondary	15 (3)	10.6 (59)
Tertiary	15 (3)	9.2 (51)
Total	100% (20)	100% (555)

Mann Whitney analysis of the data in table 4.32 ( $U = 4129.0$ ;  $p < 0.052817$ ) shows that there is a significant difference between those respondents who reported sexual contact with their patients, and those who did not, in respect of the importance of humanistic therapeutic orientation. Those who reported sexual contact with their patients were more likely to report humanistic orientation as of relevance to their therapeutic practice, and in particular were almost twice as likely to report that influence as having the first influence on their approach to therapy.

**Table 4.33. Relationship between the importance of other therapeutic orientations and sexual contact with patients (Percentages: frequencies are given in parentheses)**

Importance of other orientations	Sexual contact with patients	No sexual contact with patients
None	85 (17)	90.4 (501)
Primary	0	3.2 (18)
Secondary	5 (1)	1.3 (7)
Tertiary	10 (2)	5.1 (28)
Total	100% (20)	100% (554)

Mann Whitney analysis of the data in table 4.33 ( $U = 5259.0$ ;  $p < 0.699759$ ) shows no significant difference between those respondents who reported sexual contact with their patients, and those who did not, in respect of the importance of "other" therapeutic orientations.

**Table 4.34. Relationship between respondents' treatment of patients who were sexually involved with previous therapists and sexual contact with patients (Percentages: frequencies are given in parentheses)**

	Sexual contact with patients	No sexual contact with patients
Treated patients who had sexual contact with previous therapist	35 (7)	22.4 (124)
Has not treated patients who had sexual contact with previous therapist	65 (13)	77.6 (429)
Total	100% (20)	100% (553)

Chi square analysis of the data in table 4.34 shows that there is no significant difference ( $\chi^2 = 1.73$ ;  $df = 1$ ;  $p > 0.1883$ ) in respect of experience of treating patients who had experienced sexual contact with a previous therapist, between those respondents who had themselves had sexual contact with their own patients, and those who had not. It is clear, however, that a substantial minority of both respondents who had had sexual contact with their patients, and those who had not, had treated patients who had been sexually involved with a previous therapist. This constitutes a figure approaching a quarter for the "non-offender" group but the figure is over a third for the "offender" group.

Table 4.35 summarises respondents' differential use of various types of physical contact with patients and its relationship to sexual contact with patients.

**Table 4.35. Relationship between differential use of various forms of physical contact, and sexual contact with patients (Percentages: frequencies are given in parentheses)<sup>2</sup>**

	Sexual contact with patients (n=20)	No sexual contact with patients	Chi square statistics
Holds hands differentially with male and female patients	10 (2)	14.6 (82)	$\chi^2 = 0.35$ ; df = 1; p>0.5564
Pats the arm of male and female patients differentially	5 (1)	13.4 (75)	$\chi^2 = 0.21$ ; df = 1; p>0.2714
Hugs male and female patients differentially	15 (3)	21.1 (119)	$\chi^2 = 0.47$ ; df = 1; p>0.4934
Differential use of touching arm/shoulder for male and female patients	5 (1)	17.6 (99)	$\chi^2 = 2.20$ ; df = 1; p<0.2 *
Shakes hands with male and female patients differentially	0	3 (17)	$\chi^2 = 0.63$ ; df = 1; p>0.4277
Differential use of other forms of physical contact with male and female patients	20 (4)	2.5 (14)	$\chi^2 = 19.56$ ; df = 1; p< 0.000057 *

The data in table 4.35 show that respondents who had sexual contact with patients were significantly more likely to employ "other" forms of physical contact with patients, than were those respondents who did not engage in sexual contact with their patients. Perhaps

<sup>2</sup> Where Chi square statistics are asterisked, this indicates a significant difference.

this latter finding is unsurprising. Respondents were asked to specify the nature of "other" forms of physical contact used with patients, and when this information was given by those who reported sexual contact with patients, it was clear that forms of physical contact were reported (e.g. kissing, cuddling and massage) which usually have sexual connotations in Western culture. Respondents who did not report sexual contact with their patients were more likely to employ differential touching of the arm/shoulder of male and female patients than those respondents who did report such sexual contact. This is somewhat complex to interpret in view of the high proportion of homosexual respondents among the group reporting sexual contact with their patients. However, for no other form of physical contact was there a significant difference between the two groups' treatment of male and female patients.

Table 4.36 shows the relationship between sexual attraction towards, and sexual contact with patients.

**Table 4.36. Relationship between sexual attraction towards, and sexual contact with, patients** (Percentages: frequencies are given in parentheses)

	<b>Sexual contact with patients</b>	<b>No sexual contact with patients</b>
<b>Sexual attraction towards patients</b>	80 (16)	60.7 (337)
<b>No sexual attraction towards patients</b>	20 (4)	39.3 (218)
<b>Total</b>	100% (20)	100% (555)

Chi square analysis of the data in table 4.36 shows that there is no statistically significant difference ( $\chi^2 = 3.03$ ;  $df = 1$ ;  $p > 0.0820$ ) in respect of experience of sexual attraction to patients, between those respondents who reported sexual contact with their patients, and those who did not.

One would expect that the majority of those who engaged in sexual contact with their patients, would also experience sexual attraction to them. Of the 20 respondents who had engaged in sexual contact with their patient(s), the majority (16) stated that they had been sexually attracted to their patient(s). Interestingly, four stated that they had not. Such cases may be explicable in similar terms to those discussed in Section 4.6 for those respondents in this group who did not believe that patients could benefit from sexual contact with their therapist.

Table 4.37 shows the relationship between respondents' sexual contact with patients and the effect that sexual attraction had on therapy.

**Table 4.37. Relationship between respondents' sexual contact with patients and the effect that sexual attraction to patients had on therapy** (Percentages: frequencies are given in parentheses) The figures given in this table refer only to those respondents who reported sexual attraction to their patients.

Perceived effect on therapy of sexual attraction	Sexual contact with patients	No sexual contact with patients
Mainly adverse effects	18.8 (3)	11.3 (36)
Little or no effect	56.3 (9)	69.9 (223)
Mainly positive effects	25 (4)	18.8 (60)
Total	100% (16)	100% (319)

Chi square analysis of the data in table 4.37 shows that there is no significant difference ( $\chi^2 = 1.44$ ;  $df = 2$ ;  $p > 0.4855$ ) in respect of the effect which respondents believed that their sexual attraction towards patients had on the therapy, between those who reported sexual attraction towards patients and those who did not.

Table 4.38 shows the relationship between respondents' current feelings about sexual attraction towards patients, and sexual contact with patients.

**Table 4.38. Relationship between respondents' current feelings about sexual attraction towards patients and sexual contact with patients (Percentages: frequencies are given in parentheses)<sup>3</sup>**

<b>Current feelings about the sexual attraction</b>	<b>Sexual contact with patients</b>	<b>No sexual contact with patients</b>
Unconcerned	68.4 (13)	53.3 (289)
Concerned	10.5 (2)	6.3 (34)
Not applicable	21.1 (4)	40.4 (219)
Total	100% (19)	100% (542)

Chi square analysis of the data in table 4.38 shows that there is no significant difference ( $\chi^2 = 3.02$ ;  $df = 2$ ;  $p > 0.2204$ ) in respect of current feelings about sexual attraction towards patients.

Table 4.39 shows responses across the whole sample to the question of whether patients can benefit from sexual contact with patients, in relation to the sexual contact variable.

<sup>3</sup> The figures given in this table refer to the entire sample since those who had not experienced sexual attraction to patients comprise the "not applicable" group.

**Table 4.39. Relationship between respondents' view of potential benefit to patients from sexual contact with therapists, and sexual contact with patients (Percentages: frequencies are given in parentheses)**

	<b>Sexual contact with patients</b>	<b>No sexual contact with patients</b>
Benefit possible from sexual contact	20 (4)	3.1 (17)
No benefit possible from sexual contact	80 (16)	96.9 (529)
Total	100% (20)	100% (546)

Chi square analysis of the data in table 4.39 shows a significant difference ( $\chi^2 = 15.39$ ;  $df = 1$ ;  $p < 0.00005$ ) in respect of whether or not patients can benefit from sexual contact with therapists, between those who reported sexual contact with patients, and those who did not. Those who reported sexual contact with patients were more likely to believe that patients could benefit from such contact, than those who did not report sexual contact with patients.

When respondents' views of whether trainees could benefit from sexual contact with educators are considered in relation to whether they report sexual contact with their own patients, it emerged that 42.1% of those who reported such sexual contact did consider sexual contact between trainers and trainees to be potentially beneficial to the trainee. Only 21.1% of those who had not engaged in sexual contact with their patients took this view.

**Table 4.40. Relationship between respondents' view that trainees can benefit from sexual contact with an educator and sexual contact with patients** (Percentages: frequencies are given in parentheses)

	Sexual contact with patients	No sexual contact with patients
Belief that trainees would benefit from sexual contact with trainer	42.1 (8)	21.1 (111)
Belief that trainees would not benefit from sexual contact with trainer	57.9 (11)	78.9 (416)
Total	100% (19)	100% (527)

Chi square analysis of the data in table 4.40 showed that the difference discussed above between those respondents who had sexual contact with their patients and those who did not, in terms of their view of whether trainees would benefit from sexual contact with a trainer is statistically significant ( $\chi^2 = 25078.17$ ;  $df = 576$ ;  $p < 0.0000$ ).

Whilst the majority, both of those who reported sexual contact with their patients, and those who did not, had experienced no sexual contact with an educator at any stage in their professional training, 35% of those who reported sexual contact with their own patients as compared with 5.7% of the group with no history of sexual contact with patients, had experienced sexual contact as a postgraduate with an educator.

**Table 4.41. Relationship between sexual contact with an educator as a postgraduate and sexual contact with patients** (Percentages: frequencies are given in parentheses)

Sexual contact as postgraduate with educator	Sexual contact with patients	No sexual contact with patients
Yes	35 (7)	5.7 (32)
No	65 (13)	94.3 (525)
Total	100% (20)	100% (557)

Chi square analysis of the data in table 4.41 showed that there is a statistically significant difference ( $\chi^2 = 26.22$ ;  $df = 1$ ;  $p < 0.00005$ ) in respect of sexual contact as a postgraduate with an educator, between those who reported sexual contact with a patients, and those who did not. Those reporting sexual contact with patients were more likely to have had postgraduate sexual contact with an educator than those who did not report such sexual contact with patients.

As undergraduates, 20% of those reporting sexual contact with their own patients had sexual contact with educators, and 6.5% of those who had no sexual contact with patients had such sexual contact with educators as undergraduates.

**Table 4.42. Relationship between sexual contact with an educator as an undergraduate and sexual contact with patients** (Percentages: frequencies are given in parentheses)

	<b>Sexual contact with patients</b>	<b>No sexual contact with patients</b>
Sexual contact as undergraduate with educator	20 (4)	6.5 (36)
No sexual contact as undergraduate with educator	80 (16)	93.5 (520)
<b>Total</b>	<b>100% (20)</b>	<b>100% (556)</b>

Chi square analysis of the data in table 4.42 ( $\chi^2 = 5.46$ ;  $df = 1$ ;  $p < 0.0194$ ) showed that there is a statistically significant difference in respect of sexual contact as an undergraduate with educators, between those respondents who reported sexual contact with patients, and those who did not, that is, those who had sexual contact with patients were more likely to have experienced sexual contact with an educator as an undergraduate than those not reporting sexual contact with patients.

Table 4.43 shows that as trainers/educators (where this was relevant), the percentages of those in each group who had engaged in sexual contact with their own trainees/students were not markedly different (5.3% and 2.9% respectively for those who reported sexual contact with patients and those who did not).

**Table 4.43. Relationship between sexual contact as a lecturer/supervisor with students and sexual contact with patients (Percentages: frequencies are given in parentheses)**

Respondents' sexual contact as a trainer with trainees/students	Sexual contact with patients	No sexual contact with patients
Yes	5.3 (1)	2.9 (16)
No	84.2 (16)	78.4 (429)
Not applicable	10.5 (2)	18.6 (102)
Total	100% (19)	100% (547)

Chi square analysis of the data in table 4.43 showed that there is no statistically significant difference ( $\chi^2 = 1.07$ ;  $df = 2$ ;  $p > 0.5853$ ) in respect of sexual contact with trainees/students between those who report sexual contact with patients, and those who do not.

Table 4.44 shows that none of those respondents who had engaged in sexual contact with patients and had received personal therapy, had engaged in sexual contact with their therapist, but a small percentage (1.3%) of the respondents with personal therapy experience but no background of sexual contact with patients had experienced such sexual contact. This is shown in Table 4.44.

**Table 4.44. Relationship between sexual contact with personal therapist and sexual contact with patients (Frequencies are given in parentheses)**

	Sexual contact with patients	No sexual contact with patients
Sexual contact with personal therapist	0	1.3 (7)
No sexual contact with personal therapist	45 (9)	44.6 (246)
Not applicable	55 (11)	53.9 (297)
Total	100% (20)	100% (551)

Chi square analysis of the data in table 4.44 showed no significant difference ( $\chi^2 = 0.14$ ;  $df = 2$ ;  $p > 0.9287$ ) in respect of sexual contact with personal therapist between those who had sexual contact with a patient, and those who did not.

None of those respondents who had themselves been sexually involved with patients and who had treated patients sexually involved with a previous therapist (7) reported that the latter sexual contact had a positive effect upon the patient. However, 65% of the respondents who reported sexual contact with their own patients had not treated a patient reporting sexual contact with a previous therapist. Previous studies have found that those who have engaged in sexual contact with their patients are less likely than therapists not reporting sexual contact with their patients to report negative effects on patients of sexual contact with therapists (Holroyd and Bouhoutsos, 1985). This finding was clearly not supported by data from the present study.

#### 4.11. SUMMARY

The sample appears to have many similarities to the Division of Clinical Psychology as a whole in respect of age, gender and mean length of post-qualification practice, and a larger study of the Division of Clinical Psychology in respect of therapeutic orientation. However, it differs from the Division as a whole in that those who had experienced personal therapy were over-represented. The majority of respondents were married or in a stable relationship and were heterosexual. Most worked with adult patients in the N.H.S. Cognitive and behavioural therapeutic orientations were the most commonly cited influences on respondents' clinical practice. Uncontroversial forms of physical contact were commonly used in therapy, largely irrespective of gender of therapist and patient. The majority of respondents acknowledged sexual attraction towards their patients, men more so than women. Most believed that this attraction had little or no effect on therapy. Sexual contact with patients was reported by only a small minority of respondents and most of these respondents did not believe that such contact could benefit patients. The majority of such cases involved only one patient and most involved discharged patients only. Most of these contacts were heterosexual and had previously been disclosed. Most respondents who reported sexual contact with patients regarded it as consenting and unexploitative and the majority were unconcerned about the contact. Almost half of these contacts were one-off encounters, and in a similar proportion of cases, there was no current contact between therapist and patient. It appears that the gender breakdown of the subsample of therapists reporting sexual contact with their patients differs from North American samples in that there were more

female therapists reporting sexual contact with patients, particularly multiple sexual involvements, than in other studies.

Educator-student sexual contact was reported rather more frequently than therapist-patient sexual contact, by approximately 13% of the sample, with such educators being more likely to be male and such students female. Almost a quarter of respondents had treated patients sexually involved with previous therapists of a variety of professions, and almost 40% knew through sources other than their own patients of clinical psychologists who had been sexually involved with patients. A substantial minority of these cases had not apparently been reported to an appropriate authority.

Statistical analysis showed that respondents reporting sexual contact with their patients were older, more likely to be single, to have engaged in personal therapy, to report a humanistic influence on their therapeutic practice, and to have treated patients who had sexual contact with a previous therapist, than those who did not report such contact.



CHAPTER FIVE

QUANTITATIVE DATA: RESULTS II -  
VARIABLES PREDICTIVE OF SEXUAL  
CONTACT WITH PATIENTS



This chapter describes the results of stepwise and forced entry logistic regression analyses which were conducted on the data set. The rationale for and description of these procedures are discussed in chapter three (section 3.4.1). Variables which were predictive of sexual contact with patients are identified and the results are discussed. Two main sets of analyses were performed, one set on the whole sample, and one set on the sample with trainees removed, for reasons discussed in chapter three (section 3.4.1).

### **5.1. RESULTS FROM WHOLE SAMPLE**

In total, 21 stepwise and forced entry logistic regression analyses were conducted, one on the entire sample, and 20 analyses on the entire sample minus one respondent who had been sexually involved with patients. These 20 respondents were deleted in turn from the data set to give 20 analyses. The rationale for this procedure is given in chapter 3 (section 3.4.1). The dependent variable was whether respondents reported sexual contact with one or more current or discharged patients.

Independent variables entered into the analyses are described in detail in chapter two, but may be summarised as, the age of respondent, the respondent's marital status, the respondent's gender, the respondent's sexual orientation, the respondent's years of postqualification clinical practice, the hours spent per week by respondents in patient contact, the respondent's clinical specialty, the respondent's work setting, the respondent's therapeutic orientation, respondents' experience of personal therapy, respondents' use of physical contact of various types with male and female patients, whether respondents had been sexually attracted to patients, respondents' views of the

effects of such attraction on therapy, and respondents' current feelings about the attraction. In addition, the following were included: whether respondents believed that patients could ever benefit from sexual contact with their therapist, whether respondents believed that trainees could ever benefit from sexual contact with an educator, respondents' experience of sexual contact with educators as undergraduates and as postgraduates, and, where applicable, with a personal therapist, and, if respondents were themselves in an educative role, any sexual contact which they had experienced with their own trainees/students. Finally, whether respondents had treated patients who had been sexually involved with previous therapists was included in the analyses as an independent variable.

For all of the stepwise analyses, five cases were excluded by *SPSS PC+* due to incomplete data. In the forced entry analyses, three cases were excluded by *SPSS PC+* due to incomplete data. None of the excluded cases were those of respondents who reported sexual contact with their patients.

Although some discussion of significant results from the stepwise analyses may be warranted, it should be noted that the logistic regression model used has limited predictive capacity. For nineteen of the twenty one analyses, the model predicted only two of the nineteen cases observed. In one of the analyses, the model predicted only one of the nineteen cases observed. In the analysis of the sample with no cases removed, the model predicted only two of the twenty cases observed. Prediction testing aims to identify which of the respondents will become sexually involved with their patients. The poor predictive capacity of the model used in the logistic regression analyses implies

that if that model were used to attempt to predict which clinical psychologists will become sexually involved with their patients, few actual cases would be predicted and some cases would be falsely predicted. Although the size of the effect of the model used in logistic regression is small, it nonetheless assists the development of an understanding of the reasons why some clinical psychologists engage in sexual contact with their patients, mainly because the level of prediction obtained by the model is greater than chance.

Table 5.1 reports results for all of the 21 analyses undertaken (one on the whole data set, and 20 on the data set with one respondent removed) and shows only those variables which emerged from the logistic regression analyses as predictive of sexual contact with patients in one or more of the analyses. For each variable the results of the initial stepwise and subsequent forced entry logistic regression analyses are given. Variables which were not significant are not listed in the table.

Table 5.1. Stepwise and forced entry logistic regressions: Results (sexual contact with patients is dependent variable)

Variable	Years of clinical practice		Effect on therapy of attraction		Age of respondent		Sexual contact with educator as postgrad.		Sexual orientation	
	Stepwise	Forced entry	Stepwise	Forced entry	Stepwise	Forced entry	Stepwise	Forced entry	Stepwise	Forced entry
Respondent no. removed										
none-overall analysis										
27	*(.04)	*(.04)	*(.05)	*(.05)			*(.0001)	*(.0001)	*(.0001)	*(.0001)
30	*(.04)	*(.04)	*(.03)	*(.03)			*(.00005)	*(.00005)	*(.0029)	*(.0028)
39	*(.04)	*(.03)			*(.05)	*(.05)	*(.0013)	*(.0013)	*(.00005)	*(.00005)
59	*(.04)	*(.04)	*(.05)	*(.05)			*(.00005)	*(.00005)	*(.00005)	*(.00005)
94	*(.04)	*(.04)	#(.05)	#(.05)			*(.0001)	*(.0001)	*(.0002)	*(.0002)
119	*(.04)	*(.04)					*(.0004)	*(.0004)	*(.00005)	*(.00005)
156	*(.04)	*(.04)					*(.00005)	*(.00005)	*(.00005)	*(.00005)
183	*(.04)	*(.04)					*(.00005)	*(.00005)	*(.0013)	*(.0013)
226	*(.04)	*(.04)					*(.00005)	*(.00005)	*(.00005)	*(.00005)
251	*(.04)	*(.04)					*(.00005)	*(.00005)	*(.00005)	*(.00005)
273	*(.03)	*(.03)					*(.00005)	*(.00005)	*(.0001)	*(.0001)
291	*(.04)	*(.04)	*(.04)	*(.04)			*(.00005)	*(.00005)	*(.00005)	*(.00005)
321	*(.04)	*(.04)	*(.03)	*(.03)			*(.0018)	*(.0008)	*(.0001)	*(.0001)
376	*(.04)	*(.04)	*(.03)	*(.03)			*(.0006)	*(.0006)	*(.0001)	*(.0001)
402	*(.04)	*(.03)					*(.00005)	*(.00005)	*(.00005)	*(.00005)
416	*(.03)	*(.03)	*(.04)	*(.04)			*(.00005)	*(.00005)	*(.00005)	*(.00005)
427	*(.04)	*(.04)	*(.05)	*(.05)			*(.0018)	*(.0008)	*(.0001)	*(.0001)
518	*(.04)	*(.04)	*(.05)	*(.05)			*(.00005)	*(.00005)	*(.00005)	*(.00005)
530	*(.04)	*(.04)	*(.05)	*(.05)			*(.0001)	*(.0001)	*(.0001)	*(.0001)
564	*(.04)	*(.04)	*(.05)	*(.05)			*(.0001)	*(.0001)	*(.0001)	*(.0001)

Where a cell is blank, a significant result was not obtained. Where a result is reported, this is either statistically significant ( $p < 0.05$ ) as denoted by an asterisk (\*), or marginally significant ( $p > 0.05$ ) as denoted by a hash symbol (#).

Two variables, sexual contact as a postgraduate with an educator and sexual orientation, were predictive of sexual contact with patients in all of the 21 analyses. Experience of sexual contact with an educator as a postgraduate predicts sexual contact with patients. Homosexual sexual orientation predicts sexual contact with patients rather than heterosexual or bisexual sexual orientation. Number of years of postqualification clinical practice was significant in the overall analysis, and in 15/20 of the analyses. That is, a greater number of years of postqualification clinical practice predicts sexual contact with patients in most of the analyses. In one of the five analyses where that variable was not significant, respondents' age was significant. That is, increasing age predicted sexual contact with patients. In seven of the analyses, the effect which respondents believed their sexual attraction to a patient had exerted on therapy was significant, and in one of the analyses it was marginally significant. That is, in some of the analyses, the belief that experienced sexual attraction to patients had a positive effect on therapy predicted sexual contact with patients. It would be reasonable to conclude that since the latter variable was not consistently predictive of sexual contact with patients, it can be disregarded here.

Sexual contact with an educator as a postgraduate, years of postqualification practice and sexual orientation may hold some predictive value in relation to sexual contact with patients, but this tentative conclusion must be interpreted with considerable caution in view of the lack of predictive value in the model as discussed above.

## 5.2. RESULTS FROM ANALYSES EXCLUDING TRAINEES

In total, 21 stepwise and forced entry logistic regression analyses were conducted, one on the sample with trainees removed, and 20 analyses on the sample with trainees removed minus one respondent who had been sexually involved with patients. These 20 respondents were deleted in turn from the data set to give 20 analyses. Whether respondents admitted to sexual contact with one or more current or discharged patients was the dependent variable. The independent variables were the same as described in section 5.1.

For all of the stepwise analyses, five cases were excluded by *SPSS PC+* due to incomplete data. For the forced entry analyses, three cases were excluded by *SPSS PC+* due to incomplete data. Although some discussion of significant results may be warranted, the logistic regression model used has limited predictive capacity. For eighteen of the twenty one analyses, the model predicted only two of the nineteen cases observed. In two of the analyses, the model predicted only one of the nineteen cases observed, and in the analysis of the sample with no cases removed, the model predicted only one of the twenty cases observed.

A summary of those variables which emerged from these analyses as predictors of sexual involvement with patients, are given in table 5.2 which reports results for all of the 21 analyses undertaken (one on the whole data set, and 20 on the data set with one respondent removed) and shows only those variables which emerged from the logistic regression analyses as predictive of sexual contact with patients in one or more of the analyses. For each variable the results of the initial stepwise and subsequent forced entry

logistic regression analyses are given. Variables which were not significant are not listed in the table.

**Table 5.2. Stepwise and forced entry logistic regression analyses with trainees removed: Results (sexual contact with patients is dependent variable)**

Variable	Years of clinical practice		Age of respondent		Effect on therapy of attraction		Sexual contact with educator as postgraduate		Sexual orientation		NHS work setting	
	Stepwise	Forced entry	Stepwise	Forced entry	Stepwise	Forced entry	Stepwise	Forced entry	Stepwise	Forced entry	Stepwise	Forced entry
Respondent no. removed												
None - overall analysis	# (.05)	# (.05)										
26	* (.04)	* (.04)			* (.05)	* (.05)	* (.0001)	* (.0001)	* (<.00005)	* (<.00005)		
29			# (.05)	# (.05)			* (.0020)	* (.0019)	* (<.00005)	* (.0030)	* (.0029)	
38	* (.04)	* (.04)					* (<.00005)	* (<.00005)	* (<.00005)	* (<.00005)	* (<.00005)	
58	# (.06)	# (.06)					* (.0001)	* (.0001)	* (<.00005)	* (.0001)	* (.0001)	
90			# (.06)	# (.06)			* (.0020)	* (.0019)	* (<.00005)	* (<.00005)	* (<.00005)	
112							* (.0001)	* (.0001)	* (<.00005)	* (<.00005)	* (<.00005)	
145	# (.05)	# (.05)					* (<.00005)	* (<.00005)	* (.0009)	* (.0009)		
169	* (.05)	* (.05)					* (<.00005)	* (<.00005)	* (<.00005)	* (<.00005)	* (<.00005)	
209	* (.04)	* (.04)					* (<.00005)	* (<.00005)	* (<.00005)	* (<.00005)	* (<.00005)	
233	# (.05)	* (.04)					* (<.00005)	* (<.00005)	* (.0001)	* (.0001)	* (<.00005)	
254	* (.04)	* (.04)					* (<.00005)	* (<.00005)	* (<.00005)	* (<.00005)	* (<.00005)	
271			# (.05)	# (.05)			* (.0020)	* (.0019)	* (<.00005)	* (<.00005)	* (>.00005)	
300			# (.05)	# (.05)			* (.0020)	* (.0020)	* (<.00005)	* (<.00005)	* (<.00005)	
354	* (.05)	* (.05)					* (<.00005)	* (<.00005)	* (<.00005)	* (<.00005)	* (<.00005)	
377	* (.04)	* (.04)					* (<.00005)	* (<.00005)	* (<.00005)	* (<.00005)	* (<.00005)	
389	# (.05)	# (.05)					* (.0020)	* (.0006)	* (<.00005)	* (<.00005)	* (<.00005)	
400	* (.04)	* (.04)					* (<.00005)	* (<.00005)	* (<.00005)	* (<.00005)	* (<.00005)	
487							* (.0001)	* (<.00005)	* (<.00005)	* (<.00005)	* (<.00005)	* (.05)
497	# (.06)	# (.06)					* (.0001)	* (.0001)	* (<.00005)	* (.0001)	* (.0001)	
529	* (.05)	* (.05)					* (<.00005)	* (<.00005)	* (<.00005)	* (<.00005)	* (<.00005)	

Where the cell is blank, a significant result was not obtained. Where a result is reported, this is either statistically significant ( $p < 0.05$ ) as denoted by an asterisk (\*), or marginally significant ( $p > 0.05$ ) as denoted by a hash symbol (#).

The analyses of the data with trainees excluded showed very similar results to the analyses of the whole sample, with the exceptions that respondents' age was marginally significant in four analyses and the effect which respondents believed their sexual attraction to a patient had exerted on therapy, was significant in only one of the analyses. This suggests that the inadvertent inclusion of trainee clinical psychologists (see chapter three) did not have a significant impact upon the data.

### 5.3. DISCUSSION

In a comparison of the analyses of the entire sample and those of the sample with trainees removed, one very clear contrast is evident. When the entire sample is considered, years of postqualification clinical practice is significant in all but five of the analyses, and in one of those five, age of respondent is significant instead. However, when trainee clinical psychologists are removed from the analysis, length of postqualification clinical practice is significant or marginally significant in all but six of the analyses, but age becomes marginally significant in four. Respondents' age and years of postqualification clinical experience are correlated (Spearman's  $r = 0.76$ ;  $p < 0.05$ ), but there are some differences between these variables.

This finding suggests that years of postqualification practice becomes slightly less predictive of sexual contact with patients when trainees are removed from the analyses, but that age has somewhat more predictive value when only qualified clinical psychologists are included in the analyses. If trainees do not report sexual contact with patients (as is the case in this study) one would expect that when trainees are included in

the analysis, years of postqualification practice would be predictive of sexual contact with patients, since there would be a contrast in the data between trainees and qualified clinical psychologists in terms of years of postqualification practice where the latter are more numerous and more likely to have been sexually involved with patients. By contrast, when trainees are removed from the analyses, the level of experience of the sample rises considerably and thus length of postqualification practice is likely to be less predictive of sexual contact with patients, whereas age develops slightly more predictive value. However, it could also be argued that trainee clinical psychologists are considerably more heterogenous in terms of age than in terms of experience, and that the effect of respondents' age when trainee clinical psychologists are not included in the analysis is not great.

Using the median as the indicator of direction of significance for years of postqualification practice, the median is 16.5 years for the group which reported sexual contact with patients, but 10 years for the no sexual contact group. (Median was preferred over the mean since the distribution was skewed). For respondents' age, the median is 44.5 years for the group which reported sexual contact with patients, and 38.5 years for those who did not report sexual contact. (Like the data for years of postqualification practice, the age distribution was skewed so the median was used). Thus, it may be assumed that there are two main possible explanations, that there is a cohort effect in that at the time when older/more experienced therapists trained, there is likely to have been less emphasis on ethical matters; or that the older therapists become, the more likely they are to have sexual contact with patients. Since respondents were not asked when sexual contact with patients occurred, it is difficult to be certain in this

respect. Future research would benefit from enquiring about sexual contact within a specified period of time, say, the last six months, in order to establish whether respondents' length of clinical experience would still be a predictor of sexual contact with patients.

There is considerable variability in the age at which psychologists train, thus, it is not necessarily the case that the older the therapist, the longer s/he will have been qualified. Additionally, respondents were asked to give the total number of postqualification practice years *not* the years since they qualified so it may be that some respondents are likely to have had time out of clinical practice, for example women who have taken a career break for the purposes of maternity leave and childcare. Thus, years of postqualification clinical practice rather than respondents' age is a more precise indicator of level of experience.

Sexual contact between respondents and their educators during clinical psychology training was predictive of sexual contact with patients in all of the analyses. Those who had experienced such sexual contact constituted 35% of the group which reported sexual contact with their patients, and 5.7% of those who did not report such sexual contact. Thirteen percent of the women who had engaged in sexual contact with trainers as postgraduates had later engaged in sexual contact with their patients whereas 0.9% of the women who had no sexual contact with trainers later had sexual contact with their patients. For men too, there was a considerable difference: here the figures were 37.5% and 4.3% respectively. Similarly, in Pope et al's (1979) North American survey, 23% of women who had experienced sexual contact with their educators reported later sexual

contact with their clients, whereas only 6% of those who had not engaged in sexual contact with their educators had sexual contact as professionals with clients.

The sexual orientation variable categorised respondents as homosexual or heterosexual/bisexual. It was this variable which was significant, rather than the other sexual orientation variable which categorised respondents as heterosexual or homosexual/bisexual. In table 5.3 this variable is crosstabulated with the variable representing sexual contact with patients.

**Table 5.3. Relationship between respondents' sexual orientation and sexual contact with patients** (percentages: frequencies are given in parentheses)

Sexual orientation	Sexual contact with patients	No sexual contact with patients
Homosexual	20 (4)	1.1 (6)
Heterosexual/bisexual	80 (16)	98.9 (551)
Total	100% (20)	100% (557)

Chi square analysis of the data in table 5.3 (Yates' corrected  $\chi^2 = 4.28$ ;  $df = 1$ ;  $p = 0.386$ ) showed that self-identified homosexual clinical psychologists in this sample were more likely to report sexual contact with their patients than self-identified heterosexual/bisexual respondents.

The question of sexual orientation in this study is complex, since respondents were only asked details about their last sexual encounter with a patient (if there had been more than

one). Even where respondents currently label themselves as homosexual, their sexual orientation at the time of the sexual contact may not have been the same, particularly if the sexual contact occurred some time ago, or, even if respondents' sexual orientation was homosexual at the time of the sexual contact with a patient, the last sexual contact may not have been of a homosexual nature. Previous sexual contacts with patients, if they occurred, may or may not have been homosexual.

Respondents may regard their primary sexual orientation as homosexual, but may have engaged in heterosexual sexual contact with a patient. There may be a number of possible reasons for such behaviour, but it is known that sex offenders, for example, may have a primary adult sexual orientation, yet sexually abuse children (Abel and Rouleau, 1990). Alternatively, for those respondents who had experienced multiple sexual contacts with patients, these might include both heterosexual and homosexual contacts. There may also be a systematic difference in willingness to disclose between homosexuals and heterosexuals in general, or between those who have experienced homosexual and heterosexual sexual contact with their patients, regardless of sexual orientation.

When a comparison is made between the gender of the last patient (if there had been more than one) with whom these respondents had sexual contact and the stated sexual orientation of the respondents, there are few cases where the last sexual contact was not congruent in this respect. Of twenty cases, seventeen involved a patient whose gender was congruent with the stated sexual orientation of the psychologist. There were two cases where the patient's gender was not given so it was not possible to identify

congruence and in one case, the respondent had identified her sexual orientation as homosexual but had engaged in sexual contact with a male patient. This respondent did not report having had sexual contact with any other patients.

The above suggests that it is unlikely that for the last sexual contact with a patient the results were significantly influenced by any of the possible factors discussed above. There was only one case where stated sexual orientation did not match the gender pairing of the last reported sexual contact with a patient. The data do not support the hypothesis that respondents who currently regard themselves as homosexual had heterosexual contact with patients, either because they regarded themselves as heterosexual at the time of the sexual contact, or for any other reason. However, no data are available in relation to respondents' previous sexual contacts with patients in cases where this applies.

It may therefore be concluded that for this sample, on the basis of a consideration of respondents' last sexual contact with patients (if there had been more than one), psychologists who report their sexual orientation as homosexual were more likely to have had sexual contact with a patient or patients.

#### **5.4. SUMMARY**

Some of the findings from the logistic regression analyses are summarised in table 5.4 which gives a cross-tabulation of respondents' sexual orientation, sexual contact with an educator as a postgraduate, and sexual attraction towards patients, including its

perceived effects upon therapy. The table shows the frequencies occurring in each cell for the whole sample, and gives a breakdown for each cell of those who reported sexual contact with patients and those who did not.

**Table 5.4. Summary of significant results (n=558)**

	Sexual contact as a postgraduate with educators, e.g. supervisors or lecturers						
	Yes			No			
	Heterosexual	Homosexual	Bisexual	Heterosexual	Homosexual	Bisexual	Total
No sexual attraction to patients	Total = 14 3/11	Total = 0 0/0	Total = 0 0/0	Total = 205 0/205	Total = 4 1/4	Total = 0 0/0	223
Positive effect on therapy of sexual attraction to patients	Total = 3 0/3	Total = 1 1/0	Total = 0 0/0	Total = 58 3/55	Total = 2 0/2	Total = 0 0/0	64
Little or no effect on therapy of sexual attraction to patients	Total = 12 0/12	Total = 1 1/0	Total = 1 1/0	Total = 210 7/203	Total = 1 0/1	Total = 7 0/7	232
Negative effect on therapy of sexual attraction to patients	Total = 3 0/3	Total = 0 0/0	Total = 1 0/1	Total = 34 2/32	Total = 1 1/0	Total = 0 0/0	39
<b>Total</b>	<b>32</b>	<b>2</b>	<b>2</b>	<b>507</b>	<b>8</b>	<b>7</b>	<b>558</b>

**KEY:** Ratios in cells have as the numerator those who have had sexual contact with patients, and as the denominator those who have not.

Very few (four) of the homosexual or bisexual respondents reported experience of sexual contact with an educator, and all of them had been sexually attracted to patients. All of the homosexual/bisexual respondents who had postgraduate sexual contact with an educator had also been sexually involved with their patients. Heterosexuals who had experienced sexual contact with an educator as postgraduates and those who had not were almost equally split between those who believed that their sexual attraction to patients had a positive effect on therapy, and those who believed that it had a negative effect. None of those heterosexuals who had sexual contact with their patients and who also reported sexual attraction to them, had experienced postgraduate sexual contact with an educator. All of the bisexual respondents had been sexually attracted to patients and all but one regarded this attraction as having little or no effect on therapy. The other sexual orientation groups were split in relation to whether or not they had experienced sexual attraction towards their patients, and, if they had, the nature of its effect upon therapy.

The logistic regression analyses of the quantitative data set in its entirety, and with the trainee respondents removed, gave similar results. Three variables, sexual contact during postgraduate studies with an educator, length of postqualification clinical practice and homosexual sexual orientation predicted sexual contact with patients but these data should be interpreted cautiously in view of the poor predictive capacity of the statistical model used.



**CHAPTER SIX**

**A DETAILED ACCOUNT OF THE  
NATURE OF THE SEXUAL CONTACTS  
WITH PATIENTS REPORTED BY  
RESPONDENTS**



This chapter describes the responses of those individuals who reported sexual contact with their patients, to all questions on the questionnaire, both quantitative and open-ended. This chapter provides the only description in the thesis of responses to those open-ended questions which were only applicable to respondents who reported sexual contact with their patients (eg "how did you come to be sexually involved with this patient?"). Such an examination of individual cases was undertaken in order to provide additional and individualised information with which to extend the understanding of the phenomenon of sexual contact in therapy. Chapter 7 describes the qualitative data from those respondents who did not report sexual contact with their patients.

Some detailed information given by respondents has been slightly changed to ensure confidentiality and anonymity, for example the precise ages of patients are not given and the names of towns mentioned by respondents have been deleted. Respondents' ages are not given precisely.

Most of the reports of sexual contact with patients are restricted either to current or to discharged patients. Some respondents reported a single sexual contact with either a current or a discharged patient, whilst others reported multiple sexual contacts with a single patient. There were others who had engaged in sexual contact on one occasion with more than one current or discharged patient, and some respondents who had had sexual contact with more than one current or discharged patient on a number of occasions. Only one respondent stated that he had engaged in multiple sexual contacts with both current and discharged patients. The following case accounts group respondents according to these categories. Where information was not provided about

the number of sexual contacts which occurred between a respondent and his/her patient, it has been classified in the category which best seems to fit the information given.

## **6.1. SEXUAL CONTACTS WITH CURRENT PATIENTS ONLY**

### **6.1.1. Multiple sexual contacts with one current patient**

i) Psychologist A was a man in his early forties who described himself as heterosexual and in a stable relationship as well as widowed/divorced. He has practised as a clinical psychologist for 15 years since qualifying and described his therapeutic orientation as primarily cognitive with the second influence as behavioural and the third as systemic. He has not undertaken personal therapy. He mainly worked with an adult population in the N.H.S., and saw patients for 18 hours a week. He had less than 1% of his patients in long term therapy (defined as over 50 sessions) and 60% in short term therapy (defined as under 20 sessions).

In terms of physical contact with his patients, he had shaken the hands and touched the arm/shoulder of patients of both sexes. He had also engaged in other forms of physical contact with female patients as detailed below. He had been sexually attracted to a patient, and states that he now feels concerned about this attraction, and that it had mainly adverse effects. He did not believe that patients can ever benefit from sexual contact with their therapists.

He disclosed sexual contact with one then current patient, and did not give the number of occasions on which this occurred. He had previously disclosed this contact to a colleague and to a friend/partner. The patient was a woman in her 40's with whom he engaged in kissing, nongenital touching/holding/fondling, hand-genital contact, vaginal intercourse and oral-genital contact. He stated that the patient gave full consent to the contact and that no pain was inflicted upon her. He was involved with the patient for between 3 and 11 months and at the time of completing the questionnaire had no contact whatsoever with the patient.

He stated that sexual contact was mutually initiated and developed with the patient when a close relationship developed within treatment sessions followed by contact outside sessions, eventually developing into a sexual relationship. He stated that he believed that the contact directly had "no great adverse effects" upon the patient but the sexual involvement led to a "sidelining" of the therapeutic relationship and loss of trust. At the time of completing the questionnaire he felt concerned about the contact. He explained that he took no direct steps to dissuade the patient from disclosing the contact as she gave an assurance of maintaining confidentiality.

This psychologist stated that he believed that trainees could not benefit from sexual contact with supervisors. He had not engaged in sexual contact with a lecturer when an undergraduate or a postgraduate and denied having sexual contact with a trainee.

Although he had not treated patients who were sexually involved with previous therapists, he was aware of two clinical psychologists through other sources who have

been sexually involved with their patients. He was uncertain whether they were reported. Both were sexually involved with only one patient. He did not take any action to report the psychologists concerned because his knowledge was of past behaviour and was passed onto him by his supervisor and colleagues.

ii) Psychologist B was a woman in her late forties who described herself as bisexual and single as well as separated. She had practised as a clinical psychologist for 20 years since qualifying and described her therapeutic orientation as primarily humanistic, with the second influence psychodynamic, and the third behavioural. She had undertaken personal therapy. She mainly worked with an adult population in the N.H.S., and saw patients for 16 hours a week. She had 10% of her patients in long term therapy (defined as over 50 sessions) and 90% in short term therapy (defined as under 20 sessions).

In terms of physical contact with her patients, she had shaken the hand, patted the arm, and touched the arm/shoulder of patients of both sexes. She had also held hands with and hugged patients of both sexes. She had been sexually attracted to a patient, and stated that she was unconcerned about this, believing it to have little or no effect. She did not believe that patients can ever benefit from sexual contact with their therapists.

She stated that sexual contact took place with one then current patient on four occasions. She had previously disclosed this contact to a colleague, to her manager, to her supervisor and to a friend/partner, as well as in a supervision group some time later. The patient was a man in his 30's with whom she engaged in kissing, non-genital touching/holding/fondling and vaginal intercourse. She stated that the patient gave full

consent to the contact and that pain was not inflicted upon him. The contact lasted between 3 and 11 months, and at the time of completing the questionnaire the psychologist had no contact whatsoever with the patient. However, for two years afterwards she continued to have social contact with him, but no sexual or therapeutic contact.

She stated that the contact occurred after she felt attracted to him, and having contained her feelings during therapy which was unsupervised. After he ceased to be a patient, she became socially and subsequently sexually involved with him. When asked to specify the effects she believed this contact had on the patient, she stated that it was probably unhelpful and repeated a pattern he had followed of becoming very involved with helpers from other agencies. This was not known to her until later.

At the time of completing the questionnaire she felt concerned about the contact, which she said was mutually initiated. She explains that she took no steps to dissuade the patient from disclosing the contact, but discussed the ethical issues with him at the time. She also informed him that she had sought professional guidance and advice about the morality of the situation, even though he had been discharged. The patient did disclose to friends, to colleagues and to the person who sought help for him.

This psychologist stated that she believed that it is possible that trainees could benefit from sexual contact with supervisors. She had not engaged in sexual contact as an undergraduate with a lecturer, but had done so as a postgraduate with a trainer. She also denied having sexual contact with a trainee.

She had treated patients who were sexually involved with previous therapists, that is, a social worker and a voluntary agency therapist, all with negative consequences for the patients. She was uncertain how many of these therapists had been reported. She knew of no clinical psychologists through other sources who had been sexually involved with their patients.

### **6.1.2. Single sexual contacts with one current patient**

iii) Psychologist C was a woman in her early forties who described herself as homosexual and in a stable relationship. She had practised as a clinical psychologist for 14 years since qualifying and described her therapeutic orientation as exclusively influenced by Cognitive Analytic Therapy. She had undertaken personal therapy. She mainly worked with an adult population in the N.H.S., and saw patients for 5 hours a week. She had 20% of her patients in long term therapy (defined as over 50 sessions) and 80% in short term therapy (defined as under 20 sessions).

In terms of physical contact with her patients, she had shaken the hand of patients of both sexes. She denied having been sexually attracted to a patient, and stated that she did not know why that was. She did not believe that patients could ever benefit from sexual contact with their therapists.

She reported sexual contact with one then current patient on one occasion. She had previously disclosed this contact to a colleague, to her supervisor and to a friend/partner. The patient was a man in his 40's with whom she engaged in non genital

touching/holding/fondling. She stated that the patient gave full consent to the contact and that pain was not inflicted upon him. At the time of completing the questionnaire she no longer had contact with the patient.

She stated that she became involved with him as a first-year trainee when visiting him at home. She naively became intimate with him as a response to his distress concerning his homosexual orientation. When asked to specify the effects she believed this contact had on the patient, she stated that she did not know. At the time of completing the questionnaire she felt concerned about the contact, which she said was initiated by the patient. She explained that she took no steps to dissuade the patient from disclosing the contact, but discussed it with her supervisor and explained to the patient that it was a mistake.

This psychologist responded in the negative to questions asking about perceived benefits to trainees from sexual contact with supervisors, whether she had sexual contact as an undergraduate or postgraduate with trainers, or with her personal therapist. She also denied having sexual contact with a trainee.

Although she had not treated patients who were sexually involved with previous therapists, she knew of three clinical psychologists through other sources who have been sexually involved with their patients, none of whom were reported. She was uncertain how many were sexually involved with one, or more than one patient. She did not take any action to report the psychologists concerned because in each case she was approached for advice from colleagues of the psychologists in question.

iv) Psychologist D was a man in his early forties who described himself as heterosexual and married. He had practised as a clinical psychologist for 16 years since qualifying and described his therapeutic orientation as primarily cognitive with the second influence as behavioural and the third as humanistic. He had undertaken personal therapy. He mainly worked with an adult population in the N.H.S., and saw patients for 20 hours a week. He had 10% of his patients in long term therapy (defined as over 50 sessions) and 90% in short term therapy (defined as under 20 sessions).

In terms of physical contact with his patients, he had shaken the hands, patted on the arm, held hands with and touched the arm/shoulder of patients of both sexes. He had been sexually attracted to a patient, and stated that at the time of completing the questionnaire he felt unconcerned about this attraction, and that it had little or no effects. He did not believe that patients could ever benefit from sexual contact with their therapists.

He disclosed sexual contact with one current patient on one occasion. He had previously disclosed this contact to a colleague and to a friend/partner. The patient was a young teenage woman with whom he engaged in non-genital touching/holding/fondling. He stated that the patient gave full consent to the contact and that pain was not inflicted upon her. At the time of completing the questionnaire he had no contact with the patient. He stated that he became sexually involved with the patient when "she was very flirtatious and came and sat upon my lap". He stated that he had no idea of the effect of the contact upon the patient but estimates that this would be very little since the patient was "a very flirtatious and seductive person with several members of staff". He now

feels unconcerned about the contact, and stated that the contact was initiated by the patient. He explained that he took no direct steps to dissuade the patient from disclosing the contact. He discussed his feelings about it with a colleague.

This psychologist stated that he believed that trainees could not benefit from sexual contact with supervisors. He had not engaged in sexual contact with a lecturer when an undergraduate or a postgraduate and denied having sexual contact with a trainee or his personal therapist.

Although he had not treated patients who were sexually involved with previous therapists, he knew of one clinical psychologist through other sources who has been sexually involved with patients, and who was not reported. He was uncertain how many patients this individual was sexually involved with. He did not take any action to report the psychologists concerned because the individual was more senior and there was no conclusive proof of the sexual misconduct.

v) Psychologist E was a woman in her late thirties who described herself as heterosexual and married. She had practised as a clinical psychologist for 14 years since qualifying and described her therapeutic orientation as primarily cognitive, with the second influence as behavioural and the third as psychodynamic. She had not undertaken personal therapy. She mainly worked with a population with physical health problems in the N.H.S., and sees patients for 10 hours a week. She had 30% of her patients in long term therapy (defined as over 50 sessions) and 70% in short term therapy (defined as under 20 sessions).

In terms of physical contact with her patients, she had shaken the hand, patted the arm and touched the arm/shoulder of patients of both sexes. She had also held hands with female patients. She has not been sexually attracted to a patient, and stated that this was because "there is something about the relative roles of patient and therapist which puts male patients outside the realm of 'people who turn me on' - a bit like other peoples' husbands/partners: very intangible but there". However, she believed that patients could "very rarely" benefit from sexual contact with a therapist.

She reported sexual contact with one current patient on one occasion. She had previously disclosed this contact to a colleague, to her manager and to a friend/partner. The patient was a man in his 30's who, on a home visit, made verbal sexual suggestions to the psychologist whilst encouraging his dog to keep her in her chair. No further detail is given by the respondent, who states that the patient gave full consent to the contact and that pain was not inflicted upon him. At the time of completing the questionnaire she no longer maintained contact with the patient.

She stated that the incident occurred on an initial assessment visit. When asked to specify the effects she believed this contact had on the patient, she stated that it was "hard to assess" but that it was agreed that it would be appropriate for her to avoid further contact and to pass his case on to a colleague. At the time of completing the questionnaire she reporting feeling concerned about the contact, which she said was initiated by the patient. She explained that she took no steps to dissuade him from disclosing the contact.

This psychologist said that she believed that trainees could benefit from sexual contact with supervisors. She had sexual contact with educators when an undergraduate and as a postgraduate. She also denied having sexual contact with a trainee.

She had not treated patients who were sexually involved with previous therapists and knew of no clinical psychologists through other sources who have been sexually involved with their patients.

She commented that she felt that the term "benefit" in the questionnaire is open to a range of alternative definitions.

### **6.1.3. Multiple sexual contacts with more than one current patient**

vi) Psychologist F was a man who did not give his age and who described himself as heterosexual and married. He did not give the number of years he had practised as a clinical psychologist since qualifying and described his therapeutic orientation as primarily psychodynamic with the second influence as "other" and the third as humanistic. He had undertaken personal therapy, and mainly worked with an adult population, though he declined to give the service setting in which he mainly worked. He saw patients for 12 hours a week. He had 50% of his patients in long term therapy (defined as over 50 sessions) and 25% in short term therapy (defined as under 20 sessions).

In terms of physical contact with his patients, he had shaken the hand, patted the arm, touched the arm/shoulder, and held the hand of patients of both sexes. He had also hugged male and female patients, and has cuddled/massaged female patients only. He had been sexually attracted to a patient, and stated that at the time of completing the questionnaire he felt unconcerned about this attraction, and that it had mainly positive effects. He believed that patients could benefit from sexual contact with their therapists.

He stated that he had sexual contact with three current patients, not detailing the number of occasions on which this occurred. He had previously disclosed this to a colleague and to his personal therapist. The most recent patient with whom he had sexual contact was a woman in her 40's with whom he engaged in kissing and non-genital touching/holding/fondling. He stated that the patient gave full consent to the contact and that no pain was inflicted upon her. He had been involved with her for more than five years and continued to have both therapeutic and sexual contact with the patient.

He did not mention how he became sexually involved with the patient, nor the effects which he believed the involvement had upon her. He felt concerned about the involvement which he stated was mutually initiated. He denied having taken steps to prevent the patient from disclosing the contact.

This psychologist did not give his views about whether trainees could benefit from sexual contact with supervisors. He had not engaged in sexual contact with a lecturer when an undergraduate or a postgraduate and denies having sexual contact with his

personal therapist. He did not reply when asked whether, as an educator, he had sexual contact with a trainee.

He had treated patients who were sexually involved with previous therapists, that is, a private sector psychotherapist, with mixed effects on the patients. He knew of no clinical psychologists through other sources who have been sexually involved with their patients.

He commented that "so much meaning is missed".

vii) Psychologist G was a woman in her early forties who described herself as heterosexual and married. She had practised as a clinical psychologist for 18 years since qualifying and described her therapeutic orientation as equally influenced by behavioural, cognitive and systemic approaches. She had not undertaken personal therapy. She mainly worked with a learning difficulties population in the N.H.S., and saw patients for six hours a week. She had none of her patients in long term therapy (defined as over 50 sessions) and 100% in short term therapy (defined as under 20 sessions).

In terms of physical contact with her patients, she had shaken the hand, patted the arm and touched the arm/shoulder of patients of both sexes. She had also hugged female patients. She has not been sexually attracted to a patient, and when asked why this might be, stated that she believed this to be "a loaded question - perhaps I'm well defended!" She did not believe that patients could benefit from sexual contact with a therapist.

She admitted to sexual contact with two current patients, on two occasions. Since the total number of sexual contacts she reported was two, she clearly had just one sexual contact with each patient. She had previously disclosed these contacts to a colleague, to her manager and to a friend/partner. The last patient with whom she had sexual contact was a man in his 20's who exposed himself to her and invited her to masturbate him. She did not comply with his request. She confirms that this was the only sexual incident between them, and currently has continuing therapeutic contact with him without any sexual contact. Following the incident, she established as conditions for continued therapeutic involvement that the patient must be properly dressed and must not touch her. She believes that the incident had a positive effect on the patient in that she has continued to see him and he now uses therapy appropriately. At the time of completing the questionnaire she was concerned about the sexual episode. She did not take steps to dissuade the patient from disclosing the incident, and in fact persuaded him to discuss it jointly with herself and his key worker.

This psychologist said that she did not believe that trainees could benefit from sexual contact with supervisors. She had not had sexual contact with an educator when an undergraduate but had done so as a postgraduate. She also denied having sexual contact with trainees.

She had not treated patients who were sexually involved with previous therapists, but did know of one clinical psychologist through other sources who has been sexually involved with one patient. This psychologist was uncertain whether or not the colleague had been reported, and had not taken action to report the psychologist as the incident had

occurred some time previously and the couple were married at the time of completing the questionnaire.

She adds, "I suspect that I have not filled this in correctly. It would be easier if you defined 'sexual contact'".

## **6.2. SEXUAL CONTACTS WITH DISCHARGED PATIENTS ONLY**

### **6.2.1. Single sexual contacts with one discharged patient**

viii) Psychologist H was a woman in her late fifties who described herself as homosexual and single. She had practised as a clinical psychologist for 16 years since qualifying and described her therapeutic orientation as primarily psychodynamic, with the second influence as humanistic and the third as cognitive. She had undertaken personal therapy. She mainly worked with an adult population in the N.H.S., and saw patients for 10 hours a week. She had 60% of her patients in long term therapy (defined as over 50 sessions) and 20% in short term therapy (defined as under 20 sessions).

In terms of physical contact with her patients, she had shaken the hand, patted the arm and touched the arm/shoulder of patients of both sexes. She had been sexually attracted to a patient, and stated that she was concerned about this, believing the attraction to have had adverse effects. She did not believe that patients could ever benefit from sexual contact with their therapists.

She admitted sexual contact with one discharged patient on one occasion. She had previously disclosed this contact to her personal therapist. The patient was a woman in her early 30's with whom she engaged in kissing and hand-genital contact. She stated that the patient gave full consent to the contact and that no pain was inflicted upon her. She reported at the time of completing the questionnaire no continuing contact with the patient.

She stated that sexual contact occurred with the patient after giving in to the patient's demands. When asked to specify the effects she believed this contact had on the patient, she stated that it "woke her up to reality". At the time of completing the questionnaire she felt concerned about the contact, which she said was initiated by the patient. She explained that to dissuade the patient from disclosing the contact, she "explained the effect on her future career".

This psychologist said that she believed that trainees could benefit from sexual contact with supervisors. She had sexual contact with a lecturer when an undergraduate, but not as a postgraduate with trainers, or with her personal therapist. She also denied having sexual contact with a trainee.

She had treated patients who were sexually involved with previous therapists, that is, a probation officer, with negative effects upon the patient. She was uncertain whether this officer had been reported. She knew of no clinical psychologists through other sources who had been sexually involved with their patients.

ix) Psychologist I was a man in his late forties who described himself as heterosexual and married. He had practised as a clinical psychologist for 25 years since qualifying and described his therapeutic orientation as eclectic. He did not specify whether he had undertaken personal therapy. He mainly worked with an adult population in the N.H.S., and saw patients for 8 hours a week. He had 10% of his patients in long term therapy (defined as over 50 sessions) and 80% in short term therapy (defined as under 20 sessions).

In terms of physical contact with his patients, he had shaken the hands of patients of both sexes. He had been sexually attracted to a patient, and stated that at the time of completing the questionnaire he felt unconcerned about this attraction, and that it had little or no effect. He did not believe that patients could ever benefit from sexual contact with their therapists.

He admitted to sexual contact with one discharged patient on one occasion. He had previously disclosed this contact to a friend/partner. The patient was a woman, whose age he did not give, with whom he engaged in kissing, non-genital touching/holding/fondling, hand-genital contact, and vaginal intercourse. He stated that the patient gave full consent to the contact and that pain was not inflicted upon her. At the time of completing the questionnaire he had no contact with the patient.

He stated that sexual contact occurred with the patient as a result of mutual attraction. He was unable to say what impact the contact might have had on her. At the time of completing the questionnaire he felt unconcerned about the contact, which he described

as mutually initiated. He claimed that he took no direct steps to dissuade the patient from disclosing the contact.

This psychologist stated that he believed that trainees could not benefit from sexual contact with supervisors. He had not engaged in sexual contact with a lecturer when an undergraduate or a postgraduate, nor with his personal therapist. He admitted to having had sexual contact with a trainee.

He had treated patients who were sexually involved with previous therapists, that is, a clinical psychologist. This therapist was reported and the sexual contact had negative effects upon the patient. The psychologist was aware of one clinical psychologist through other sources who had been sexually involved with patients. He was uncertain whether this individual had been reported and how many patients he/she had been sexually involved with. He took action to prevent the continuation of such contacts.

#### **6.2.2. Multiple sexual contacts with one discharged patient**

x) Psychologist J was a man in his early forties who described himself as heterosexual and in a stable relationship. He had practised as a clinical psychologist for 17 years since qualifying and described his therapeutic orientation as primarily psychodynamic with the second influence as cognitive and the third as humanistic. He had undertaken personal therapy. He mainly worked with an adult population in the N.H.S., and saw patients for 12 hours a week. He had 5% of his patients in long term

therapy (defined as over 50 sessions) and 85% in short term therapy (defined as under 20 sessions).

In terms of physical contact with his patients, he had shaken the hands, patted the arms and touched the arm/shoulder of patients of both sexes. He had also hugged and kissed female patients. He had been sexually attracted to a patient, and stated that at the time of completing the questionnaire he felt unconcerned about this attraction, and that it had mainly positive effects. He did not believe that patients could ever benefit from sexual contact with their therapists.

He stated that he had sexual contact with one discharged patient on "too many occasions to count". He had previously disclosed this contact to a colleague and to a friend/partner. The patient was a woman in her late 30's with whom he engaged in kissing, non genital touching/holding/fondling, hand-genital contact, vaginal intercourse and oral-genital contact. He stated that the patient gave full consent to the contact and that pain was not inflicted upon her. He had been sexually involved with the patient for more than five years and at the time of completing the questionnaire was married to or in a stable relationship with her.

He stated that contact began four years after therapy had ended when they had both moved to another town. He believed that the effects of the contact upon her were positive. At the time of completing the questionnaire he felt unconcerned about the contact, which he said was mutually initiated. He explained that she took no steps to dissuade her from disclosing the contact.

This psychologist stated that he believed that trainees could benefit from sexual contact with supervisors. He had engaged in sexual contact with a lecturer when an undergraduate, but responded in the negative when asked whether he had had sexual contact with an educator as a postgraduate, or with his personal therapist. He also denied having sexual contact with a trainee.

Although he had not treated patients who were sexually involved with previous therapists, he knows of two clinical psychologists through other sources who have been sexually involved with their patients, one of whom was reported. Both were sexually involved with only one patient. He did not take any action to report the psychologists concerned because the matter was dealt with in both cases by the District Psychologist. This psychologist also stated that he had known of alleged sexual contacts which were later shown to be fictitious.

xi) Psychologist K was a man in his late thirties who described himself as homosexual and single. He had practised as a clinical psychologist for 12 years since qualifying and described his therapeutic orientation as primarily cognitive with the second influence as behavioural and the third as humanistic. He had not undertaken personal therapy. He mainly worked with an adult population in the N.H.S., and saw patients for 23 hours a week. He had 4% of his patients in long term therapy (defined as over 50 sessions) and 55% in short term therapy (defined as under 20 sessions).

In terms of physical contact with his patients, he had shaken the hands of patients of both sexes. He had also moved female patients away from him when they clung to him.

He had been sexually attracted to a patient, and stated that at the time of completing the questionnaire he felt unconcerned about this attraction, and that it had mainly positive effects. He did not believe that patients could ever benefit from sexual contact with their therapists.

He admitted to having been sexually involved with one discharged patient on one occasion. He had not previously disclosed this contact, and gave no further details.

He stated "I need to emphasise that it was an ex-patient who I had seen only twice. Eight months later we met in a gay bar in of all places, X (a city abroad)! I guess we took it from there but didn't have sex/physical contact till a few months later, once we agreed to meet up in Y (a city in the U.K.), and emphasised we were friends. But now so many years down the line (we have been together 11 years) we are lovers - still trying to have children." It is unclear whether this implies a heterosexual relationship or refers to adoption by a homosexual couple.

This psychologist stated that he believed that trainees could benefit from sexual contact with supervisors. He had engaged in sexual contact with educators both as an undergraduate and as a postgraduate and denies having sexual contact with a trainee.

He had not treated patients who were sexually involved with previous therapists, nor did he know of clinical psychologists through other sources who have been sexually involved with their patients.

xii) Psychologist L was a man in his early forties who described himself as heterosexual and married. He had practised as a clinical psychologist for nine years since qualifying and described his therapeutic orientation as primarily behavioural with the second influence as cognitive and the third as humanistic. He had not undertaken personal therapy. He mainly worked with an elderly population (though only for the two years before completing the questionnaire) in the N.H.S., and saw patients for 15 hours a week. He had none of his patients in long term therapy (defined as over 50 sessions) and 75% in short term therapy (defined as under 20 sessions).

In terms of physical contact with his patients, he had shaken the hands, patted the arm, held the hand, and touched the arm of patients of both sexes, and had hugged patients of both sexes. He had been sexually attracted to a patient, and stated that at the time of responding to the questionnaire he felt unconcerned about this attraction, and that it had little or no effect. He did not believe that patients could ever benefit from sexual contact with their therapists.

He admitted to having had sexual contact with one discharged patient on 10 occasions. He had not previously disclosed this contact. The patient was a woman in her late 20's with whom he engaged in kissing, non- genital touching/holding/fondling, hand-genital contact, vaginal intercourse, oral-genital contact and anal penetration. He stated that the patient gave full consent to the contact and that pain was not inflicted upon her. He was sexually involved with the patient for less than three months and reports no continuing contact with her. He stated that sexual contact occurred with her because of mutual weakness and vulnerability, though states that "the responsibility was and is mine

alone". He believed that the effect of the sexual involvement was "continuing emotional damage" to the patient. At the time of responding to the questionnaire he felt concerned about the contact, which he saw as having been mutually initiated. He stated that he took no direct steps to dissuade the patient from disclosing the contact.

This psychologist stated that he believed that trainees could not benefit from sexual contact with supervisors. He had not engaged in sexual contact with a lecturer when an undergraduate or a postgraduate and denied having sexual contact with a trainee.

He had treated patients who were sexually involved with previous therapists, that is, a clinical psychologist, and rated the effects of this involvement as negative. Neither of the clinical psychologists of whom he had knowledge through this source have been reported.

This psychologist knew of three clinical psychologists through other sources who have been sexually involved with patients. One of these had been reported, and the other two had not. Two of the psychologists were sexually involved with one patient, and one was sexually involved with more than one patient. The psychologist took no action to report the above contacts because one of the psychologists in question was dismissed from his post, one was the psychologist's supervisor during training, and one discontinued the relationship.

xiii) Psychologist M was a man in his early forties who described himself as heterosexual and married. He had practised as a clinical psychologist for 16 years since

qualifying and described his therapeutic orientation as primarily cognitive with the second influence as humanistic and the third as systemic. He had undertaken personal therapy. He mainly worked with an adult population in the N.H.S., and saw patients for 16 hours a week. He had 10% of his patients in long term therapy (defined as over 50 sessions) and 70% in short term therapy (defined as under 20 sessions).

In terms of physical contact with his patients, he had shaken the hands and patted the arm of patients of both sexes, and had touched the shoulder/arm of male patients. He had been sexually attracted to a patient, and stated that at the time of completing the questionnaire he felt unconcerned about this attraction, though it had mainly adverse effects on the patient. He did not believe that patients could ever benefit from sexual contact with their therapists.

He admitted sexual contact with one discharged patient on three occasions. He had previously disclosed this contact to a colleague, to his manager and to a friend/partner. The patient was a woman in her early 30's with whom he engaged in kissing, non-genital touching/holding/fondling, hand-genital contact, vaginal intercourse and oral-genital contact. He stated that the patient gave full consent to the contact and that no pain was inflicted upon her. The sexual contact lasted for less than three months and at the time of completing the questionnaire he had no current contact with the patient.

He stated that the sexual contact occurred following correspondence after the patient's discharge. The psychologist moved from the city in which he had resided and arranged to meet the patient there two years later. It is unclear whether the psychologist arranged

to meet the patient at the time of discharge or whether he contacted her again two years later. He stated that they "both felt it had been a glorious weekend but very much an unrepeatable interlude that had 'rounded off' our relationship". At the time of completing the questionnaire he felt unconcerned about the contact, which he describes as having been mutually initiated. He reported having taken no direct steps to dissuade the patient from disclosing the contact.

He stated, "I have felt sexual attraction to clients both before and since the one with whom I had a brief sexual relationship. In no other case, however, have I contemplated acting on it. The lady in question and I were aware of mutual non-transference attraction (had we met in any other circumstances that attraction plus the desire to act upon it would have been there). We became friends after discharge - admittedly because of that attraction - and the sexual contact took place within that context. We continued to be friends after the contact until we both became involved with others whom we married.

I cannot now contemplate acting on sexual attraction to a patient - either during or after therapy. Many of my patients are now survivors of child sexual abuse and to do so - even if I could rationalise it to myself - would be a repeat of using a position of vulnerability to obtain sexual gratification. My patients are very much now confined to "work time" professional relationships. I find other women outside of work attractive too but have no desire to act upon it because of my love and commitment towards my wife and children. The friendship with this lady grew from our meeting through work and the sexual relationship grew out of that. She was, and is, very much the exception in my professional life - I still remember her with great affection".

This psychologist stated that he believed that trainees could not benefit from sexual contact with supervisors, but neither would this be harmful. He had not engaged in sexual contact with a lecturer when an undergraduate or a postgraduate and denied having sexual contact with a trainee. He had not treated patients who were sexually involved with previous therapists, nor did he know of clinical psychologists through other sources who have been sexually involved with patients.

xiv) Psychologist N was a woman in her mid-thirties who described herself as heterosexual and married. She had practised as a clinical psychologist for seven years since qualifying and described her therapeutic orientation as exclusively behavioural. She had not undertaken personal therapy. She mainly worked with people with learning difficulties in the N.H.S., and saw patients for 10 hours a week. She had 90% of her patients in long term therapy (defined as over 50 sessions) and 5% in short term therapy (defined as under 20 sessions).

In terms of physical contact with her patients, she had shaken the hand, patted the arm and touched the arm/shoulder of patients of both sexes. She had also held hands with and hugged both male and female patients. She had not been sexually attracted to a patient, but does not specify why this might be. She did not believe that patients could benefit from sexual contact with a therapist.

She admitted having been sexually involved with one discharged patient, but did not state on how many occasions sexual contact occurred. She had not previously disclosed this experience. She gave few details about the involvement but did mention that the

involvement had lasted for more than five years and that at the time of completing the questionnaire she was married to or in a committed relationship with the individual and unconcerned about the relationship.

This psychologist said that she believed that trainees could benefit from sexual contact with supervisors. She had not had sexual contact with educators when an undergraduate but had done so as a postgraduate. She also denies having sexual contact with a trainee.

She had not treated patients who were sexually involved with previous therapists and knew of no clinical psychologists through other sources who had been sexually involved with their patients.

xv) Psychologist O was in his/her late thirties but did not give his/her gender. The psychologist is heterosexual and divorced but in a stable relationship, and had practised as a clinical psychologist for 13 years since qualifying. This individual described his/her therapeutic orientation as primarily cognitive with the second influence as behavioural and the third as systemic. He/she had not undertaken personal therapy. He/she mainly worked with an adult population in the N.H.S., and saw patients for 15 hours a week. He/she had 20% of his/her patients in long term therapy (defined as over 50 sessions) and 40% in short term therapy (defined as under 20 sessions).

In terms of physical contact with patients, he/she had shaken the hands of patients of both sexes and had patted their arms, touched their arm/shoulder and hugged them. This psychologist had been sexually attracted to a patient, and stated that he/she felt at the

time of completing the questionnaire unconcerned about this attraction, and that it had little or no effect. He/she believed that patients could benefit from sexual contact with their therapists.

S/he admitted to having had sexual contact with one discharged patient on six occasions. He/she had previously disclosed this contact to a colleague. The patient was a woman in her mid 20's, with whom he/she engaged in kissing, non-genital touching/holding/fondling, and hand-genital contact.

The psychologist stated that the patient gave full consent to the contact and that no pain was inflicted upon her. The sexual contact lasted for less than three months and at the time of completing the questionnaire the psychologist had continued social contact with the patient, but no sexual or therapeutic contact.

This individual stated that sexual involvement with the patient occurred following re-establishment of contact by the patient after discharge, and that they met socially rather than professionally. He/she stated that the sexual contact raised issues about the patient's commitment to her existing boyfriend and was distressing for her for much of the period that it continued. At the time of completing the questionnaire, the psychologist believed that the sexual contact had little or no effect on the patient. The psychologist reported that s/he felt unconcerned about the contact, which is described as having been mutually initiated. He/she asserted that no direct steps were taken to dissuade the patient from disclosing the contact.

This psychologist stated that he/she believed that trainees could benefit from sexual contact with supervisors. He/she had not engaged in sexual contact with a lecturer when an undergraduate or a postgraduate. He/she denied having had sexual contact with a trainee.

This psychologist had not treated patients who were sexually involved with previous therapists. The psychologist was not aware of one clinical psychologist through other sources who have been sexually involved with patients.

xvi) Psychologist P was a man in his late thirties who described himself as heterosexual and married. He had practised as a clinical psychologist for 12 years since qualifying and described his therapeutic orientation as primarily cognitive, with joint secondary influences as behavioural and systemic. He had not undertaken personal therapy. He mainly worked with an elderly population in the N.H.S., and saw patients for one hour a week. He had none of his patients in long term therapy (defined as over 50 sessions) and 100% in short term therapy (defined as under 20 sessions).

In terms of physical contact with his patients, he had shaken the hands of, patted on the arm and touched the arm/shoulder of patients of both sexes. He had also held the hand of female patients. He had been sexually attracted to a patient, and stated that he felt unconcerned at the time of completing the questionnaire about this attraction, and that it had little or no effect upon the patient. He believed that patients could "very rarely" benefit from sexual contact with their therapists.

He stated that sexual contact had occurred between himself and one discharged patient on two occasions. The sexual contact occurred about six months after the patient had been discharged and the patient had moved abroad. He had previously disclosed this contact to a supervisor and friend/partner. The patient was a woman in her early 20's and the psychologist was at that time in his mid 20's. He reports engaging in kissing, non-genital touching/holding/fondling, hand-genital contact, vaginal intercourse and oral-genital contact with the patient. He stated that the patient gave full consent to the contact and that pain was not inflicted upon her. He described the sexual contact as a single sexual encounter (though this would appear to contradict his earlier statement that sexual contact occurred on two occasions) and currently no longer has any contact with the patient.

He stated that he became sexually involved with the patient when he was lonely and inexperienced as a trainee therapist, and attributed the involvement to the "mutual liking" between them. Regarding the impact the contact might have had upon her, he stated that he wrote to her a number of years later expressing guilt and she reassured him that she had not been harmed. He felt at the time of completing the questionnaire unconcerned about the contact, but stated that he would not repeat it even if he were single. He described the contact as having been mutually initiated, and reported that the patient travelled from a country in Northern Europe specifically to see him. He explained that he took no direct steps to dissuade her from disclosing the contact.

He stated, "I believe no therapist should engage in a sexual relationship with a client in treatment. There may be a case for "allowing" it after a reasonable period of discharge

provided the patient obtains support/counselling from another source. Subsequent to my experience, I asked female therapists to take over two patients who became over-involved with me and I found it difficult to continue my role as an effective therapist. Both had been subjected to sexual abuse in childhood or adolescence. Without my experience gained it would have been easy for an inappropriate sexual relationship to develop. This would definitely have been damaging to the patients involved if it had occurred."

This psychologist stated that he believed that trainees could benefit from sexual contact with supervisors, but added that this could occur only if it were a genuine relationship. He had not engaged in sexual contact with a lecturer when an undergraduate or a postgraduate. He denied having had sexual contact with a trainee.

He had not treated patients who were sexually involved with previous therapists. The psychologist was not aware of clinical psychologists through other sources who had been sexually involved with patients.

xvii) Psychologist Q was a man in his late sixties who described himself as heterosexual and divorced but in a stable relationship. He had practised as a clinical psychologist for 35 years since qualifying and described his therapeutic orientation as primarily behavioural, with a secondary influence as cognitive. He had not undertaken personal therapy. He worked for 33 years with an adult population in the N.H.S., but had been in private practice for the last 18 months before completing the questionnaire. He saw patients for 20 hours a week. He had 10% of his patients in long term therapy

(defined as over 50 sessions) and 75% in short term therapy (defined as under 20 sessions).

In terms of physical contact with his patients, he had shaken the hands of and patted on the arm patients of both sexes. He had been sexually attracted to a patient, but did not state how he felt about this attraction at the time of completing the questionnaire. He believed that it had a positive effect on therapy at the time. He believed that patients could not benefit from sexual contact with their therapists.

He disclosed sexual contact with one discharged patient, but did not specify the number of occasions on which sexual contact occurred. He had not previously disclosed this contact. He did not give the age or sex of the patient, or specify the nature of the sexual contact which took place; nor did he state whether the patient gave full consent to the contact, or if pain was inflicted upon him/her. At the time of completing the questionnaire he was married to or in a committed relationship with the patient.

He stated that he became sexually involved with the patient nine months to a year after discharge when they met again through mutual friends. After his divorce, he started dating the patient. In terms of the impact the contact might have had upon the patient, he stated that she changed her lifestyle and commenced a degree. At the time of completing the questionnaire she lived with the psychologist and was head of a department in a higher education establishment.

The psychologist did not state whether he felt concerned or unconcerned about the involvement, which he reported to be mutually initiated. He stated that he made no attempt to dissuade the patient from disclosing the contact, as she was no longer in therapy with him.

He stated, "The therapeutic relationship is a very special one in which the therapist has an advantage since he/she can be seen by the patient as an understanding, benign, knowledgeable person who has the patient's interests at heart (almost altruistic) and will be able to improve their life and help solve the difficulties and problems. The therapist may be the first person to listen and understand the patient's problems. If the therapist changes this relationship the trust and the advantages to the patient can be detrimental as the relationship will change. Also it is never worth your whole professional life, standing, etc., which will always be in jeopardy and trusting it to a person who usually cannot manage their own lives and can now hold power over the therapist.

In the course of one's life patients sometimes make covert or blatant passes or let it be known to the therapist that they would like the relationship to become sexual but in these cases it may be an aspect of their pathology or need for "love" which they are not getting from their partners or through socially acceptable ways, e.g. a person lacking in social skill, etc. I have utilized such instances firstly by explaining the therapeutic relationship, describing the limits and then directing the patient's needs more appropriately".

This psychologist stated that he believed that trainees could not benefit from sexual contact with supervisors. He had not engaged in sexual contact with a lecturer when an undergraduate or a postgraduate. He denied having had sexual contact with a trainee. He had treated patients who were sexually involved with previous therapists, that is, a clinical psychologist, a psychiatrist, a social worker, a G.P. and a nurse. He rated the effects of these sexual contacts as "mixed" and stated that none of the therapists was reported.

The psychologist knew of three clinical psychologists through other sources who have been sexually involved with patients. None of these clinical psychologists was reported. Two were sexually involved with one patient and one was sexually involved with more than one patient. He took action to prevent the continuation of the sexual contacts.

xviii) Psychologist R was a man in his early fifties who described himself as heterosexual and married. He had practised as a clinical psychologist for 22 years since qualifying and described his therapeutic orientation as primarily humanistic, with secondary influence as cognitive, and the third as psychodynamic. He had not undertaken personal therapy. He mainly worked with elderly people in the N.H.S., and saw patients for 25 hour a week. He had none of his patients in long term therapy (defined as over 50 sessions) and 90% in short term therapy (defined as under 20 sessions).

In terms of physical contact with his patients, he had shaken the hands of patients of both sexes. He had also patted male patients on the arm. He had been sexually attracted

to a patient, and stated that at the time of completing the questionnaire he felt unconcerned about this attraction, and that it had little or no effect. He did not believe that patients could benefit from sexual contact with their therapists.

He admitted to sexual contact with one discharged patient on two occasions. He had previously disclosed this contact to a colleague. The patient was a woman in her early 20's. They engaged in kissing, hand-genital contact and oral-genital contact. He stated that the patient gave full consent to the contact and that pain was not inflicted upon her. He described his involvement with the patient as lasting for one sexual encounter (though this would appear to contradict his earlier statement that sexual contact occurred on two occasions) and at the time of completing the questionnaire had continuing social contact with the patient, but no sexual or therapeutic contact.

He stated that he became sexually involved with the patient almost 25 years ago, when they were both very immature and unsettled in their personal lives. There was a physical attraction and a shared sense of humour/philosophy of life. In terms of the impact the contact might have had upon the patient, he stated that there was certainly no long-term harm, and he did not believe that either of them became involved in the relationship at the time. At the time of completing the questionnaire he felt unconcerned about the contact, which he stated he initiated himself. He explained that he took no direct steps to dissuade the patient from disclosing the contact.

He states, "I saw "Anne" (the pseudonym used for the patient by the respondent) perhaps 15-20 times over a year long period in 1968 after she had been discharged from hospital.

On two occasions our contacts became sexual. I moved away from the area within a year or two but have kept written contact (two to three times a year) with "Anne" and have seen her twice. Her life remained very unsettled until 1974 and during this time she wrote to me and occasionally phoned and in the broadest sense of the word I believe our contact was therapeutic - the more recent letters are on a friendship level. "Anne" has married, developed a good career and achieved national success in a leisure pursuit.

We both knew what we were doing was "wrong". I fully appreciated the thorough unprofessionalism of my actions, though did not believe it would harm my friend - but in retrospect I don't think that was a mature decision - it could have gone seriously wrong but I believed "Anne" to be more stable than her admission to hospital suggested. As I say, this was almost 25 years ago and the action of a very immature young man. I can still treat myself to the odd fantasy when seeing a female to whom I'm attracted but I leave it at that.

P.S. I've just re-read what I have written and if it isn't obvious there is almost a confessional aspect to this. My Catholic/Freudian friends tell me that confession is good for you so I expect I can relax now and wait for the good feelings to roll in, if it wasn't for my anxieties (just about manageable) about disclosure."

This psychologist stated that he did not believe that trainees could benefit from sexual contact with supervisors. He had not engaged in sexual contact with a lecturer when an undergraduate or a postgraduate. He had not treated patients who were sexually involved

with previous therapists. The psychologist was not aware of clinical psychologists through other sources who have been sexually involved with patients.

### **6.2.3. Single sexual contacts with more than one discharged patient**

xix) Psychologist S was a woman in her mid-forties who described herself as heterosexual and single. She had practised as a clinical psychologist for 23 years since qualifying and described her therapeutic orientation as primarily cognitive, with the second influence as behavioural and the third as humanistic. She had undertaken personal therapy. She mainly worked with an adult population in the N.H.S., and sees patients for 25 hours a week. She had 10% of her patients in long term therapy (defined as over 50 sessions) and 60% in short term therapy (defined as under 20 sessions).

In terms of physical contact with her patients, she had shaken the hand and touched the arm/shoulder of patients of both sexes. She had also hugged female patients only. She has been sexually attracted to a patient, and stated that she was unconcerned about this at the time of completing the questionnaire, believing the attraction to have had little or no effect. She did not believe that patients could ever benefit from sexual contact with their therapists.

She admitted to sexual contact with three discharged patients on one occasion each. She stated that it was impossible to quantify the number of occasions on which sexual contact had occurred as she had long term relationships with two of the patients, but estimated 1000 plus occasions. She had previously disclosed her involvement to a

colleague, to her manager and to her personal therapist. The most recent patient with whom she had had sexual contact was a man in his 30's with whom she engaged in kissing, non-genital touching/holding/fondling, hand-genital contact, vaginal intercourse and oral-genital contact. She stated that the patient gave full consent to the contact and that pain was not inflicted upon him. The sexual involvement lasted for more than five years and at the time of completing the questionnaire she had continuing social, but no sexual or therapeutic contact with the patient.

She stated that the contact occurred following an immediate mutual attraction. At the second session, the patient declared that he had only kept his appointment because of this attraction, and did not feel the need for therapy. She stated, "I knew I had to do something before a therapist-patient pattern developed and revealed my attraction to him. I immediately discontinued therapy". This respondent seems to be suggesting that she felt that action needed to be taken before she developed a therapeutic relationship with the patient and in some way thereby revealed her attraction to him. Perhaps she is also suggesting that she discontinued therapy because she was already aware of a pattern in her therapy practice in which she would reveal her attraction to patients and feared repeating it here.

When asked to specify the effects she believed this contact had on the patient, she stated that this was positive since they had a "very good, committed relationship and are now good friends". She felt unconcerned about the contact at the time of completing the questionnaire, which she stated was mutually initiated. She reported that she took no steps to dissuade the patient from disclosing the contact.

This psychologist said that she believed that trainees could not benefit from sexual contact with supervisors. She had no sexual contact with a lecturer when an undergraduate, nor as a postgraduate with trainers. She also denied having sexual contact with a trainee.

She had treated no patients who were sexually involved with previous therapists. She knew of no clinical psychologists through other sources who have been sexually involved with their patients.

Finally, this psychologist comments "I know of an N.H.S. psychiatrist/ analytic psychotherapist who had sexual contact with a number of female clients. All of those I heard about had a history of childhood sexual abuse and he "interpreted" allegations in this context. For all those I heard about it was a negative experience. He was reported, suspended and eventually resigned, though continues to practice privately and to deny responsibility, despite a weight of evidence against him. Old boys' network! I know of a psychiatric nurse who was immediately sacked for what I'd regard as a far less damaging sexual involvement".

### **6.3. SEXUAL CONTACTS WITH BOTH CURRENT AND DISCHARGED PATIENTS**

xx) Psychologist T was a man in his mid-forties who described himself as homosexual and single. He had practised as a clinical psychologist for 20 years since qualifying and described his therapeutic orientation as primarily humanistic, with a secondary influence as behavioural and the third as psychodynamic. He had undertaken

personal therapy. He mainly worked with an psychosexual population in the N.H.S., and saw patients for six hours a week. He had 5% of his patients in long term therapy (defined as over 50 sessions) and 90% in short term therapy (defined as under 20 sessions).

In terms of physical contact with his patients, he had shaken the hands of, patted on the arm, touched the arm/shoulder, hugged and held the hands of patients of both sexes. He had also touched the penis of male patients. He had been sexually attracted to a patient, and stated that he felt unconcerned at the time of completing the questionnaire about this attraction, and that it had little or no effect. He believed that patients could benefit from sexual contact with their therapists.

He admitted to sexual contact with six patients, one after discharge and five whilst the patient was in therapy. His sexual contacts with current patients number five in all, i.e. one with each patient, but the total rises to 800+ when his relationship with the discharged patient is included. The sexual contacts with current patients occurred only within therapy sessions. He had previously disclosed to a colleague, to his personal therapist and to a friend/partner. The most recent patient with whom he had sexual contact was a teenage man with whom he engaged in hand-genital contact. He states that the patient gave full consent to the contact and that pain was not inflicted upon him. The patient was then, and continues to be, in therapy with him, but there was no further sexual contact following this solitary occasion.

He stated that the sexual contact occurred because the patient was concerned about the size of his penis and, having poor literary skills, was not sure about how to use condoms. In terms of the impact the contact might have had upon the patient, he stated that he felt mildly embarrassed, but was reassured by feedback about the size of his penis and clearer about the use of condoms. The psychologist felt unconcerned about the contact at the time of completing the questionnaire and claimed that the contact was initiated by the patient. He explained that he took no direct steps to dissuade the patient from disclosing.

He stated, "The sexual contacts referred to within therapy are not mutual and arose from concerns about penile size, tight foreskins, uncertainty about correct use of condoms, fibrous scar on penile shaft causing crooked erection and explaining surgical strategies in sex reassignment. None were orgasmic or directly construed as a sexual contact by the clients as far as I know.

The other contact was a four year relationship which was embarked upon after the client had been discharged for six months. Over a three or four session contact it became explicitly discussed that he and I found each other sexually and physically attractive prior to therapy as we had met on one previous social occasion. As we were falling in love, I terminated the contract, transferred the case to a colleague and maintained a prohibition on contacting him for six months. As soon as the six month embargo was ended he contacted me proposing a meeting. We became lovers for four years.

When I was counselling teenage gay men, I was frequently propositioned within sessions, either verbally or by the lad rubbing an erection through his trousers. I was tempted on many occasions but refused the invitations. I regard the five contacts within sessions as mildly to moderately abusive in that I should have suggested that they consult a medical practitioner; there was secondary sexual gratification for me; but the contact itself was no more than what a medical practitioner would do or might do. Where erection was achieved the client masturbated to arousal." It is unclear whether the respondent is here referring to orgasm rather than arousal, and if so, this would contradict his previous statement that the contacts were not orgasmic.

"A female supervisor frequently unzipped my trousers and attempted to arouse me to erection manually or orally. I was embarrassed, confused, but felt foolish if I objected or complained."

This psychologist stated that he did not believe that trainees could benefit from sexual contact with supervisors. He had not engaged in sexual contact with a lecturer when an undergraduate, but had done so as a postgraduate. He denied having had sexual contact with his personal therapist or with a trainee. He had treated patients who were sexually involved with previous therapists, that is, a clinical psychologist, a psychiatrist and a private sector psychotherapist. He rated the effects of these sexual contacts on the patients as "mixed" and all three had not been reported. The psychologist was not aware of clinical psychologists through other sources who have been sexually involved with patients.

#### 6.4. SUMMARY AND CONCLUSIONS

The above case descriptions suggest a somewhat mixed picture. Whilst many of the respondents show considerable recognition of the negative or unhelpful impact of the sexual encounters with patients, and state that patients cannot benefit from sexual contact with their therapists, there are also several areas for concern. Some respondents blame the patient for the sexual contact, showing little or no appreciation of the power issues in therapy. Many felt that the contact was mutually initiated. Several of these respondents' reluctance to give information about themselves was evidenced in their tendency to leave many questions unanswered, and not to provide any additional comments.

Most of these respondents had previously disclosed their sexual contact with patients. Many described themselves as not having been sexually attracted to patients, despite their sexual contact, but some of these disclosures are probably not appropriately regarded as sexual contact, since they involve patient initiated, rather than mutual behaviours, such as the patient inviting the therapist to masturbate him/her, or the patient sitting on the therapist's knee, with no response from the therapist.

The majority of the sexual contacts occurred post-discharge and some of these respondents regard sexual contact with current patients as unacceptable. In the light of the current debate concerning the legitimacy or otherwise of post-discharge sexual contact, and the recent statement in the Professional Practice Guidelines of the British Psychological Society (British Psychological Society/Division of Clinical Psychology,

1996) that post-discharge sexual contact with patients may be acceptable under certain circumstances, it could be argued that in some cases of therapist-patient sexual contact disclosed in this research, for example where sexual contact took place four years after the termination of therapy, such sexual contact was not inappropriate.

A number of issues are raised by these accounts. For example, psychologist E describes how a patient known to be flirtatious sat upon his lap. It is not clear to what extent the respondent responded to this patient, but if he did so, such behaviour raises the issue of professional responsibility to maintain the sexual boundary in therapy in order to protect the interests of the patient, no matter how the patient behaves.

Psychologist T describes physical contact with a patient in respect of his patient's concerns about his penis. Although the nature of the contact between this psychologist and his patients was thought by the respondent to be equivalent to the intervention of a G.P. under similar circumstances, and raises the issue of medical versus sexual contact, it is arguable whether a clinical psychologist is appropriately qualified to provide such an intervention, and it is probably inappropriate for such contact to be offered as part of a psychological intervention. Most importantly, the respondent admitted that he derived sexual gratification from the contact. On the basis of the latter alone, it may be argued that it would have been more appropriate for a medical practitioner to address the patient's concerns about his penis in order that the patient's need for advice and reassurance was met rather than risking the psychologist prioritising his needs above those of the patient.



CHAPTER SEVEN

QUALITATIVE DATA: RESULTS



This chapter describes the responses to the four open-ended questions. It also reports data regarding the reliability of the rating of these responses on a four-point scale. There were also several questions which required open-ended responses from those who had engaged in sexual contact with their patients. For these respondents, no data is provided in this section; rather, detail is provided in chapter six.

All direct quotations from these data are verbatim, with a small number of exceptions where slight alterations have been made to the responses in order that the statements are logical and comprehensible to the reader. Any emphasis given in quotations derive from the original responses given.

The questions requiring these answers are given in table 7.1.

**Table 7.1. Open-ended questions**

<p>1. Have you ever felt sexually attracted to one of your patients? YES/NO</p> <p>If NO, why not?</p>
<p>2. Have you ever had what you regard as sexual contact with one of your patients, no matter whether current or discharged? YES/NO</p> <p>If NO, what has stopped you?</p>
<p>3. Do you know through sources other than your own patients, of clinical psychologists who have been sexually involved with their patients? YES/NO</p> <p>Have you taken any action to prevent the continuation of such contacts, for example to report a contact or to discuss the matter with the psychologist concerned? YES/NO</p> <p>If NO, why not?</p>
<p>4. Any further comments.</p>

A content analysis was performed for each of the above questions, and a definitions manual derived from the data in order to develop categories which described the responses (appendix 4). The unit of analysis to which the categories were applied was the entire response to each question by each respondent. Many respondents offered more than one reason within a question, with the result that some responses were categorised more than once. Thus the total number of responses across categories for each question may exceed the total number of respondents who completed each question.

There were a large number of responses to each question, and many of these were similar or identical. Space does not permit a full report of all responses to the qualitative questions. However, examples of responses to each category for each question are given which were chosen by the author, and salient issues and themes are discussed.

The categories were developed by examining half of the questionnaires returned. Subsequently the author categorised the remaining data using this category system. The categories were developed by reading all responses to each question and identifying common themes among the data. Whilst some minor revisions were made to the category system on the basis of the second half of the data, it was clear that the category system applied, on the whole, to the second half of the data. A rating scale of 1 to 4 was used, where 1 = definitely applies; 2 = probably applies; 3 = possibly applies, 4 = does not apply. Each question had a "miscellaneous or uncodeable" and "other" category. The responses coded in these categories did not receive a rating.

For each question, categories are presented in descending order of frequency of popularity. A brief description of the meaning of each category is given in this chapter. For a fuller description, the reader is referred to appendix 4.

### **7.1. RELIABILITY DATA**

Following the author's initial categorisation and rating of all responses, a second rater who had not previously been involved in the research in any capacity categorised and rated all data from the first two questions to provide an indication of the reliability of the

author's ratings. There is no independent test using data derived from other sources, of the reliability of the final category system: further research is required to test it.

Inter-rater agreement was examined separately for each coding category of each of the two questions. For each response, there were two decisions about which the two raters could agree or disagree: was the response codeable, and if so, how should the response be coded on the three point rating scale? In combination, these two decisions mean that each response was assigned to one of four categories; not appropriate to code, level 1, level 2 or level 3. Overall inter-rater agreement was assessed using Cohen's Kappa coefficient computed on the 4 x 4 agreement matrices. An indication of the frequency of disagreement is provided below by comparing the number of responses for each category which both raters agreed should be coded within that category, with the number of responses coded for that category by the author.

Table 7.2 shows for the question relating to sexual attraction towards patients (Have you ever felt sexually attracted to one of your patients? YES/NO. If NO, why not?) the number of responses which both raters agreed should be coded within that category, and the percentage of those responses where both raters agreed on the rating. Also shown is the frequency of responses in that category recorded by the author. For this and subsequent such tables, the categories "miscellaneous" and "other" are not shown in the table since ratings were not allocated to responses coded in those categories.

**Table 7.2. Reasons given for avoiding sexual attraction towards patients: Inter-rater reliability (Frequencies: percentages are given in parentheses)**

Category	Frequency of responses agreed by both raters	Frequency with which raters agreed on point on rating scale (percentage in parentheses)	Frequency coded in this category by author	Cohen's Kappa value
Features of patient population	65	57 (87.7%)	81	0.77
Fortuitous	26	18 (69.2%)	41	0.46
Ethical concerns	26	15 (57.7%)	57	0.53
Nature of therapeutic relationship	16	9 (56.3%)	23	0.44
Don't know	12	11 (91.7%)	20	0.72
Existing relationship	17	17 (100%)	17	0.97
Taboo/repression	9	9 (100%)	10	0.75
Self management	1	1 (100%)	7	0.33
Respondent experiences feelings for patients which preclude the sexual	4	4 (100%)	5	0.72
Traumatic experience	1	1 (100%)	1	1.0

The data in table 7.2 show that for five of the ten categories, there was 100% agreement between the two raters in respect of the point on the rating scale to which responses were allocated. However, in the case of only two categories did both raters allocate the same number of responses to the category and agree on the rating allocated to those responses.

For two categories the inter-rater agreement was only slightly higher than 50%. In the case of two categories the agreement between the raters was in the region of 90%.

The Kappa value was higher than 0.5 (moderate, Landis and Koch, 1977) in the case of all but two categories. For 50% of the categories the value of Kappa was greater than 0.70. A mean Cohen's Kappa was calculated for the data in table 7.2. The mean Kappa value was 0.67, which shows that the mean inter-rater reliability for this category was substantial (Landis and Koch, 1977).

Table 7.3 shows for the question relating to sexual contact with patients (Have you ever had what you regard as sexual contact with one of your patients, no matter whether current or discharged? YES/NO. If NO, what has stopped you?) the frequency with which both raters agreed responses should be coded within that category, and the percentage of those responses where both raters agreed on the rating on the three point rating scale. Also shown is the frequency of responses in that category recorded by the author.

**Table 7.3. Reasons given for avoiding sexual contact with patients: Inter-rater reliability** (Frequencies: percentages are given in parentheses)

Category	Frequency of responses agreed by both raters	Frequency with which raters agreed on point on rating scale (percentage in parentheses)	Frequency coded in this category by author	Cohen's Kappa value
Professional values/ethics	215	146 (68.0%)	264	0.57
Personal values/ethics in relation to therapeutic practice	162	130 (80.2%)	175	0.80
Not having experienced any desire to engage in sexual contact	121	109 (90.1%)	146	0.80
Boundary issues	96	60 (62.5%)	130	0.50
Impact upon the patient	72	60 (83.3%)	121	0.57
Negative personal consequences for self	59	50 (84.7%)	69	0.75
Negative professional consequences for self	26	14 (53.8%)	35	0.57
Lack of opportunity	16	14 (87.5%)	18	0.72
Supervision	3	3 (100%)	4	0.46
Fear of potential negative consequences within the therapy relationship	3	2 (66.7%)	3	0.62
Traumatic experience	1	1 (100%)	1	1.0
Avoidance of sexual contact	1	1 (100%)	1	0.67

The data in table 7.3 show that for three of the twelve categories, there was 100% agreement between the two raters in respect of the point on the rating scale to which responses were allocated. However, in the case of only two categories did both raters allocate the same number of responses to the category and agree on the rating allocated to those responses. For one category the two raters agreed on the number of responses allocated to the category, but disagreed somewhat on the point of the scale to which the responses should be allocated. For one category, whilst the author rated more responses in that category, those which both raters agreed upon were identically rated on the scale. For five categories the inter-rater agreement was higher than 80%.

The Kappa value was less than 0.5 (moderate, Landis and Koch, 1977) in the case of only one of the categories. For five categories, the Kappa value was greater than 0.70. A mean Cohen's Kappa was calculated for the data in table 7.3. The mean Kappa value was 0.67, which shows that the mean inter-rater reliability for this category was substantial (Landis and Koch, 1977).

It may be concluded that for the two open-ended questions included in the reliability analyses, there was some variability between the two raters in their categorisation of the data but that the mean inter-rater reliability as described by Cohen's Kappa was at a substantial level. This suggests that, whilst the category system derived by the author requires further research and validation, it may be viewed, albeit with some caution, as a reasonable method of organising the data from the open-ended questions.

**7.2. CATEGORIES DERIVED FOR EACH QUESTION AND NUMBER OF RESPONSES TO EACH**

**7.2.1. Have you ever felt sexually attracted to one of your patients? YES/NO  
If NO, why not?**

Number of responses coded in only one category: 34

Number of responses coded in two categories: 85

Number of responses coded in three categories: 5

Total number of respondents answering this question: 124

**a) Features of the patient population**

The respondent makes an explicit or implicit statement that s/he works with children, those with learning disabilities, the elderly, same sex patients, or some other group that does not fall within the ambit of the psychologist's sexual orientation.

Table 7.4 shows the number of responses rated by the author in each category for this question.

**Table 7.4. Number of responses and ratings: Features of the patient population**

(Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	66 (81)
Probably applies	12 (15)
Possibly applies	3 (4)
Total	81 (100)

Examples of representative responses to this question include:

1) I don't feel sexually attracted to children; 2) Most are severely disabled and sexual attraction for me is related to intellectual and conceptual issues more than physical attraction; 3) Don't know, I have not had many male patients of my age.

**b) Fortuitous**

The respondent explicitly states that s/he has not felt attracted to patients, either per se, or because, by chance, the respondent has not (yet) been attracted to a patient.

Table 7.5 shows the number of responses rated by the author in each category for this question.

**Table 7.5. Number of responses and ratings: Fortuitous** (Frequencies percentages are given in parentheses)

	Number of responses
Definitely applies	26 (64)
Probably applies	12 (29)
Possibly applies	3 (7)
Total	41 (100)

Examples of representative responses to this question include:

1) Patients have not been attractive; 2) Too busy observing and tackling problems! I don't rule out that I might be attracted to a patient in the future - it just has not happened yet!

**c) Ethical concerns**

The respondent cites reasons for not being attracted to a patient, which would involve ethical concerns about the inappropriateness of attraction to a patient.

Table 7.6 shows the number of responses rated by the author in each category for this question.

**Table 7.6. Number of responses and ratings: Ethical concerns** (Frequencies: percentages are given in parentheses)

	<b>Number of responses</b>
Definitely applies	15 (43)
Probably applies	14 (40)
Possibly applies	6 (17)
Total	35 (100)

Examples of representative responses to this question include:

1) Imbalance of relationship - power, status, etc; 2) There have been male patients I have liked more than others but I would not feel it is right to work therapeutically with anyone I was personally involved with, even if this were mainly sexual attraction; 3) The same reasons as not finding colleagues sexually attractive - trying to keep boundaries between home life and work life, and sexual thoughts feelings about patients to me constitutes a risk of an abusive relationship, and if ever I did feel this way would seek supervision/advice.

**d) Nature of the therapeutic relationship**

Contextual factors within therapy are mentioned by the psychologist which prevent attraction towards a patient from developing.

Table 7.7 shows the number of responses rated by the author in each category for this question.

**Table 7.7. Number of responses and ratings: Nature of the therapeutic relationship**

(Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	13 (57)
Probably applies	9 (39)
Possibly applies	1 (4)
Total	23 (100)

Examples of representative responses to this question include:

1) Not the right setting for me to feel interested; 2) It feels as though I am engaged in a certain job and that issues of sexual attractiveness are not part of that job. I notice that someone is or is not attractive but the boundaries, I feel, seem to prevent my actually BEING sexually attracted; 3) Context/atmosphere of meetings/position/majority of patients are women - I don't know, maybe I've never had any whom I found attractive. I find it hard to imagine a context where it would happen.

e) **Don't know**

The respondent offers no explanation or understanding of his/her stated lack of sexual attraction towards patients, stating explicitly that s/he does not understand it. Alternatively, the respondent states that s/he is unable to answer the question.

Table 7.8 shows the number of responses rated by the author in each category for this question.

**Table 7.8. Number of responses and ratings: Don't know** (Frequencies: percentages are given in parentheses)

	<b>Number of responses</b>
Definitely applies	16 (80)
Probably applies	3 (15)
Definitely applies	1 (5)
Total	20 (100)

Examples of representative responses to this question include:

- 1) I don't know;
- 2) No idea! Situation never arose - not an appropriate context.

**f) Existing relationship**

The respondent states that the fact that s/he is already in a relationship has prevented him/her from becoming attracted to patients.

Table 7.9 shows the number of responses rated by the author in each category for this question.

**Table 7.9. Number of responses and ratings: Existing relationship** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	17 (100)
Probably applies	0 (0)
Possibly applies	0 (0)
Total	17 (100)

Examples of representative responses to this question include:

- 1) I think because I am very content and fulfilled within my partnership with my husband;
- 2) I have been in the same married relationship since before training.

**g) Miscellaneous or uncodeable**

This category may include instances when the respondent has apparently misunderstood the question, or makes comments about the question itself which do not lend themselves to coding in other categories.

Total = 16

Examples of representative responses to this question include:

1) Stupid question; 2) Why? seems more to the point; 3) Just "no".

**h) Taboo/repression**

The psychologist makes a statement that s/he has not been attracted to a patient because of a taboo upon it, or some form of repression/suppression/denial of sexual feelings for patients.

Table 7.10 shows the number of responses rated by the author in each category for this question.

**Table 7.10. Number of responses and ratings: Taboo/repression.** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	8 (80)
Probably applies	2 (20)
Possibly applies	0 (0)
Total	10 (100)

Examples of representative responses to this question include:

1) Taboo: "not allowed"; 2) I'm not quite sure - possibly a) I'm happily married b) I'm trying to understand my clients' behaviour and situation - my personal feelings are under control c) Perhaps I'm using denial!

i) **Self management**

The respondent mentions explicitly that his/her thoughts or assumptions are either aimed to avoid attraction to patients or would function in such a way as to exclude it.

Table 7.11 shows the number of responses rated by the author in each category for this question.

**Table 7.11. Number of responses and ratings: Self management** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	3 (43)
Probably applies	3 (43)
Possibly applies	1 (14)
Total	7 (100)

Examples of representative responses to this question include:

1) It would be so out of "role" that it would not enter into the thought sequence. I'm too busy problem solving! 2) Cognitive set aimed to avoid it.

**j) Other**

Any response which does not fit into the other categories.

Total = 5

Examples of representative responses to this question include:

1) It's not compulsory; 2) Why should we? Implies OUGHT!

**k) Respondent experiences feelings for patients which preclude the sexual**

The psychologist describes feelings such as maternal or protective feelings towards patients, which preclude sexual feelings.

Table 7.12 shows the number of responses rated by the author in each category for this question.

**Table 7.12. Number of responses and ratings: Respondent experiences feelings for patients which preclude the sexual** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	4 (80)
Probably applies	1 (20)
Possibly applies	0 (0)
Total	5 (100)

Examples of representative responses to this question include:

1) I don't feel attracted to people who are dependent on me; 2) Don't know: client group I work with tend to inspire maternal/protective instincts rather than sexual; 3) There is a fairly big gap, educationally and socially (between respondent and patients).

### 1) Traumatic experience

The respondent mentions a negative personal/sexual experience with a patient, which exerted a traumatic effect and has resulted in an inhibition of any sexual feelings towards patients.

Table 7.13 shows the number of responses rated by the author in each category for this question.

**Table 7.13. Number of responses and ratings: Traumatic experience** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	1 (100)
Probably applies	0 (0)
Possibly applies	0 (0)
Total	1 (100)

The response to this question was:

1) May be something to do with a nasty experience eleven years ago when I was "touched up" by a high security prisoner so I am very practised at switching off.

Table 7.14 summarises the number of responses rated by the author in each category for this question.

**Table 7.14. Summary of number of responses to each category: Reasons given for not experiencing sexual attraction to patients**

Features of patient population	81 (31)
Fortuitous	41 (16)
Ethical concerns	35 (13)
Nature of therapeutic relationship	23 (8)
Don't know	20 (8)
Existing relationship	17 (7)
Miscellaneous or uncodeable	16 (6)
Taboo/repression	10 (4)
Self management	7 (3)
Other	5 (2)
Respondent experiences feelings for patients which preclude the sexual	5 (2)
Traumatic experience	1 (1)
Total	261 (100)

A substantial proportion (28%) of respondents offered no reason for their lack of sexual attraction to patients, either by not responding to this question (145), or by responding that they did not know why they had not been attracted to their patients (20). Some respondents (41) stated that it had been fortuitous that they had not been attracted to patients, for example because attraction had never occurred or had not yet occurred. Seventeen clinical psychologists attributed their lack of sexual attraction to patients to the fact that they had an existing relationship, this somehow precluding such attraction. Many respondents cited ethical concerns (35) or therapeutic considerations such as the nature of the relationship (23) or features of the patient population (81) as factors in their lack of attraction to patients.

The implication in the responses of many respondents was either that sexual attraction was unacceptable in itself or that they had not thought about the issue. It may be argued that this approach to therapy is potentially problematic and may constitute a predisposing factor which places therapists at risk for sexual contact with patients (Pope and Bouhoutsos, 1986).

**7.2.2. Have you ever had what you regard as sexual contact with one of your patients, no matter whether current or discharged? YES/NO**

**If NO, what has stopped you?**

Number of responses coded in only one category: 305

Number of responses coded in two categories: 91

Number of responses coded in three categories: 13

Number of responses coded in five categories: 2

Total number of respondents answering this question: 411

**a) Professional values/ethics**

The respondent mentions purely professional and/or ethical reasons which relate to a code of practice rather than personal moral judgment for refraining from sexual contact with patients.

Table 7.15 shows the number of responses rated by the author in each category for this question.

**Table 7.15. Number of responses and ratings: Professional values/ethics**  
(Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	220 (83)
Probably applies	16 (6)
Possibly applies	28 (11)
Total	264 (100)

Examples of representative responses to this question include:

1) Ethics - it is entirely inappropriate and harmful to patients; 2) I think it is totally unacceptable - I think it is exploiting a therapist's professional position of trust and is harmful to the patient. Also I believe in being faithful to my husband; 3) I think it would be extremely unprofessional and potentially abusive.

**b) Personal values/ethics in relation to therapeutic practice**

The respondent defines his/her own values as excluding sexual contact with patients: by implication, the rationale for this is related to the power issue in therapy and the potential negative effects upon the patient.

Table 7.16 shows the number of responses rated by the author in each category for this question.

**Table 7.16. Number of responses and ratings: Personal values/ethics in relation to therapeutic practice** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	129 (74)
Probably applies	23 (13)
Possibly applies	23 (13)
Total	175 (100)

Examples of representative responses to this question include:

1) Boundaries of therapy and my own values of being therapist; 2) Idea didn't occur to me, not attractive to me, and I believe it would be wrong to do so even if wanted to; 3) It promises what cannot be given - it implies that it is part of therapy, it damages therapy, breaks trust and goes against personal values.

**c) Not having experienced any desire to engage in sexual contact**

The respondent explains that s/he has not engaged in sexual contact with patients because of a failure to find a patient, or patients as a category, or the particular client group with which they work, attractive.

Table 7.17 shows the number of responses rated by the author in each category for this question.

**Table 7.17. Number of responses and ratings: Not having experienced any desire to engage in sexual contact** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	136 (93)
Probably applies	9 (6)
Possibly applies	1 (1)
Total	146 (100)

Examples of representative responses to this question include:

- 1) I've never had the desire for sexual contact with one of my clients as far as I can remember;
- 2) Concern for the patient, i.e. not exploit; not that keen on any patient seen; wish to maintain professionalism;
- 3) No temptation.

**d) Boundary issues**

The respondent provides as a rationale for refraining from sexual contact with patients the notion that to do so would be to transgress boundaries of therapy and thus, by implication, have a therapeutically unhelpful effect upon the patient.

Table 7.18 shows the number of responses rated by the author in each category for this question.

**Table 7.18. Number of responses and ratings: Boundary issues** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	67 (52)
Probably applies	33 (25)
Possibly applies	30 (23)
Total	130 (100)

Examples of representative responses to this question include:

1) Not beneficial for them - my sexual attraction belongs to me (countertransference) or needs to be addressed in a session (transference); 2) Belief that limits should be set and made clear; 3) I have not been attracted to a patient as such. Professional and personal boundaries and situations prevented me from pursuing contact with carers (response received from respondent working with children).

**e) Impact upon the patient**

The potentially negative impact upon the patient of sexual contact with their psychologist, is put forward by the respondent as a reason for his/her avoidance of such behaviour.

Table 7.19 shows the number of responses rated by the author in each category for this question.

**Table 7.19. Number of responses and ratings: Impact upon the patient**

(Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	103 (85)
Probably applies	15 (12)
Possibly applies	3 (3)
Total	121 (100)

Examples of representative responses to this question include:

1) Because I believe it is unprofessional, exploitative and unlikely to be of any therapeutic value, indeed it would be harmful; 2) Never seemed relevant or appropriate in the situation I work in. Belief that it would be exploitative and would break a basic trust; 3) Anxiety re consequences, feeling that it is unlikely to be good for patient, patient unlikely to agree, it just is not done.

**f) Negative personal consequences for self**

The psychologist states that there were personal reasons for refraining from sexual contact with patients.

Table 7.20 shows the number of responses rated by the author in each category for this question.

**Table 7.20. Number of responses and ratings: Negative personal consequences for self** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	54 (78)
Probably applies	11 (16)
Possibly applies	4 (6)
Total	69 (100)

Examples of representative responses to this question include:

1) 1 Unethical 2 unprofessional 3 counterproductive therapeutically 4 likely damage to own sexual relationship; 2) A happy marriage, an enjoyable career, no wish to put either in jeopardy.

**g) Negative professional consequences for self**

The psychologist provides as a reason for avoiding sexual contact with patients the potential negative consequences for him/herself professionally.

Table 7.21 shows the number of responses rated by the author in each category for this question.

**Table 7.21. Number of responses and ratings: Negative professional consequences for self** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	17 (49)
Probably applies	14 (40)
Possibly applies	4 (11)
Total	35 (100)

Examples of representative responses to this question include:

1) Not really wanting to, ethical reasons, damage to further therapy, damage to career, etc; 2) Self control/would not benefit patient or self; 3) Code of ethics/damage to patient/relationship damage to professional reputation - damage to personal relationship, insufficient attraction.

**h) Lack of opportunity**

The respondent states that the reason for his/her lack of sexual contact with patients is because of lack of opportunity.

Table 7.22 shows the number of responses rated by the author in each category for this question.

**Table 7.22. Number of responses and ratings: Lack of opportunity** (Frequencies: percentages are given in parentheses)

	<b>Number of responses</b>
Definitely applies	17 (94)
Probably applies	2 (6)
Possibly applies	0 (0)
Total	18 (100)

Examples of representative responses to this question include:

1) No appropriate opportunity; 2) The situation has not arisen; 3) Never socialised/in situation to lead to sexual contact - consider it unethical.

**i) Other**

Any response which does not fit into the other categories.

Total = 17

Examples of representative responses to this question include:

1) Wrong environment; 2) Thinking; 3) It was merely a physical attraction.

**j) Miscellaneous or uncodeable**

This category may include instances when the respondent has apparently misunderstood the question, or makes comments about the question itself which do not lend themselves to coding in other categories.

Total = 12

Examples of representative responses to this question include:

1) What sort of question is this? 2) I have not needed anything to stop me! 3) If something never starts, it does not require stopping.

**k) Supervision**

The respondent cites the opportunity in supervision to discuss issues of attraction in therapy, as safeguarding the respondent from acting out sexual feelings with the patient.

Table 7.23 shows the number of responses rated by the author in each category for this question.

**Table 7.23. Number of responses and ratings: Supervision** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	4 (100)
Probably applies	0 (0)
Possibly applies	0 (0)
Total	4 (100)

Examples of responses to this question include:

1) Ethical considerations - but thank goodness for excellent supervision received; 2) Supervision - appreciation of inequalities in therapy. Would have sexualized client, would have been sexual abuse of considerable damage; 3) I firmly believe this to be damaging and abusive to the patient. Supervision is a help.

**1) Fear of potential negative consequences within the therapy relationship**

The respondent states that s/he lacks the confidence to approach a patient if s/he were attracted to one.

Table 7.24 shows the number of responses rated by the author in each category for this question.

**Table 7.24. Number of responses and ratings: Fear of potential negative consequences within the therapy relationship** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	3 (100)
Probably applies	0 (0)
Possibly applies	0 (0)
Total	3 (100)

Examples of responses to this question include:

1) The implications, and that includes not doing the job they need done. And, to be honest, a degree of 'shyness' and the potential for rejection, I suppose; 2) Indolence, shyness, fear, professionalism;

m) **Don't know**

The respondent makes an explicit statement that s/he can provide no rationale for his/her failure to become sexually involved with patients.

Table 7.25 shows the number of responses rated by the author in each category for this question.

**Table 7.25. Number of responses and ratings: Don't know** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	3 (100)
Probably applies	0 (0)
Possibly applies	0 (0)
Total	3 (100)

Examples of responses to this question include:

1) Don't know: client group I work with tend to inspire maternal/protective instincts rather than sexual; 2) Don't know.

**n) Traumatic experience**

The respondent cites a traumatic/negative experience in relation to patients, as reason for failure to engage in/avoidance of sexual contact with them.

Table 7.26 shows the number of responses rated by the author in each category for this question.

**Table 7.26. Number of responses and ratings: Traumatic experience** (Frequencies: percentages are given in parentheses)

	<b>Number of responses</b>
Definitely applies	1 (100)
Probably applies	0 (0)
Possibly applies	0 (0)
Total	1 (100)

The response to this question was:

Not felt attracted enough - would not feel it is appropriate to abuse position of trust. Also early experience with client in prison setting groped me and I had him charged (and convicted), therefore I probably strive to be "neuter" at work.

**o) Avoidance of sexual contact**

The respondent has deliberately avoided situations in which sexual contact with patients might occur.

Table 7.27 shows the number of responses rated by the author in each category for this question.

**Table 7.27. Number of responses and ratings: Avoidance of sexual contact**

(Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	1 (100)
Probably applies	0 (0)
Possibly applies	0 (0)
Total	1 (100)

The response to this question was:

I stayed well away so as not to get into that situation.

Table 7.28 summarises the number of responses rated by the author in each category for this question.

**Table 7.28. Summary of number of responses to each category: Reasons given for refraining from sexual contact with patients**

Professional values/ethics	264 (26)
Personal values/ethics in relation to therapeutic practice	175 (18)
Not having experienced any desire to engage in sexual contact	146 (15)
Boundary issues	130 (13)
Impact upon the patient	121 (12)
Negative personal consequences for self	69 (7)
Negative professional consequences for self	35 (3)
Lack of opportunity	18 (2)
Other	17 (2)
Miscellaneous or uncodeable	12 (1)
Supervision	4 (0.4)
Fear of potential negative consequences within the therapy relationship	3 (0.2)
Don't know	3 (0.2)
Traumatic experience	1 (0.1)
Avoidance of sexual contact	1 (0.1)
Total	999 (100)

An area of interest in respondents' answers to this question is the reasons given for refraining from sexual contact with patients other than those related to professional/ethical/therapeutic issues or the potential impact upon the patient. The majority of respondents gave such "ethical" reasons: from 999 responses, 690 fell into these categories. However, 47 respondents gave as their sole reason for refraining from sexual contact with patients the fact that they had not experienced a wish to engage in

sexual contact with them, implying that had they experienced sexual attraction, they may have attempted actual sexual contact, and 146 gave this as one of their reasons.

Although 35 respondents cited fear of negative professional consequences for themselves as a reason for not having had sexual contact with patients, and 69 reported fear of negative personal consequences, only one individual gave fear of negative professional consequences as the sole reason for refraining from sexual contact, and no respondent gave fear of negative personal consequences as the sole rationale. A total of 18 respondents cited lack of opportunity for sexual contact with patients as one of their reasons for refraining from sexual involvement with patients.

Thus, a large number of respondents implied or even explicitly stated in their answers that they might consider sexual contact with patients if they were to be sexually attracted to them. For example, one respondent stated that sexual contact had not occurred because he was "not attracted to them *yet*" (my emphasis). Others stated that they had not had sexual contact with patients because of a lack of attraction to them, thus implying that sexual contact might be a possibility were attraction to occur.

A variety of views were expressed by respondents in relation to the issue of sexual contact with discharged patients, though this was not a topic which was directly raised in this question. Three respondents in their answers to this question stated that they felt that post-termination sexual contact with patients would be acceptable. However, one respondent stated that "sexual contact with a patient would be exploitative and detrimental to therapy even after treatment sessions have ended" (respondent 270).

Another respondent expressed the view that sexual contact with patients, both within and after the termination of, the therapeutic relationship, was unacceptable.

Only one previous empirical study has asked respondents to give their reasons for refraining from sexual intimacies with patients (Pope et al, 1986). The categories identified in that survey are as follows,

Unethical
Countertherapeutic/exploitative
Unprofessional practice
Against therapist's personal values
Therapist already in a committed relationship
Fear of censure/loss of reputation
Damaging to the therapist
Disrupts handling of the transference/countertransference
Fear of retaliation by client
Attraction too weak/shortlived
Illegal
Self-control
Common sense
Miscellaneous

Clearly many of these categories are similar to those identified in the present study, in particular professional/ethical and therapeutic concerns, as well as personal values and the fact that many therapists were already involved in a relationship. Some of the differences between the present findings and those of Pope et al (1986) lie in differences in the legal system between Britain and North America, rendering "illegal" a valid

category in the U.S.A. but not relevant in Britain. No respondents in this study stated that their attraction to a patient was too weak or short-lived.

**7.2.3. Do you know through sources other than your own patients, of clinical psychologists who have been sexually involved with their patients? YES/NO**

**Have you taken any action to prevent the continuation of such contacts, for example to report a contact or to discuss the matter with the psychologist concerned? YES/NO**

**If NO, why not?**

Number of responses coded in only one category: 132

Number of responses coded in two categories: 42

Number of responses coded in three categories: 3

Total number of respondents answering this question: 179

**a) Action had already been taken**

The respondent felt that action was not warranted since other parties had taken relevant action regarding the sexual contact between the psychologist and patient, or another form of action had been taken.

Table 7.29 shows the number of responses rated by the author in each category for this question.

**Table 7.29. Number of responses and ratings: Action had already been taken**  
(Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	80 (93)
Probably applies	6 (7)
Possibly applies	0 (0)
Total	86 (100)

Examples of representative responses to this question include:

- 1) Because I only heard of the contact through hearing of the disciplinary procedures being carried out;
- 2) Was communicated to me by someone on the investigatory panel;
- 3) Action already been taken.

**b) Hearsay only**

The respondent did not report a sexual contact between a therapist and patient because his/her knowledge of the contact was indirect.

Table 7.30 shows the number of responses rated by the author in each category for this question.

**Table 7.30. Number of responses and ratings: Hearsay only**

	Number of responses
Definitely applies	35 (95)
Probably applies	2 (5)
Possibly applies	0 (0)
Total	37 (100)

Examples of representative responses to this question include:

1) This was hearsay concerning an individual and the alleged relationship occurred five years ago; 2) Heard through a third party: no direct observation; 3) Knowledge gained via personal/social grapevine rather than personal knowledge/evidence.

c) **The respondent did not believe it to be his/her responsibility to take action**

The respondent has not reported a sexual contact between psychologist and patient because s/he felt that this was not his/her responsibility.

Table 7.31 shows the number of responses rated by the author in each category for this question.

**Table 7.31. Number of responses and ratings: The respondent did not believe it to be his/her responsibility to take action** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	26 (84)
Probably applies	5 (6)
Possibly applies	0 (0)
Total	31 (100)

Examples of representative responses to this question include:

1) Not directly involved/action already taken; 2) No contact, etc; 3) Not in my district, one was rumour, one was charged with assaulting a minor, and I don't know if this was a patient.

**d) The sexual contact was not current**

The respondent states that a sexual contact between a psychologist and patient had occurred in the past and had now ceased, thus suggesting that reporting was inappropriate **mainly** on the basis that the event had occurred in the past.

Table 7.32 shows the number of responses rated by the author in each category for this question.

**Table 7.32. Number of responses and ratings: The sexual contact was not current**

(Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	22 (91)
Probably applies	1 (4.5)
Possibly applies	1 (4.5)
Total	24 (100)

Examples of representative responses to this question include:

1) Not current - hearsay only; 2) This was hearsay concerning an individual and the alleged relationship occurred five years ago; 3) Knowledge of past behaviour, passed on to me by supervisor and colleagues.

**e) Other**

Any response which does not fit into the other categories.

Total = 11

Examples of responses to this question include:

- 1) Feel the issues of distorted therapist/client relationship more relevant to adult work;
- 2) As above, I am inherently opposed to exploitation of therapeutic relationship;
- 3) The situation has never arisen.

**f) No risk of reoffending**

The respondent states that s/he did not/does not believe that action is required or justified in relation to a case of sexual contact between psychologist and patient.

Table 7.33 shows the number of responses rated by the author in each category for this question.

**Table 7.33. Number of responses and ratings: No risk of reoffending** (Frequencies: percentages are given in parentheses)

	<b>Number of responses</b>
Definitely applies	6 (86)
Probably applies	1 (14)
Possibly applies	0 (0)
Total	7 (100)

Examples of representative responses to this question include:

1) The psychologist in question stopped practising; 2) Action already taken in two cases. In one case the psychologist is dead; 3) Only found out after psychologists had left employment.

**g) Miscellaneous or uncodeable**

This category may include instances when the respondent has apparently misunderstood the question, or makes comments about the question itself which do not lend themselves to coding in other categories.

Total = 6

Examples of responses to this question include:

1) Knowledge only gained after the event - thereafter action taken; 2) Not necessary; 3) It was generally known about psychologist in the area by colleagues. Not sure if he has been reported.

**h) The sexual contact was not considered to be harmful to the patient**

The respondent implies or explicitly states that s/he believes that action was not warranted because there was, in his/her opinion, no harmful consequences for the patient.

Table 7.34 shows the number of responses rated by the author in each category for this question.

**Table 7.34. Number of responses and ratings: The sexual contact was not considered to be harmful to the patient** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	6 (100)
Probably applies	0 (0)
Possibly applies	0 (0)
Total	6 (100)

Examples of representative responses to this question include:

1) In one case, it was suspected but not witnessed so no opportunity was available to report. In the other case, the psychologist married the client; 2) The sexual contact was in the context of a genuine, long term relationship which took place after therapy had finished and I therefore believed there was no deliberate exploitative element; 3) All were women who subsequently married the patient- no-one was complaining.

**i) Fear of retribution/retaliation**

The respondent states or implies that no action was taken because of the offender's senior/power position in relation to him/her, or because of other reasons for fearing negative consequences to him/herself as a result of action.

Table 7.35 shows the number of responses rated by the author in each category for this question.

**Table 7.35. Number of responses and ratings: Fear of retribution/retaliation**

(Frequencies: percentages are given in parentheses)

	<b>Number of responses</b>
Definitely applies	4 (100)
Probably applies	0 (0)
Possibly applies	0 (0)
Total	4 (100)

Examples of responses to this question include:

1) The individual was senior to me, and no definite proof was available; 2) One was dismissed from his post; one was my supervisor during clinical training; one discontinued the relationship; 3) This man has now been medically retired on separate/distinct health grounds. I did however consider taking action but rejected it as my relationship with this man was so awful, I would not have been believed, and might

have been dismissed myself for making the subject known. He was my district psychologist and had previously suspended me from work, initially for making a stand on client confidentiality.

**j) No understanding of the importance of taking action**

The respondent acknowledges that action should have been taken but recognises that at the time s/he did not understand that this was necessary.

Table 7.36 shows the number of responses rated by the author in each category for this question.

**Table 7.36. Number of responses and ratings: No understanding of the importance of taking action** (Frequencies: percentages are given in parentheses)

	<b>Number of responses</b>
Definitely applies	3 (75)
Probably applies	1 (25)
Possibly applies	0 (0)
Total	4 (100)

Examples of representative responses to this question include:

1) One was a long time ago before I realised how important it is to take action; 2) At the time I was uncertain of the facts. Also it was early in my career and I did not

appreciate the gravity of the situation. If a similar situation arose now I think I would be more likely to firstly talk to the therapist concerned and if necessary report him/her; 3) I heard many years ago that a woman I knew slightly had been involved sexually with her therapist. This had happened a long time ago and I did not know where the therapist was working. In any case I did not know of any specific action that I should have taken.

**k) The sexual contact occurred after termination of therapy**

A clear statement should be made by the respondent that because the sexual contact between psychologist and patient began after therapy had ended, there was no reason to consider it inappropriate, and therefore no reason to report it.

Table 7.37 shows the number of responses rated by the author in each category for this question.

**Table 7.37. Number of responses and ratings: The sexual contact occurred after termination of therapy** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	3 (100)
Probably applies	0 (0)
Possibly applies	0 (0)
Total	3 (100)

Examples of representative responses to this question include:

1) Event occurred after cessation of therapeutic contact, several years ago; 2) The patient was discharged before the relationship was consummated. The psychologist was well aware of the professional issues involved and behaved responsibly in ending their professional relationship before entering a personal one; 3) In one case, the sexual contact began after the psychologist had discharged the patient. They then formed a stable relationship. In the other one, the information came from a clinical psychologist friend in a geographically distant N.H.S. department regarding that head of department. She was trying to take some action.

**1) Suspicion only**

The respondent only suspected that a clinical psychologist had engaged in sexual contact with a patient. This should be a **personal** suspicion, based on factors other than the suspicions/allegations of third parties.

Table 7.38 shows the number of responses rated by the author in each category for this question.

**Table 7.38. Number of responses and ratings: Suspicion only** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	1 (50)
Probably applies	0 (0)
Possibly applies	1 (50)
Total	2 (100)

Examples of representative responses to this question include:

1) In one case, it was suspected but not witnessed so no opportunity was available to take action. In the other case, the psychologist married the client; 2) The information was second hand and contact had ceased. Individual identities were also vague; 3) No information.

**m) The respondent was a friend of the offending psychologist**

The respondent states explicitly or implies that s/he did not report the offending psychologist **because** of a personal relationship between him/herself and the psychologist.

Table 7.39 shows the number of responses rated by the author in each category for this question.

**Table 7.39. Number of responses and ratings: The respondent was a friend of the offending psychologist** (Frequencies: percentages are given in parentheses)

	<b>Number of responses</b>
Definitely applies	1 (100)
Probably applies	0 (0)
Possibly applies	0 (0)
Total	1 (100)

The response in this category was as follows:

The person was a close friend of mine and I discussed my views but did not take it further.

**n) Patient was to blame for the sexual contact**

The respondent puts forward the view that the sexual contact was not the fault of the psychologist, but that of the patient, and that therefore no action was warranted.

Table 7.40 shows the number of responses rated by the author in each category for this question.

**Table 7.40. Number of responses and ratings: Patient was to blame for the sexual contact**

	Number of responses
Definitely applies	0
Probably applies	0
Possibly applies	0
Total	0

There were no responses in this category.

Table 7.41 summarises the number of responses rated by the author in each category for this question.

**Table 7.41. Summary of number of responses to each category: Reasons given for not reporting sexual contact with patients by clinical psychologists**

Action had already been taken	86 (39)
Hearsay only	37 (17)
The respondent did not believe it to be his/her responsibility to take action	31 (14)
The sexual contact was not current	24 (11)
Other	11 (5)
No risk of reoffending	7 (3)
Miscellaneous or uncodeable	6 (2)
The sexual contact was not considered to be harmful to the patient	6 (2)
Fear of retribution/retaliation	4 (2)
No understanding of the importance of taking action	4 (2)
The sexual contact occurred after termination of therapy	3 (1)
Suspicion only	2 (1)
The respondent was a friend of the offending psychologist	1 (1)
Patient was to blame for the sexual contact	0 (0)
Total	222 (100)

The largest number of responses in any one category in this question (86) related to the fact that some action had already been taken about a psychologist who had engaged in sexual contact with a patient and thus no further action was necessary by the respondent. A further substantial number of respondents (37) lacked evidence to take action, for example because their knowledge was based on hearsay only.

However, some clinical psychologists had taken no action to report colleagues who had engaged in sexual contact with patients because the sexual contact was not current (24), because it occurred after termination of therapy (3) or because it was not considered to be harmful to the patient (6). Seven respondents stated that they did not believe that the psychologist in question was at risk of reoffending. It is not clear from the British Psychological Society Code of Conduct (1991) that these are legitimate grounds for refraining from taking action in relation to sexual abuse of patients, and such responses are thus causes for concern, suggesting that education of British Psychological Society members in relation to the Code of Conduct (British Psychological Society, 1991) is necessary, beyond mere distribution of the document.

A number of respondents (31) stated that they did not believe it to be their responsibility to take action for various reasons, often because they lived some distance away from the offending psychologist. Such attitudes may potentially result in psychologists who sexually abuse patients escaping the consequences of this behaviour, and are thus problematic, particularly since the British Psychological Society Code of Conduct (1991) suggests that professional misconduct on the part of colleagues is always the concern of members.

Only a few psychologists were unaware of the need to take action in relation to colleagues who engage in sexual contact with patients (4), were unable to do so because of fear of retribution/retaliation (4), or because they were a friend of the offending psychologist (1). These responses do demonstrate that a small minority of cases of

sexual contact with patients may never come to light for such reasons, and thus are also causes for concern.

#### **7.2.4. Any further comments**

Number of respondents coded in only one category: 209

Number of respondents coded in two categories: 53

Number of respondents coded in three categories: 23

Number of respondents coded in four categories: 3

Number of respondents coded in five categories: 1

Total number of respondents answering this question: 289

##### **a) Comments supporting the research**

Positive comments about the research are made by the psychologist, who may also offer help or resources to the author.

Table 7.42 shows the number of responses rated by the author in each category for this question.

**Table 7.42. Number of responses and ratings: Comments supporting the research**

(Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	91 (97)
Probably applies	3 (3)
Possibly applies	0 (0)
Total	94 (100)

Examples of representative responses to this question include:

1) Please publish your research: I am interested in your results! 2) Just to encourage you in this study - I hope people reply, are honest and that you publish! 3) I'm glad you are doing this research and hope the results will be published. It's time this issue was acknowledged and dealt with in Britain.

**b) Other**

Any response which does not fit into the other categories.

Total = 33

Examples of responses to this question include:

1) An issue that needs a lot more emphasis and discussion during clinical training. Also an issue about false accusations about us - we are sometimes vulnerable - alone with clients; 2) As indicated in section six, on the one occasion on which I became aware of a psychologist being sexually involved with a client, I reported it to the authorities. It is not an experience I would wish to repeat. The psychologist denied the charges and was cleared subsequently. The authority made no attempt to contact the client or other people who knew of the circumstances. I and my colleague who reported it also, were humiliated at the disciplinary hearing and made to feel we were "on trial". It was clear they wanted to "hush" the matter up. Maybe I will keep my mouth shut next time. 3) I think that this is an important study to carry out. I do, however, think that physical contact with a client can be useful and sometimes necessary, e.g. holding a child's hand to help them climb some stairs. It is, however, also possible for therapists to use physical contact in an abusive way, exploiting the power they have in the client-therapist relationship. I'm sure that you are aware of this, I just think it is a shame that your questionnaire has not addressed this factor.

**c) Comments about the research methodology**

The psychologist makes comments about the research methodology, including the way in which the questionnaire is constructed or structured.

Table 7.43 shows the number of responses rated by the author in each category for this question.

**Table 7.43. Number of responses and ratings: Comments about the research methodology** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	24 (75)
Probably applies	8 (25)
Possibly applies	0 (0)
Total	32 (100)

Examples of representative responses to this question include:

1) In some of your questions "do you believe such a person can ever benefit" - is a rather broad question, and as such makes it more difficult to answer. In some of your questions I would have chosen a don't know box had there been one. I think there should have been; 2) Question two section two doesn't really lend itself to a yes/no answer. When does recognition that a person is attractive become sexual attraction? If the answer to this is that a degree of physical arousal, fantasy, or wish to establish a sexual relationship is required then my answer to this question is correct. If you used the question to mean recognition that under some other circumstances the other might be a sexual partner then it is incorrect; 3) Boxes for numerical responses were too small.

**d) Comments on sexual relationships between educators and trainees**

The psychologist offers some comments about the issue of sexual relationships between educators and trainees, either supporting the practice or not.

Table 7.44 shows the number of responses rated by the author in each category for this question.

**Table 7.44. Number of responses and ratings: Comments on sexual relationships between educators and trainees** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	30 (100)
Probably applies	0 (0)
Possibly applies	0 (0)
Total	30 (100)

Examples of representative responses to this question include:

1) In terms of sexual relationships between supervisors and trainees, it seems perfectly legitimate for consenting adults to enjoy sharing their sexuality **as long as this is not exploitative** (original emphasis) on the part of either partner. In this particular type of relationship, boundary confusion could be problematic but not insuperable. After all, people still fall in love - don't they?! 2) In terms of getting through training some students do seem to benefit from relationships with supervisors/lecturers i.e. better

marks, extra academic help etc. Also some "benefits" in terms of finding a successful long term relationship. However, I do not feel students/trainees benefit on a personal level from such relationships. It seems they are often abusive and power-based. 3) Undergraduate sexual contact based on power relationship i.e. fear of effects of rejecting lecturer's advances. In the 1960's there was no possibility of reporting. Sexual harassment as such was not recognised. I am aware of many unreported advances towards myself and other female undergraduates by male lecturers which were unreported. When I became a lecturer myself and was privy to lecturers' discussions I realised male lecturers "picked out" the ones with whom they wanted affairs as they were enrolling, i.e. being processed as new students.

**e) Comments on sexual attraction in therapy**

General comments are offered on the issue of sexual attraction in therapy, for example as an issue in its own right, which should be considered in depth.

Table 7.45 shows the number of responses rated by the author in each category for this question.

**Table 7.45. Number of responses and ratings: Comments on sexual attraction in therapy** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	25 (96)
Probably applies	1 (4)
Possibly applies	0 (0)
Total	26 (100)

Examples of representative responses to this question include:

1) Perhaps it is important to look at influence of attraction between patient and therapist which does not involve sexual contact. Attraction is bound to influence duration, number of sessions undertaken and outcome, and be a factor in a majority of therapeutic encounters. Maybe through this survey you are only touching the tip of the iceberg of the role/influence that attraction has in the therapy situation, as the numbers, surely, will be very small where actual sexual contact has taken place; 2) I found Section 2.4 difficult to answer in the sense that my sexual attraction to a client "concerns" me being of therapeutic interest/significance and informative whilst not "concerning" me vis-à-vis damage to the client/ethically wrong etc. I have taken the item to refer to the latter interpretation of "concern". 3) I think it's unprofessional to act on sexual attraction towards patients either during therapy or at any time after. It's impossible not to be attracted to at least one patient over many years as a therapist.

**f) Ethical issues**

The psychologist comments that therapist-patient sexual contact is an ethical issue, or makes remarks which carry this implication.

Table 7.46 shows the number of responses rated by the author in each category for this question.

**Table 7.46. Number of responses and ratings: Ethical issues** (Frequencies: percentages are given in parentheses)

	<b>Number of responses</b>
Definitely applies	20 (87)
Probably applies	3 (13)
Possibly applies	0 (0)
Total	23 (100)

Examples of representative responses to this question include:

1) I think it is morally and ethically not appropriate and if you are in the N.H.S. then it can be one of the reasons for dismissal. Our professional training does not allow you to see a patient as a sexual object; 2) I would have thought that any question of sexual behaviour with a patient by a psychologist would be explicitly ruled out - certainly by section 19 of the 1983 guidelines (of the British Psychological Society) and would if claimed or discovered result in the psychologist's being struck from the register (if

chartered) and from the British Psychological Society membership (if a member). The probability is therefore that therapist/patient sex would be much more likely to occur when the psychologist is neither chartered nor British Psychological Society (member)! Other non-sexual contacts are, in my experience, common, especially in the care of the handicapped; 3) There is a code of ethics which **MUST** be followed. Vulnerable people do not need to be placed in dangerous situations and therapists who cannot keep their private life separate from work should not be allowed to practice.

**g) Questioning whether respondents would answer the questionnaire truthfully**

The psychologist makes a statement about the possibility that respondents may not answer some of the questions honestly, possibly because of the delicate/sensitive nature of some of the questions.

Table 7.47 shows the number of responses rated by the author in each category for this question.

**Table 7.47. Number of responses and ratings: Questioning whether respondents would answer the questionnaire truthfully** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	20 (91)
Probably applies	2 (9)
Possibly applies	0 (0)
Total	22 (100)

Examples of representative responses to this question include:

1) Are you going to get truthful answers: it was easy for me to fill in as I am certain that I have never had any sexual contact but if I had, I might have been very unhappy about filling in the section; 2) My responses in sections four and five refer to a psychologist with whom I worked. I was totally unaware that he was sexually abusing several female clients until he was suspended and subsequently dismissed following a statement made by an ex-patient to the Unit General Manager. I feel that it is important to point out that if he, or others like him, were to receive this questionnaire it is unlikely that they would return it and/or complete it honestly; 3) I wonder how honest people are going to be?!

**h) Detail of colleagues who have had sexual contact/behaved sexually inappropriately with patients**

The respondent mentions other professionals who s/he knows to have behaved inappropriately in sexual terms with patients.

Table 7.48 shows the number of responses rated by the author in each category for this question.

**Table 7.48. Number of responses and ratings: Detail of colleagues who have had sexual contact/ behaved sexually inappropriately with patients** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	19 (95)
Probably applies	1 (5)
Possibly applies	0 (0)
Total	20 (100)

Examples of representative responses to this question include:

1) I worked with a colleague who I realised had more than once formed a sexual relationship with a patient after the clinical contact had cease. He was a psychiatrist, not a clinical psychologist. At the time I thought this was "a bit iffy", rather than unethical.

Now I think it was probably unethical behaviour, as it happened twice to my knowledge (i.e. once could have been put down to an unfortunate mutual attraction); 2) I have not thought of it before but interestingly I know of other professionals who have had sexual contact with patients but none of them psychologists - mainly psychiatrists; 3) I was aware of a female patient being sexually "abused" by her previous G.P. in the name of "sex therapy", which made her unwilling to see male therapists in future.

**i) Preventative suggestions**

The respondent makes suggestions for the prevention of sexual contact between therapists and trainees, such as compulsory supervision, encouraging patients to assume more power in therapy.

Table 7.49 shows the number of responses rated by the author in each category for this question.

**Table 7.49. Number of responses and ratings: Preventative suggestions**  
(Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	15 (79)
Probably applies	3 (16)
Possibly applies	1 (5)
Total	19 (100)

Examples of representative responses to this question include:

1) I recognise occasions where sexual attraction occurs and feel it is very important for all therapists to be in supervision or have someone with whom they can understand and make sense of this; 2) I know of several cases of sexual "passes", sexual contact and harassment made to and of trainees and assistant psychologists by lecturers and supervisors but have no information on patients. The profession needs to consider ways of addressing these issues: we do not know what people do in their consulting rooms. Maybe live supervision (as in family therapy) is one answer; 3) If professionalism is stressed in training and your department, there is an absolute taboo on sexual contact with patients as being completely unprofessional and antitherapeutic, it is never on the agenda/never contemplated, i.e. a complete physical and mental no-go area. If such a strong taboo exists it helps to remove desire. If it was admitted as a real possibility I would expect to be troubled with temptation more.

**j) Therapist-patient sexual contact can be damaging**

The respondent states that s/he believes that sexual contact (and perhaps other forms of intimacy such as friendship) between therapist and patient is unjustifiable because of its negative effects on the patient.

Table 7.50 shows the number of responses rated by the author in each category for this question.

**Table 7.50. Number of responses and ratings: Therapist-patient sexual contact can be damaging** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	11 (85)
Probably applies	2 (15)
Possibly applies	0 (0)
Total	13 (100)

Examples of representative responses to this question include:

1) Offering friendship or a special relationship to a client can be damaging even if sexual contact is not involved; 2) I would see sexual involvement with clients/trainees etc. as a serious breach of trust; 3) I consider that it is an abuse of the therapeutic relationship- there is a difference between sexual attraction- which is "normal"- and you can't actually control what you feel- but you can control what you do with your feelings, and expression of sexual feelings between an active therapist-client relationship seems totally wrong- contrary to therapeutic- in my opinion.

**k) Miscellaneous or uncodeable**

This category may include instances when the respondent has apparently misunderstood the question, or makes comments about the question itself which do not lend themselves to coding in other categories.

Total = 12

Examples of responses to this question include:

1) I attended a study day for clinical psychologists on child sexual abuse three years ago. A member of audience said they knew of sexual contact between psychologist and client. This created much uproar and denial/protests from the audience; 2) I would be surprised if this were such an issue in the U.K. - particularly in the NHS where the ambience is far removed from U.S. "west coastism"; 3) If sexual contact/attraction occurs, the psychologist should immediately seek advice from their supervisor or a senior psychologist, as to the management of problem and further care of patient.

#### **D) Power issues in therapy**

Comments are made about the salience of power issues in the area of sexual contact between therapist and patient.

Table 7.51 shows the number of responses rated by the author in each category for this question.

**Table 7.51. Number of responses and ratings: Power issues in therapy**  
(Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	11 (100)
Probably applies	0 (0)
Possibly applies	0 (0)
Total	11 (100)

Examples of representative responses to this question include:

1) These are issues of abuse of power; 2) Exploiting any relationship where a power imbalance exists for sexual purposes is obviously wrong. I think anyone who believes sex with a patient could benefit them is deceiving him or herself; 3) I believe sexual contact between therapist and patient/lecturer and student is like sexual contact between parent and child - an abuse of power and a betrayal of trust.

**m) Disclosure of personal experience of sexual abuse or sexual dilemmas**

The respondent makes a disclosure not contained elsewhere in the questionnaire about personal experiences which are relevant.

Table 7.52 shows the number of responses rated by the author in each category for this question.

**Table 7.52. Number of responses and ratings: Disclosure of personal experience of sexual abuse or sexual dilemmas** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	7 (70)
Probably applies	3 (30)
Possibly applies	0 (0)
Total	10 (100)

Examples of representative responses to this question include:

1) I have knowledge of a personal friend who was sexually involved with her psychotherapist. She now regards this relationship as damaging and exploitative on the part of the therapist; 2) As a nursing assistant before clinical training I felt an attraction for a male patient on a secure ward. The attraction was mutual and acknowledged. The only physical contact that ever occurred was when he gave me surprise peck on the lips once during a game of pool. The experience of feeling attracted to this person was very distressing for me, as I felt it was unprofessional and not in the best interests of the patient. I eventually had to reject contact with him when he continued to write to me after his discharge. He had then moved away from the area. The last I heard about him was four years ago when he went to prison. The experience has made me very aware of my feelings for clients and has certainly made me sure that sexual involvement with a client would be unacceptable for both me and the other party; 3) As a technician my supervisor asked me to go to bed with him and said he found it difficult to supervise me

because he found me sexually attractive. I think that he has responded similarly with at least one other supervisee. I did not report this.

**n) I had not thought about or experienced this before or tend not to consider patients in a sexual way**

The respondent states that s/he had not given consideration to the issues of sexual contact with patients, or had not been sexually attracted to patients, or had not been aware of the issues, prior to receiving the questionnaire.

Table 7.53 shows the number of responses rated by the author in each category for this question.

**Table 7.53. Number of responses and ratings: I had not thought about or experienced this before or tend not to consider patients in a sexual way**  
(Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	5 (56)
Probably applies	3 (33)
Possibly applies	1 (11)
Total	9 (100)

Examples of representative responses to this question include:

1) I never used to consider the possibility of child sexual abuse until it hit the headlines, and so was virtually unaware of it. It has never occurred to me that any of my professional colleagues would allow themselves to act out any attractions they felt. Perhaps I have been naive; 2) I was very concerned at receiving this questionnaire as I had not expected sexual abuse of patients to be an issue, and if it occurred I would have hoped this would be reported; 3) I have never considered this question before.

**o) Sexual contact with ex patients or ex trainees is acceptable**

The respondent makes an explicit statement that s/he believes that it is acceptable to have a sexual relationship with a discharged client or a former trainee.

Table 7.54 shows the number of responses rated by the author in each category for this question.

**Table 7.54. Number of responses and ratings: Sexual contact with ex-patients or ex-trainees is acceptable** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	8 (89)
Probably applies	1 (11)
Possibly applies	0 (0)
Total	9 (100)

Examples of representative responses to this question include:

1) I think any sexual contact with clients or juniors i.e. students is exploitative and can NEVER be justified. Ex-clients or ex-students are different: both have completely free choice; 2) A situation where a sexual contact results from or becomes part of a long standing commitment or marriage I think is a different situation from the one implied throughout the questionnaire. This should have been indicated; 3) In terms of sexual relationships between supervisors and trainees, it seems perfectly legitimate for consenting adults to enjoy sharing their sexuality **as long as this is not exploitative** on the part of either partner. In this particular type of relationship, boundary confusion could be problematic but not insuperable. After all, people still fall in love - don't they?! In other types of relationship covered by the survey, I find it difficult to imagine a scenario where patient/therapist sexual involvement would be beneficial **IN THE COURSE** of therapy. This might POSSIBLY be legitimate after case closure, though even then I think there are ethical and professional problems.

**p) Suggestions for further research**

The respondent makes a specific suggestion for future research in this or a related field, or mentions an issue which s/he does not feel was covered by the research/questionnaire.

Table 7.55 shows the number of responses rated by the author in each category for this question.

**Table 7.55. Number of responses and ratings: Suggestions for further research**

(Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	6 (86)
Probably applies	1 (14)
Possibly applies	0 (0)
Total	7 (100)

Examples of representative responses to this question include:

1) I feel that it would be interesting to give a similar questionnaire to psychiatrists; 2) Your survey doesn't seem to deal with sexual harassment at work, e.g. staff and secretary etc., or issues of inappropriate sexual relationships at work e.g. staff having sexual relationships on a ward (which has occurred in this district); 3) I suspect the gender of the therapist makes a big difference with regard to sexual attraction/contact with patients. I hope your questionnaire does gain information from people who engage in sexual relationships with clients. It would be interesting to compare your findings with a random sample of clinical psychologists' patients views one day!

**q) Sexual contact with patients can be acceptable under some circumstances**

The respondent offers the view that there may be times or circumstances under which it can be acceptable for therapist and patient to have a sexual relationship, for example if both parties "consent".

Table 7.56 shows the number of responses rated by the author in each category for this question.

**Table 7.56. Number of responses and ratings: Sexual contact with patients can be acceptable under some circumstances** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	6 (86)
Probably applies	1 (14)
Possibly applies	0 (0)
Total	7 (100)

Examples of representative responses to this question include:

1) Psychologists are humans first and therapists second. Sexual attraction is not a crime, taking advantage of a therapeutic relationship is. Two consenting adults may do entirely

as they please: the emphasis is on the word **CONSENTING**; 2) I have responded sexually but only on a cognitive level, to probably three or four female outpatients, in about 20 years. I just think it would be unacceptable to have sexual contact with them, and that's quite enough to inhibit me. In terms of a specific sex therapy approach, there may well be therapeutic benefits from a therapist-patient relationship, but this is the sole situation, as far as I can see, where such sexual contact would be appropriate; 3) Whilst it is just possible that sexual contact between therapist and patient could be helpful I would think that overwhelmingly such contact would be considered non-beneficial, and a transgression of a trusting and professional relationship. The question of supervisor/trainee relationships is more open. Would these be considered to be any more "special" than any other "workplace" sexual relationship?

**r) Negative comments about the research**

Explicitly negative comments are made about the research topic or approach. Specifically negative comments about the questionnaire should be coded under i).

Table 7.57 shows the number of responses rated by the author in each category for this question.

**Table 7.57. Number of responses and ratings: Negative comments about the research** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	2 (33)
Probably applies	4 (67)
Possibly applies	0 (0)
Total	6 (100)

Examples of representative responses to this question include:

1) What a boring dissertation; 2) I feel this questionnaire should be dated April 1st; 3) Although I have completed this questionnaire I do not feel it is ethical to send out material asking questions of this nature. I am very surprised if it has been passed by the ethical committee - which I suspect it has not.

s) **Gender issues**

The respondent mentions the relevance of gender issues to the subject of therapist-patient sexual contact.

Table 7.58 shows the number of responses rated by the author in each category for this question.

**Table 7.58. Number of responses and ratings: Gender issues** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	6 (100)
Probably applies	0 (0)
Possibly applies	0 (0)
Total	6 (100)

Examples of representative responses to this question include:

1) I have attended two workshops recently where I have been concerned about gender differences in attitudes towards sexual contact i.e. male psychologists seeing sexual contact as not necessarily taboo. For myself, seeing a caseload which primarily comprises women who have been abused, I see any sexual contact - therapist/client, supervisor/trainee, lecturer/student, as a blurring/violation of boundaries and an abuse of the unequal power dynamic of the situation; 2) The department I work in has evolved such that there is a great deal of supervision, both peer and with an external supervisor. There is also an analytically run staff group with an external facilitator. Sexual issues come up (with enormous anxiety) but the overall effect is to raise consciousness about the issues. I think now that if anyone had a sexual relationship with, for example, a trainee on placement, there would be enormous public expressed condemnation, even if the perpetrator wasn't the supervisor. Sex with a patient would be even worse of course. One factor is the fact that the external supervisor is a feminist who has considerable experience of sex abuse and I think that this is very significant in terms of naming issues

(e.g. power), especially from the point of view of we men in the department. In other words good regular feminist supervision is important for all male psychologists/psychotherapists. As a man, my experiential awareness has been increased by contact with the strong feminist views of friends and my partner, who worked in rape crisis. This has made self-deception (which I am as good at as anyone else) more problematic when involved in seemingly innocent activities such as flirting! 3) I have been looking at sexual harassment in clinical psychology in the South West for my M.Sc. in clinical psychology. Men seem to be reporting most "harassment" from clients - which could be interpreted as sexuality etc. in therapy being interpreted/handled "wrongly" by therapists.

**t) Comments about dealing with sexual impropriety**

The respondent makes comments about the issues involved in managing actual or suspected sexual impropriety either between therapist and patient or between psychologist and supervisor.

Table 7.59 shows the number of responses rated by the author in each category for this question.

**Table 7.59. Number of responses and ratings: Comments about dealing with sexual impropriety** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	2 (67)
Probably applies	1 (33)
Possibly applies	0 (0)
Total	3 (100)

An example of a representative response to this question is:

1) I have stated that one psychologist was sexually involved with more than one patient. There was no absolute proof of this, but there was very strong circumstantial evidence. The strongest evidence arose in the last few days of his employment. It was discussed among members of the Psychology Department, including a secretary. Subsequent discussions with the Medical Director revealed that the person had left a previous hospital ten years earlier after forming a sexual relationship with a patient and marrying her. A very difficult situation occurs when the problem lies with the Head of Department who writes references for other posts, has influence within the hospital and when one does not know of anyone else who has previous knowledge of inappropriate behaviour. With trainees and assistants the problem of liking/disliking and sexual attraction can be discussed, and anyone showing potentially problematic behaviour can be largely controlled by discussion, laying down rules, and ultimate sanction as referees, failing placements, etc., although I've not had to do the latter.

**u) Some allegations of sexual abuse by therapists are false**

The respondent comments that some patients may make false allegations against their therapists of sexual abuse.

Table 7.60 shows the number of responses rated by the author in each category for this question.

**Table 7.60. Number of responses and ratings: Some allegations of sexual abuse by therapists are false** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	2 (100)
Probably applies	0 (0)
Possibly applies	0 (0)
Total	2 (100)

The responses to this question were:

1) I have known of alleged sexual contacts which were later held to be fictitious; 2) This is an issue that needs a lot more emphasis and discussion during clinical training. Also an issue about false accusations about us - we are sometimes vulnerable - since our practice frequently means that we are alone with clients.

**v) Hearsay only**

The respondent mentions that some of his/her responses to the questionnaire are based on hearsay only rather than direct experience.

Table 7.61 shows the number of responses rated by the author in each category for this question.

**Table 7.61. Number of responses and ratings: Hearsay only** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	1 (50)
Probably applies	1 (50)
Possibly applies	0 (0)
Total	2 (100)

The responses to this question were:

- 1) Section six - I have answered "no" because anything I have heard has been rumour only and I do not feel able to document this;
- 2) Often the situation is known about through rumour - not necessarily substantiated.

**w) Comments about theoretical orientation**

The respondent mentions the issue of theoretical orientation in relation to the issue of sexual contact between therapists and their patients.

Table 7.62 shows the number of responses rated by the author in each category for this question.

**Table 7.62. Number of responses and ratings: Comments about theoretical orientation**

	<b>Number of responses</b>
Definitely applies	1 (100)
Probably applies	0 (0)
Possibly applies	0 (0)
Total	1 (100)

The response to this question was:

1) As I look back over my replies, I seem possibly to represent a state of blissful ignorance. But I think that's because I'm less concerned with cataloguing historic events (with clients) than with getting on with constructional skills development.

**x) Organisational/professional responsibility**

A statement is made that the issue of sexual contact between therapist and patient is not the responsibility of the therapist, but of the profession or of the organisation.

Table 7.63 shows the number of responses rated by the author in each category for this question.

**Table 7.63. Number of responses and ratings: Organisational/professional responsibility** (Frequencies: percentages are given in parentheses)

	Number of responses
Definitely applies	1 (100)
Probably applies	0 (0)
Possibly applies	0 (0)
Total	1 (100)

The response to this question was:

I would hold the profession rather than the individuals responsible. Training courses do not adequately address these issues. Holding the notion of countertransference still seems to be viewed with hostility and bewilderment in all too many quarters.

y) **I have felt tempted but I keep myself under control**

The respondent states explicitly that s/he has felt sexually attracted to patients but has consciously kept such impulses under control.

Table 7.64 shows the number of responses rated by the author in each category for this question.

**Table 7.64. Number of responses and ratings: I have felt tempted but I keep myself under control** (Frequencies: percentages are given in parentheses)

	<b>Number of responses</b>
Definitely applies	0 (0)
Probably applies	1 (100)
Possibly applies	0 (0)
Total	1 (100)

The response to this question was:

Maybe this questionnaire will read like a "heavily repressed me". However, I feel I can't deny that I occasionally feel sexual attraction to a woman at work but I also think the therapist/supervisor role is a very privileged one, and certainly the former carries very compelling responsibilities on men to keep their gonads under control. If they can't do it they should go and do another job.

Table 7.65 summarises the number of responses rated by the author in each category for this question.

**Table 7.65. Summary of number of responses to each category: Any further comments**

Comments supporting the research	94 (24)
Other	33 (8)
Comments about the research methodology	32 (8)
Comments on sexual relationships between educators and trainees	30 (8)
Comments on sexual attraction in therapy	26 (7)
Ethical issues	23 (6)
Questioning whether respondents would answer the questionnaire truthfully	22 (6)
Detail of colleagues who have had sexual contact/behaved sexually inappropriately with patients	20 (5)
Preventative suggestions	19 (5)
Therapist-patient sexual contact can be damaging	13 (3)
Miscellaneous or uncodeable	12 (3)
Power issues in therapy	11 (3)
Disclosure of personal experience of sexual abuse or sexual dilemmas	10 (3)
I had not thought about or experienced this before or tend not to consider patients in a sexual way	9 (2)
Sexual contact with ex clients or ex trainees is acceptable	9 (2)
Suggestions for further research	7 (1)
Sexual contact with patients can be acceptable under some circumstances	7 (1)
Negative comments about the research	6 (1)
Gender issues	6 (1)
Comments about dealing with sexual impropriety	3 (0.75)
Some allegations of sexual abuse by therapists are false	2 (0.5)
Hearsay only	2 (0.5)
Comments about theoretical orientation	1 (0.2)
Organisational/professional responsibility	1 (0.2)
I have felt tempted but I keep myself under control	1 (0.2)
<b>Total</b>	<b>399 (100)</b>

Three respondents commented in their responses to this question that if they had engaged in sexual contact with their patients, they would not disclose it in this questionnaire. Thus, the question of the accuracy of the responses received is raised, as well as whether a proportion of those clinical psychologists who did not return their questionnaires had been sexually involved with their patients.

Ninety four of the 289 clinical psychologists who responded to this question gave positive feedback about the research, whereas only six made negative comments. This lends encouragement to the view that the sexual abuse of patients by therapists is becoming an increasing cause for concern in Britain, and that psychologists are beginning to take the matter seriously and welcome research and action in the field.

It may be suggested that a failure to acknowledge or experience, or even to deny, sexual attraction towards patients may be a predisposing factor in terms of sexual contact with patients. One respondent to this question made a comment which supports this view, "the answer to section two, question two (the question relating to sexual attraction to patients), if answered negatively, could be a pointer towards denial". In their consideration of sexual attraction in therapy, Rodolfa et al (1994) suggest that:

*"Psychologists who do not accept their feelings (of attraction) will be inadequately prepared to effectively use them appropriately in therapy" (p170)*

An extension of this argument is that such psychologists may be disposed to *use* their feelings of attraction inappropriately.

Nine respondents expressed the view that improved training in the field of sexual attraction/contact and boundary issues is warranted for clinical psychologists as a preventative measure in terms of sexual contact with patients.



**CHAPTER EIGHT**

**DISCUSSION AND CONCLUSIONS**



The return rate of 58.1% achieved in the present research compares favourably with the highest return rates reported for similar surveys conducted in North America. Such surveys, conducted with a variety of professional groups, have yielded return rates between 26% (Gartrell et al, 1986) and 58.6% (Derosis et al, 1987). It is arguable that there are cultural differences between Britain and North America in respect of attitudes towards sexual matters, for example, sexual matters may be more widely discussed in some more progressive areas of the U.S.A. Whilst such a difference may adversely influence willingness in a British sample to respond to a survey concerned with sexual issues, the difference may be less pronounced in professional populations. It is also possible that willingness to respond to this survey was positively influenced by the recent increase of attention which has been afforded in the U.K. to the issue of sexual contact between therapists and their patients, both in public and professional domains (cf. chapter one, section 1.1.).

#### **8.1. DISCUSSION OF QUANTITATIVE DATA**

The present findings should be interpreted cautiously in the light of the discrepancies found in research studies between psychologists' reported ethical beliefs and their behaviour (Folman, 1991). The results of this study may represent an underestimate of therapist-patient sexual contact, and present a more positive picture of British clinical psychologists' ethical beliefs than may be warranted.

### 8.1.1. Prediction of prevalence of therapist-patient sexual contact

In this survey, 3.4% of the sample reported that they had engaged in what they regarded as sexual contact with at least one of their patients. Using the information given by respondents regarding the type of sexual contact which took place, the sexual contact may be separated into two categories, sexual intercourse and other sexual intimacies. However, in those cases where a respondent had sexual contact with more than one patient, the precise nature of contacts with previous patients is unknown since detailed information regarding the nature of the sexual contact was only requested in relation to the *last* patient with whom sexual contact took place, if there had been more than one such contact. The level of psychologist-patient sexual *intercourse* (that is, vaginal intercourse and anal penetration) reported in this study was broadly in accordance with that reported in recent U.S. studies. The rate of 2% is remarkably similar to that of 1.9% reported by Pope et al (1987) in a North American survey of psychologists. There are no recent North American figures for *non intercourse* erotic activity but the figure found in this study (1.4%) is considerably lower than the 4.6% reported by Holroyd and Brodsky (1980).

Other studies which have recently enquired about sexual contact *in general* have reported comparable findings. For example Rodolfa et al (1994) report that 4% of their sample of psychologists had engaged in "sexual intimacies" with their patients and Gechtman (1989), in a survey of social workers, found that 3.8% of respondents reported engaging in "erotic contact" with clients. These figures are very similar to the overall figure for sexual contact with patients in this study of 3.4%.

It was noted in chapter one that recent surveys conducted in North America have reported lower rates of sexual contact between mental health professionals and their patients than surveys conducted some time ago. Whilst some American researchers have concluded that this indicates a decrease in frequency in the incidence of therapist-patient sexual contact, there are some methodological problems in reaching such a conclusion, notably that the way in which respondents are asked about their sexual contact with patients may differ from survey to survey. It is not possible from the present data to consider the question of changes in the incidence of therapist-patient sexual contact, since the survey was cross-sectional.

Whilst this study was designed in order to gain information about all sexual contact which has ever occurred in a therapist's lifetime, such methodology has the consequence that the results of this study cannot be used in the future to consider the question of changes in therapist-patient sexual contact in Britain. Future research might address itself to the question of the annual proportion of therapeutic relationships in which sexual contact occurs, in order that changes in such behaviour could be monitored.

If under-reporting of respondents' own sexual contact with patients occurred in this study, responses to other questions may compensate for this. That is, respondents' treatment of patients who were sexually involved with previous therapists, and their knowledge through other sources of clinical psychologists who had sexual contact with their patients, are alternative avenues to estimating the prevalence of sexual contact. However, there is inevitable overlap between respondents in their knowledge of such

psychologists, so estimates of prevalence based on such reports may exceed true prevalence rates.

The proportions of respondents in this sample who had treated patients who were sexually involved with their therapists, and who knew of clinical psychologists who had engaged in sexual contact with their patients were substantial (22.7% and 38% respectively). This provides some indication that the proportion of British therapists treating patients who have been sexually involved with a previous therapist may be lower than in the U.S.A.: in Stake and Oliver's (1991) sample of North American psychologists, for example, 44% of respondents had treated a patient who had been sexually involved with a previous therapist. In practice, however, even the figure of 22.7% reported in this survey may be somewhat elevated since some respondents who described having treated patients who had been sexually involved with a previous therapist included in this category sexual contact with professionals (e.g. G.P.) other than psychotherapists. Additionally, some cases could be reported more than once. However, it is possible that respondents may not have been aware of all sexual contact which had occurred between their patients and former therapists due to lack of disclosure by some patients.

It could be argued that there is likely to be less duplication of reporting of cases of therapist-patient sexual contact in respondents' reports of treating patients who had been sexually involved with previous therapists, than in their reports of knowledge through other sources of clinical psychologists who had sexual contact with their patients, since one patient is likely to be treated by only a small number of therapists, whereas many

clinical psychologists could be aware of certain "notorious" cases of sexual contact between colleagues and their patients.

A substantial minority (over 38%) of respondents reported knowledge through sources other than their patients, of clinical psychologists who had been sexually involved with their patients. It is possible that many respondents reported the same cases here (usually, perhaps, through "grapevine" knowledge of notorious cases in the area), and it is therefore likely that the reporting rate of 38% is likely to over-estimate the prevalence of sexual contact between clinical psychologists and their patients.

However, the difference between the self-report figure of 3.4% and the 22.7% of respondents whose patients had been sexually involved with a previous therapist does suggest that there may be some under-reporting in the present survey of respondents' own sexual contact with patients as a result either of non-responding, or of non-disclosure.

In this study, 61% of respondents had been sexually attracted towards their patients, and of these, just over 10% expressed some concern about the attraction. In studies conducted in North America, remarkably similar results have been found. Between 85% (Stake and Oliver, 1991) and 88% (Rodolfa et al, 1994) of respondents in similar surveys have reported feeling sexually attracted to their patients. Of Rodolfa et al's (1994) sample, approximately half of those who reported sexual attraction had experienced some discomfort, anxiety or guilt about it. Thus, whilst a smaller proportion of the present sample reported sexual attraction to their patients, there appears to be less

concern amongst these individuals about the appropriateness of such attraction. The differences in reported sexual attraction towards patients between the present survey and surveys conducted in North America may be the consequence of cultural differences since it would appear that in the surveys carried out in the U.S.A., questions about sexual attraction to patients were asked in a similar manner to that used in the present study. In general, surveys have asked respondents whether they have *ever* been attracted to a *patient*, thus suggesting that any experience of such attraction, even in relation to one patient, should be included.

#### **8.1.2. Predictive variables**

A small number of variables were shown in the present study to be predictive of clinical psychologists' sexual contact with their current or discharged patients. These variables were sexual contact as a postgraduate trainee clinical psychologist with an educator, number of years of postqualification practice as a clinical psychologist, and sexual orientation. That is, those clinical psychologists who had sexual contact with an educator during their professional (i.e. postgraduate) training were more likely to engage in later sexual contact with one or more of their patients than those who had not experienced such postgraduate sexual contact, those respondents who had been qualified for longer were more likely to report sexual contact with patients than those who qualified more recently, and clinical psychologists who described their sexual orientation as homosexual were more likely to report sexual contact with their patients than were those whose sexual orientation was bisexual or heterosexual.

Reversal theory (Apter, 1989) would suggest that sexual contact with an educator as a student or trainee, and possibly emotional "burnout" as a consequence of lengthy clinical practice could result in an impaired ability to experience sympathy and allocentric states, the states necessary for appropriate clinical practice, or a difficulty in reversing to those states. It is less clear how one might explain the increased likelihood of homosexually oriented respondents engaging in sexual contact with their patients but some possibilities present themselves. Further information, particularly in relation to the patient's sexual orientation, for example, is required to provide a detailed formulation, but it is possible that the data support the contention that patients in such situations are likely to be exploring their sexual orientation in therapy, or that the therapists felt uncomfortable with their homosexual feelings (Benowitz, 1994). Alternatively, it is possible that those respondents who were prepared to admit their homosexuality to themselves or in completing the questionnaire, were more likely to admit to sexual involvement with their patients.

The above findings must be interpreted with caution in view of the poor predictive capacity of the statistical model employed. In addition, it is not possible to conclude that other variables included in the model, such as therapeutic orientation, marital status and experience of personal therapy are not predictive of clinical psychologists' sexual contact with patients. Rather, it may be concluded that this research was unable to establish any predictive value for such variables, and it may be suggested that further research could address those variables.

Although only a small number of variables were found to **predict** which clinical psychologists engaged in sexual contact with their patients, other statistical tests used in the research (e.g. chi square tests) may shed some light on the reasons why such contact occurs. Chi square analyses in relation to the variables which were found to be predictive of such contact also showed that those respondents who reported sexual contact with their patients were more likely to regard themselves as homosexual, to report sexual contact as a postgraduate with an educator, and to have practised for a longer period of time than those who did not report sexual contact with their patients.

A number of other variables were found, on chi square analysis, to differentiate respondents who reported sexual contact with their patients from those who did not. There was a significantly greater proportion of men in the group which reported sexual contact with their patients than in the group which reported no sexual contact. There was a significantly greater proportion of respondents who were single or in a stable relationship in the former group. This finding affords some support to the psychodynamic explanation of sexual contact between therapists and their patients in that single therapists are perhaps, in Strean's (1993) terms, more likely to crave love in their lives, thus seeking it from their patients. However, the opposite could be argued in relation to the finding that those in stable relationships were better represented in the group reporting sexual contact with patients.

Those who reported sexual contact with their patients were more likely to view sexual contact with a therapist as beneficial for patients than respondents who did not report such contact. Similarly, clinical psychologists who had been sexually involved with their

patients were more likely than their counterparts who did not report such contact, to view sexual contact with an educator as beneficial for trainees. Those who reported sexual involvement with their patients were more likely to have experienced undergraduate sexual contact with an educator than those who did not report such sexual involvement.

Such attitudes may be understood in terms of cognitive dissonance theory (Festinger, 1957) which suggests that human beings are motivated to maintain cognitive consistency in order to avoid discomfort; thus a therapist who has engaged in sexual contact with patients must modify his/her beliefs in order that they become congruent with that behaviour. Reversal theory (Apter, 1989) also offers an understanding of this phenomenon in that such therapists may not experience a reversal of motivational state when engaging in sexual contact with their patients and may thus be able to maintain the belief that such contact was beneficial to the patient.

Respondents who had been sexually involved with a patient were no more likely than their colleagues who did not report such contact, to use various forms of physical contact differentially with opposite sex patients. The opposite has been found in the U.S.A. (Holroyd and Brodsky, 1980). Differential use of physical contact with opposite sex patients occurs where the professional is more likely to use non erotic physical contact with patients of one sex than the other. It is possible that no significant difference was found in relation to differential use of physical contact with opposite sex patients because of the method used to code the data prior to the statistical analyses. That is, all types of physical contact with patients were collapsed into one category

which may have proved too general to distinguish between relatively uncontroversial forms of touch such as handshakes, and more contentious types such as hugging. This finding may also have occurred because a substantial minority of the sexual contacts reported in this study were homosexual in nature.

Few studies have attempted to identify variables which predict which therapists are likely to engage in therapist-patient sexual contact, but in a study of counsellors, Thoreson et al (1993) found that, overall, the best predictor of sexual contact with patients was that the more favourable their view of sexual contact with patients, the more likely counsellors were to report such behaviour. Thoreson et al do, however, acknowledge that such attitudes may not have preceded sexual contact, but may merely represent a rationalisation mechanism. The identification and exploration of such attitudinal factors would be a fruitful area for further research in this field.

One might have expected that those who engaged in sexual contact with their patients may have been more likely to report sexual attraction to them than those who did not engage in such contact. However, this was not the case. Two of the reported incidents of sexual contact with patients occurred when the respondent was not an active participant. For example, one respondent described being physically restrained by the patient's dog whilst the patient made verbal sexual suggestions to her. Another reported responding to the patient's sexual concerns, yet not being sexually attracted to him. These respondents did not report sexual attraction to any of their other patients. This, and the high reported level of sexual attraction towards patients among the sample generally, may explain the

absence of an association between sexual attraction towards patients and sexual contact with them.

Perhaps one of the main distinctive contributions of the present research in comparison to other surveys is that there was no significant gender difference in the group of respondents which reported sexual contact with their patients, and that those respondents who identified their sexual orientation as homosexual were more likely to report sexual contact with their patients.

### **8.1.3. Prevalence of trainer-trainee sexual contact in this, and other, surveys**

In this study, two main means of accessing information about the prevalence of trainer-trainee sexual contact were employed. First, respondents were asked whether they had engaged in sexual contact with their educators, either as undergraduates and as postgraduates, and second, those respondents who were lecturers/supervisors were asked whether they had engaged in sexual contact with their own students/trainees.

Just under 7% (40) of the sample reported sexual contact with an educator as an undergraduate and a similar figure (39) reported such sexual contact as a postgraduate student. There was relatively little overlap between these groups: only eight respondents reported sexual contact with educators both as an undergraduate and as a postgraduate. Thus, a total of 71, or 12.2% of this sample engaged in sexual contact with educators.

There are a number of North American surveys which report levels of trainer-trainee sexual contact in applied psychology (but none relating to other mental health professions), though only that of Glaser and Thorpe (1986) distinguishes between sexual contact during undergraduate and postgraduate education. In a survey of members of the Psychotherapy Division of the American Psychological Association, Pope et al (1979) found that 10% reported sexual contact as students with their educators. Two other surveys investigated respondents' levels of sexual contact during training with their educators. Robinson and Reid (1985, cited in Pope, 1989) found that 13.6% of American Psychological Association members (not only clinicians) reported sexual contact with at least one educator. In a survey of clinical psychologist members of the same organisation, Glaser and Thorpe (1986) report that 17% of their sample reported "intimate sexual contact" with one or more psychology educators during their **graduate** training.

In sum, the North American research suggests that some 10-13% of psychologists have experienced sexual contact with their educators during training. Sexual contact during postgraduate training may be rather more common than such contact during undergraduate studies, according to Glaser and Thorpe (1986). The results of the present study suggest that a very similar proportion of British psychologists report sexual contact with educators, but that there is no evidence to support Glaser and Thorpe's (1986) finding that sexual contact during postgraduate studies is more prevalent than that which occurs during undergraduate studies.

If the present data on respondents' sexual contact with their educators as undergraduates and postgraduates are examined in relation to gender, 9.5% of the women respondents but only 2.5% of the male respondents reported such contact. Of Pope et al's (1979) female respondents, 16.5% reported sexual contact with educators when they were students, whereas only 3% of the male respondents reported such contact. These figures suggest that whilst in Britain a similar gender difference pertains, rather fewer women than in North America report sexual contact as a student with an educator.

In the present study, 2.9% of those respondents in an educative role reported sexual contact with their students/trainees. By contrast, Pope et al (1979) report that 13% of the educator respondents to their survey admitted sexual contact with their own students. Of those respondents in the present study who were in an educative role ( $n=464$ ), 1.1% of women, and 2.6% of men reported engaging in sexual contact with a student or trainee. In Pope et al's (1979) survey, 19% of male educators and 8% of female educators reported that they had engaged in sexual contact with their students.

When gender was examined in relation to sexual contact, substantially more women than men in this survey reported sexual contact with their educators as students. This picture is supported when respondents' own sexual contact with their students is considered, which suggests that over twice as many men as women had engaged in such contact. The findings of the present study therefore suggest that fewer British than U.S. psychologists report engaging in educator-student sexual contact, either when they were students, or as educators, but that in both countries such contact occurs mainly between male educators and female students.

These data provide an important perspective on the question of whether sexual contact with an educator during training is associated with sexual contact with patients later in one's career. It would appear that whilst a greater proportion of women become sexually involved with their educators than do men, conversely, a greater proportion of men become sexually involved with their patients than do women. Thus, whilst Pope et al's (1979) "modelling effect" may have some relevance, clearly it is no simple effect, but is likely to be mediated by gender and perhaps other, variables such as power issues.

#### 8.1.4. Other issues arising from the data

There were no associations in the present data set between theoretical orientation, work setting or clinical specialty, and sexual contact with patients. No such associations have been reported in the American literature either.

Although it might have been anticipated that number of hours spent in clinical contact with patients, on the grounds of increased opportunity for sexual contact, and that having a higher proportion of patients in long-term therapy, on the grounds of intensified transference, would predict sexual contact between therapists and their patients, this was not the case for either variable.

Whilst associations in the above areas were not found in this study, future research might benefit from exploring possible links, particularly in other professional groups.

The present research suggests that a minority of clinical psychologists engage in multiple sexual contacts with patients. Further research is necessary to consider the effects of such contacts upon patients, in comparison with single sexual contacts.

The majority of sexual contacts reported in this study between respondents and their patients were of short-term duration. The largest category of sexual contacts with patients reported in this study was that of once-only sexual encounters (44%), and 22% lasted for less than three months. However, almost a quarter lasted for more than five years. This question was phrased identically to one of the questions in Gartrell et al's

(1986) survey and some useful comparisons may be drawn between the two studies. Only 19% of Gartrell et al's respondents described their sexual contacts with patients as once-only encounters, in comparison with the 44% reported here. None of the respondents in the present survey described their last sexual contact with a patient as lasting between one and five years, whereas 21% of Gartrell et al's respondents did so. This is suggestive of a possible difference between the British and North American experience, which requires further investigation, but which may be summarised here as a relatively uniform distribution in the U.S.A. of length of therapist-patient sexual relationships, compared with a bimodal distribution in the U.K.

Over half (58%) of the patients with whom respondents had engaged in sexual contact were discharged at the onset of the sexual contact. It might be argued that in these cases there are less pressing ethical problems (Coleman, 1988) than cases where sexual contact occurs with a patient whose therapy is ongoing, or even that there should be no ethical objection to such sexual contacts. This is clearly an area which could be investigated in future research, for example in terms of therapists' attitudes towards sexual contact with current versus discharged patients or their perceptions of the differential effects of such contacts. However, the exercise of considerable caution in this respect is suggested by the empirical finding (e.g. Pope and Vetter, 1991) that such contact causes harm to the patient, as well as the suggestion that therapists may at times discharge a patient specifically in order to engage in a sexual relationship with him/her, thus giving low priority to the therapeutic needs of the patient (Coleman, 1988).

## **8.2. COMPARISON OF DATA FROM THIS STUDY WITH THAT FROM OTHER SURVEYS**

### **8.2.1. Sample characteristics**

It is difficult to establish the extent to which the present sample is representative of British clinical psychologists as a whole, for two main reasons. First, not all U.K. clinical psychologists are members of the British Psychological Society, and only a subsample of those who are, are also Division of Clinical Psychology members. It has been estimated that less than 10% of British qualified clinical psychologists are non-British Psychological Society members (Aggus, 1996, personal communication), and these individuals may be part-time or full-time N.H.S. employees and/or part-time or full-time self-employed. Although no data are available from the British Psychological Society to indicate how many of its members are qualified clinical psychologists but not Division of Clinical Psychology members, it is likely that only a small number fall into this category (Aggus, 1996, personal communication). Second, although some data are available to describe aspects of the total Division of Clinical Psychology membership (i.e. age and gender) (cf. chapter four, sections 4.3.1 and 4.3.2), it is unknown whether and in what other respects the 415 clinical psychologists who did not respond to the survey differ from the 585 who did so.

However, some comparisons were made in chapter four between the present sample, the current Division of Clinical Psychology membership (Bull, 1995, personal communication) and data reported by Norcross et al (1992a,b). These comparisons show

some similarities and some differences between the two samples, some of the differences possibly being explicable in terms of the controversial subject matter of the present survey. Whilst in some areas there are differences between the present sample and the Division of Clinical Psychology as a whole and Norcross et al's sample, some relatively modest and some more significant, the present sample is probably relatively representative of U.K. clinical psychologist Division of Clinical Psychology members and some cautious inferences may be made from the present data about British clinical psychologist Division of Clinical Psychology members as a whole. However, there may be important differences, including, possibly, differences in prevalence of therapist-patient sexual contact, between Division of Clinical Psychology members, non Division of Clinical Psychology members who are British Psychological Society members, and clinical psychologists who are not British Psychological Society members. For example, those clinical psychologists who are not members of the British Psychological Society may not wish to abide by its Code of Conduct (1991), may wish to avoid the influence of the investigatory and disciplinary procedures of the British Psychological Society, or may have been expelled from the Society as a result of breaches of the Code of Conduct (1991).

In this sample, 6% more respondents had experienced personal therapy than Norcross et al's (1992b) sample. Those who had experienced personal therapy were either somewhat over-represented in this sample, or under-represented in Norcross et al's sample. One possible explanation for this small difference is that those who received the questionnaire and who had experienced personal therapy were more prepared to respond because of greater sensitivity to the issue of boundaries in therapy.

### 8.2.2. Predictive variables

The association between sexual contact with a trainer whilst a postgraduate (but not whilst an undergraduate) and later sexual contact with patients supports Pope et al's (1979) contention that educator-student sexual contact is associated with, and possibly models, subsequent such contact with patients, at least for women therapists. It would appear that this modelling effect occurs in those situations which directly parallel the relationship between patient and therapist (the postgraduate supervisor-trainee contact) rather than the undergraduate-lecturer/tutor relationship. However, no association was found between sexual contact with one's personal therapist and sexual contact with patients, the relationship with most parallels with the therapist-patient relationship, though Gartrell et al (1986) do report such an association. It is possible that characterological variables, for example an interest in power issues in relationships, may provide an explanatory mechanism for the pattern observed in those individuals who as students experience sexual contact with educators, and who subsequently, as therapists, engage in sexual contact with their patients. However, neither explanation accounts both for the absence of an association between sexual contact as an undergraduate with educators, and later sexual contact with patients, or between sexual contact with one's personal therapist and sexual contact with patients in this sample.

Gender may be a relevant issue in this respect: if those with experience of sexual contact with their personal therapist and sexual contact with their patients are considered according to gender, it can be seen that not only did a greater proportion of female respondents (49.9%) than male (37%) undertake personal therapy, but over half (57.1%)

of these women also reported sexual contact with their patients. By comparison, only 36.4% of the male respondents who had personal therapy also reported sexual contact with their patients. Additionally, it was found in the present research that female respondents were more likely than male respondents to report sexual contact with educators as students and/or trainees. It would therefore seem appropriate to test Pope et al's (1979) hypothesis separately for men and women. For example, men who report sexual contact with their educators as students and/or trainees may be more likely than other men to have sexual contact with patients.

No significant predictive relationship emerged in this sample between gender of respondent and sexual contact with patients. Although the majority of the respondents who reported sexual contact with their patients were male, this difference was not significant. North American research suggests that the typical pattern occurring in therapist-patient sexual contact is that of the older, male psychotherapist becoming sexually involved with patients (Bouhoutsos et al, 1983; Dahlberg, 1970). However, more recent studies (e.g. Stake and Oliver, 1991) have suggested that there may be fewer discrepancies (at least in recent years) in the levels of sexual contact with patients reported by male and female therapists, than research has previously suggested. Results from the present study would support such a conclusion.

This suggests that an analysis of the problem of therapist-patient sexual contact should look further than a model based exclusively or mainly on gender issues. Further research is required to examine further the question of gender pairings in therapist-patient sexual contact. Any explanatory model should contain sufficient flexibility in order that the

relative contribution of a variety of variables can be established: for example, gender may be an important issue in some cases of therapist-patient sexual contact, but not in others, and its influence may depend upon whether the therapist-patient pairing is heterosexual or homosexual.

The suggestion from North American research (Gartrell et al, 1986) that engaging in personal therapy may be a predictor of later sexual contact with patients was not replicated in this study.

### **8.3. DISCUSSION OF QUALITATIVE DATA**

#### **8.3.1. Reasons given for refraining from sexual contact with patients**

When respondents were asked to provide their reasons for refraining from sexual contact with their patients, the most frequently cited categories of reasons given related to professional and personal values and ethics, and many respondents mentioned boundary issues and the impact upon the patient in this respect. Such reasons closely resemble the rationales which one would expect professionals such as psychologists to give and appear to be broadly based on the British Psychological Society Code of Conduct (1991) and Professional Practice Guidelines (British Psychological Society/Division of Clinical Psychology, 1996).

These reasons for refraining from sexual contact with patients may be conceptualised in terms of Finkelhor's (1984) model of sexual offending, and provide considerable support

for that approach. All of the reasons for refraining from sexual contact described above conform to Finkelhor's model: lack of motivation refers to the first precondition, lack of opportunity, to the third, and a consideration of the consequences of discovery, to the question of disinhibition. Professional and personal values and ethics may be viewed in terms of the second precondition, that of overcoming internal inhibitions.

However, responses which give more cause for concern, some of which were frequently given, include the negative personal and professional consequences of such contact for the psychologist, and lack of opportunity to engage in such contact. Responses of this nature suggest that were circumstances to occur which were more conducive to sexual contact with patients, for example if opportunities arose, or if there were no possibility of negative consequences, either professional or personal, many respondents would consider sexual contact with their patients. A total of 133 respondents contributed these answers, and 55 gave responses only in these categories. There is thus likely to be a small proportion of respondents for whom the removal of such obstacles would allow for sexual contact to occur. This suggests that the provision of ethics training with particular attention to sexual contact with patients should be a priority for clinical trainees and for those who are qualified.

### **8.3.2. Reasons given for not experiencing sexual attraction towards patients**

A substantial minority (38%) of respondents reported that they had not experienced sexual attraction towards their patients. Whilst many of these responses may be understood in terms of an incongruity between the client group with which some

respondents worked and respondents' sexual orientation, such an explanation cannot account for all cases of lack of sexual attraction. Over 26% of those respondents working with adult populations (adult mental health, physical health and neuropsychology) reported that they had not experienced sexual attraction towards their patients.

The reasons given by almost 40% of those respondents who had not experienced sexual attraction towards their patients related to the nature of the client group with which they work, for example where respondents work with children but have an adult sexual orientation. This was the most frequent response and suggests, in the absence of further information from respondents, that the respondents who replied in this way may not regard sexual attraction to patients as inappropriate.

However, a substantial proportion of respondents (20%) responded in such a way as to suggest that they considered sexual attraction to their patients to be in some way inappropriate. For example, ethical concerns were frequently expressed about the experience of attraction and many respondents in this category suggested that sexual attraction and sexual contact with patients were interchangeable in terms of the ethical issues. Some respondents cited notions of taboo and repression in relation to sexual attraction to patients.

According to Pope et al (1986), the therapist's sexual attraction towards patients is a common and entirely normal process in therapy, and insufficient consideration of this issue in training programmes can result in clinicians believing that sexual attraction

towards their patients is unethical and most appropriately avoided. In this way, substantial numbers of therapists may be losing valuable therapeutic information which could be gained through a recognition and consideration of their sexual feelings towards patients. This suggests that the issue of sexual attraction towards patients could usefully be included in professional training programmes.

It could be argued that where sexual attraction towards patients is taboo, and where there is a lack of understanding that patients are frequently sexually attracted to their therapist, a set of conditions is potentially created in which it becomes possible for the therapist to believe that this mutual attraction is somehow special and peculiar to him/her and this particular patient, rather than a phenomenon which occurs frequently in the therapeutic situation. Under such conditions, sexual contact with the patient could be more likely to occur.

### **8.3.3. Reasons given for not taking action in relation to clinical psychologists known to have engaged in sexual contact with their patients**

The main reason given by respondents who knew of a clinical psychologist engaging in sexual contact with patients, and who did not report that colleague, was that action in some form had already been taken. This suggests that many psychologists are aware of their professional duty to take action in respect of unprofessional behaviour by colleagues, and that they would take such action if appropriate.

However, very common reasons given for lack of action in relation to such colleagues were that respondents did not consider taking action to be their responsibility, that the sexual contact was not current, that there was no risk of reoffending, or that sexual contact was not considered by the respondent to have been harmful to the patient. Clearly, sexual contact between a colleague and his/her patient is the responsibility of the psychologist who becomes aware of such a contact, in the sense that such behaviour is a breach of the British Psychological Society Code of Conduct (1991). The fact that a number of its members appear to be either unaware of the correct procedures to follow when its Code of Conduct has been breached, or appear to be taking it upon themselves to judge the impact or appropriateness of unethical behaviour, should be a matter for serious concern on the part of the British Psychological Society.

Only four respondents stated that they were unaware of the importance of taking action, but four also gave as their reason for failing to report psychologist-patient sexual contact, fear of retaliation or retribution. The latter is clearly a matter for some concern, and may also deserve British Psychological Society attention.

No respondents reported that they had refrained from taking action in respect of sexual contact between clinical psychologist colleagues and their patients for reasons associated with ascribing blame to the patient for the development of the sexual relationship. It had been anticipated that such a rationale might be offered by some respondents, for example that some such patients might be considered seductive and thus at fault when actual sexual contact occurred. Future research might offer a check list of possible

reasons in respect of this, and other open-ended questions, including some potentially controversial responses.

#### **8.3.4. Other comments given by respondents**

The most frequently given category of "other comments" was that of supportive comments about the research. This, and the frequent mention by respondents of ethical and preventative issues in this section, is evidence of considerable concern among British clinical psychologists about the problem of psychologist-patient sexual contact.

Small numbers of respondents made more controversial comments, such as the view that sexual contact with former patients or former trainees is acceptable, that sexual contact with current patients may be acceptable under certain circumstances, and that some allegations of sexual abuse by therapists made by patients are false. One of the respondents who raised the latter issue was an individual who had engaged in sexual contact with a patient. It might be hypothesised that such individuals would be more likely to attend to or give credence to notions of false accusations by patients in order to justify their own behaviour.

A number of respondents did not complete the open ended questions. For the question about reasons for lack of sexual attraction to patients, 145 of those to whom the question was relevant did not respond. For the question about lack of sexual contact with patients, 41 of those to whom the question was relevant did not respond, and for the question about reporting practices in relation to colleagues known to have been sexually involved

with patients, 19 of those to whom the question was relevant did not respond. Whilst providing a response to the open ended questions, it is also possible that some respondents may have avoided providing *meaningful* responses which assist an understanding of the reasons why certain behaviours may be avoided. For example, in responding to the question about sexual contact with patients, some respondents stated that they had avoided such contact because of their lack of interest in sexual contact with patients, without stating their reasons for such lack of interest.

#### **8.4. CRITICAL REVIEW OF METHODOLOGY**

It is possible that some respondents may not have answered the questionnaire honestly, or that a significant proportion of those with experience of sexual contact with patients may have chosen not to return the questionnaire (Holroyd and Brodsky, 1977) but this is by no means clear (Williams, 1992). A number (20) of respondents themselves raised this issue, some commenting that had they engaged in sexual contact with their patients, they would not report it in a survey. Perhaps there is little action which could be taken to enhance the response rate in surveys such as this, but the present data could be enhanced by considering it alongside other data, including surveys of patients and complaints to professional bodies and/or legal actions taken.

Clearly the results of this study must be interpreted with caution in the light of possible sampling bias (Williams, 1992). For example, what are the motives of those therapists who did reply, and of those who did not? Was the failure to return questionnaires systematic, and was it related or not to sexual involvement with patients? Although

some previous North American research suggests that non-responders are more likely to have engaged in sexual contact with patients than those who do respond to surveys (Holroyd and Brodsky, 1977), there is a suggestion that the opposite may be true (Bouhoutsos et al, 1983) and some researchers have concluded that there is no difference between withholders and returners (Akamatsu, 1988). It is therefore difficult to make confident statements about the prevalence of therapist-patient sexual contact on the basis of the results of this study.

An issue raised by one respondent in making further comments was that clinical psychologists who sexually abuse patients may be less likely either to be members of the British Psychological Society or to be chartered psychologists or both, since were they to be chartered their chartered status could be withdrawn if the sexual contact were to be discovered. Alternatively, some psychologists might have been reported for sexual contact and subsequently resigned from the British Psychological Society or had their membership withdrawn. However, accessing clinical psychologists who are not British Psychological Society members for the purposes of a survey would be extremely difficult, since locating those in private practice or even in some N.H.S. locations would be problematic. Clearly it would be possible to access such psychologists but such research would by necessity be conducted differently to the present national random survey. However, information which could be gained by contacting psychologists of this kind would be most valuable.

Because only a small proportion of respondents disclosed sexual contact with their patients, the statistical tests used had poor capacity to detect predictor variables, and the

likelihood of type II error is increased. This suggests that a substantially larger study would be required to identify a more confident prediction model in relation to therapist-patient sexual contact.

The design of the questionnaire was such that its remit was broad since no previous research had been undertaken in Britain, and the study thus attempted to be as inclusive as possible. This led to a lack of detailed information in many areas, particularly in exploring the meaning for respondents of sexual contact with patients. In an attempt to make the questionnaire appear as short as possible and thus increase the response rate, too little space was allocated to comments, and the layout was somewhat cramped, thus making it potentially difficult for respondents to make use of the "tick boxes".

Whilst in designing the questionnaire, every attempt was made to cover as much ground as possible whilst avoiding an over-lengthy questionnaire, it would have been useful to have asked respondents to specify whether their clinical work had been supervised, in order to identify whether the clinical work of those therapists who have been sexually involved with their patients was supervised at the time of the sexual contact. In this way, hypotheses could have been explored concerning failures in supervision, or direct lack of supervision leading to sexual contact with patients.

Whilst it would have been useful to ask respondents to state whether they had engaged in sexual contact with a patient in a recent specific time period, for reasons discussed in chapter six such an approach would have resulted in the loss of information concerning all sexual contacts with patients. Since this was the first British study in this area, it is

argued that the approach taken was appropriate and that future studies could consider the adoption of a research approach based on incidence rather than prevalence, in order to begin to monitor changes in behaviour in respect of therapist-patient sexual contact, and to establish whether a link exists between years of clinical experience and sexual contact with patients. Whilst the latter issue was addressed in the present survey, a research approach based on incidence would be better placed to establish whether such a link exists.

#### **8.5. SUGGESTIONS FOR PREVENTATIVE ACTION**

This study demonstrates that sexual contact with patients by clinical psychologists and other psychotherapists does occur in Britain and is largely perceived by subsequent therapists to be damaging to patients. Action could be taken to prevent and address this problem, particularly by the profession of clinical psychology, as follows:

##### **8.5.1. Implications for professional bodies**

Whilst the question of sexual contact with discharged patients was not explicitly raised in the research, some respondents did refer to it in completing the questionnaire, some stating that they viewed such post-discharge sexual contact as acceptable and thus distinct from sexual contact with current patients. It would therefore be helpful for professional bodies such as the British Psychological Society to take an explicit stance on the issue of sexual contact with discharged patients.

The responses to the open ended questions show that there is some confusion on the part of British Psychological Society members in respect of the Code of Conduct (British Psychological Society, 1991) generally. It would therefore be useful for the Code of Conduct (British Psychological Society, 1991) and Professional Practice Guidelines (British Psychological Society/Division of Clinical Psychology, 1996) to be clearer and more vigorously promulgated by the British Psychological Society, particularly in the case of the latter document, which has recently been issued and for the first time provides explicit guidance to members in respect of sexual contact with current and discharged patients.

The British Psychological Society (and other professions) could give consideration to developing clearer guidelines for members in particular in relation to the circumstances under which they are required to report colleagues for unethical behaviours, since many respondents in this study were either uncertain of the existing guidelines' content, unable to interpret the guidelines, or failed to take action because of lack of clarity (as they saw it) in the guidelines.

**8.5.2.** Consideration should be given to the treatment of offending therapists, and **evaluated** rehabilitation programmes should be considered by professional bodies. The British Psychological Society could take the initiative in providing these for psychologists, other professionals and non professionals, in line with the recommendations of the Management Advisory Service report on clinical psychology (1989).

**8.5.3.** Most therapists in a recent study had received little or no training about sexual attraction to patients (Pope et al, 1986), and in the present study, there is a suggestion that many respondents viewed sexual attraction to patients as potentially problematic or taboo. Thus, the issues of attraction to patients and sexual contact with them could be addressed in professional training courses (cf. Thoreson, 1986). The British Psychological Society could take a lead in this respect and make this an accreditation criterion for clinical, counselling and educational psychology training courses. Other matters which might usefully be raised in professional training include, concepts of transference, countertransference and boundaries (Folman, 1991). In particular, Gutheil (1989) argues that training should equip therapists with a knowledge of transference and its power to produce flattering attitudes in the patient, and of countertransference, with its potential to trigger the feeling that the therapist and only the therapist can "save" the patient. Such issues may also be raised with trainees in supervision.

A presentation of the research-based literature in the area of dual relationships as well as discussion of ethical implications of sexual contact with patients (Borys and Pope, 1989) can serve to raise awareness in training. Educational programmes for psychotherapists could aim to provide a supportive environment within which students and educators can consider their own impulses which might tempt them into unethical dual relationships (Borys and Pope, 1989).

**8.5.4.** In the light of the finding that sexual contact as a postgraduate with an educator predicts later sexual contact with patients, action by professional training courses would appear imperative. Educational establishments could take preventative and remedial

action to address the problem of educator-student/trainee sexual contact (Garrett and Thomas-Peter, 1992). Organisationally, the appropriate procedures could be followed, written guidelines and standards could usefully be formulated concerning dual relationships between educators and students, and procedures could be developed for avoiding conflicts of interest in monitoring and enforcing such standards.

#### **8.6. SUMMARY OF RECOMMENDATIONS FOR FUTURE RESEARCH**

This section summarises the recommendations for further research contained in this, and previous, chapters.

It may be reasonable for the present to draw some broad conclusions from these results about the overall prevalence of psychotherapist-patient sexual contact in Britain, but further research is clearly required to establish whether any interprofessional differences exist in this respect. In view of the widespread lay practice of counselling and psychotherapy in Britain, and of the current lack of statutory regulation of this activity in the U.K., research is required to define any differences which may exist between professional and lay groups in this respect. Such research might also aim to establish whether the findings of this study can be replicated with other professional and para-professional groups such as psychiatrists and counsellors, and to examine the predictive value of other variables, as well as those investigated in the present study. The author has been contacted by a number of researchers for advice on carrying out surveys with other professionals such as psychiatrists and analytical psychotherapists, and it would thus appear that other studies are currently being planned. Such research would assist in

establishing whether the conclusions from the North American literature are applicable to Britain and whether there are any differences between the two countries in this respect.

It is inappropriate to rely solely upon self-report as a measure of prevalence of therapist-patient sexual contact (Williams, 1992) and it would therefore be beneficial for British research to be undertaken with therapy patients to consider their experience of sexual contact with therapists and to compare the results of such research, complaints to professional bodies, legal actions and the results of surveys such as this.

Future research would benefit from enquiring about sexual contact within a specified period of time, say, the last six or twelve months, in order to establish whether respondents' length of clinical experience would still be a predictor of sexual contact with patients, and in order that changes in the incidence of therapist-patient sexual contact could begin to be measured. Future research based on prevalence could enquire of respondents who had sexual contact with patients, the point during their career at which the sexual involvement with a patient occurred, with particular reference to whether such contact might be more likely to occur when the psychologist was inexperienced.

Further research is necessary to consider the effects of multiple sexual contacts upon patients, in comparison with single sexual contacts, ideally using a patient population.

Further research would benefit from testing out particular theoretical models relating to therapist-patient sexual contact, such as reversal theory. Such an approach might include, for example, interviewing patients and therapists using structured interviews containing concepts from reversal theory, such as changes in motivational state prior to sexual contact.

Further consideration of the issues of gender and sexual orientation could focus on the onset of therapist-patient sexual contact in relation to the gender of therapists and patients in order to examine Benowitz's (1994) contention that onset occurs earlier in female therapist-female patient pairings. The robustness of the finding in this study and that of Thoreson et al (1993) that homosexuality of the therapist predicts sexual contact with patients could be considered in future studies.

The notion that sexual contact with patients may occur as a failure of supervision or as a consequence of lack of supervision has some face validity. Such an argument would be based on the role of supervision as an opportunity to explore emotional issues in the therapeutic relationship, in particular countertransference reactions which, if neglected may lead to the sexualisation of the therapeutic relationship. This question could readily be incorporated into future empirical studies. The tentative association between experience of personal therapy and sexual contact with patients (Gartrell et al, 1986) could be further examined in future research, and in particular establishing the timing of the personal therapy in relation to sexual contact with patients (that is whether therapy occurred before or after sexual contact with patients) would assist in understanding any such association which might emerge.

A potentially fruitful area of research enquiry in relation to the understanding of sexual contact between therapists and their patients would be the question of the connection between therapists' experience of sexual (and perhaps physical) abuse during childhood and later sexual contact with patients. No study has considered this question thus far but there is some evidence to show that, at least among North American psychologists, the experience of childhood sexual abuse is relatively common. Pope and Feldman-Summers (1992) found that approximately one third of their 500 respondents reported physical or sexual abuse in their past.

The identification and exploration of attitudinal variables would be a fruitful area for further research in this field, for example attitudes towards sexual contact with current versus discharged patients. Future studies could enquire of those respondents admitting to sexual contact with discharged patients to specify the length of time since discharge when the sexual contact occurred and the circumstances under which discharge took place. This would provide information regarding the process of discharge and any relationship which it might have to subsequent sexual contact.

Further research could consider by gender the beliefs of those therapists who become sexually involved with their patients, such as the suggestion that female therapists are more likely than male therapists to hold the view that sexual contact is less harmful and more beneficial to patients (Benowitz, 1994). Gabbard's (1994) view that male therapists who engage in sexual contact with their patients are more likely to over-identify with patients than such female therapists, could also usefully be considered. Some of these

issues could be addressed through interviews with therapists who acknowledge sexual contact with their patients.

In relation to the open-ended questions included in this research, future studies could offer a check list of possible reasons, including some potentially controversial responses, where respondents are asked to explain why they take, or to avoid, a particular course of action.

### **8.7. SUMMARY**

This study demonstrates that sexual contact between clinical psychologists and their patients occurs in a minority of cases in the U.K. It also provides evidence that other professionals abuse their position by engaging in sexual contact with their patients. It suggests that homosexual sexual contact between therapists and their patients constitutes a significant proportion of cases and that there are complex gender issues involved in therapist-patient sexual contact. The research raises a number of questions which may usefully inform future research.



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- The Publication Manual of the American Psychological Association (A.P.A., 1983) was used in the preparation of this thesis.



**APPENDIX 1**

**COVERING LETTER SENT WITH  
QUESTIONNAIRE**



December 1991

Dear Colleague

I am currently doing an MSc in Psychotherapy at Warwick University. As part of this course, I am required to undertake a research dissertation. I have decided to look at physical and sexual contact between therapists and their patients within the profession of Clinical Psychology. There has been a good deal of research done in this field in the USA, but, to my knowledge, none in the UK. Yet we are seeing more and more books and articles being published, as well as the formation of self-help groups for patients who have been sexually involved with their therapists.

The purpose of my research is to establish the experience of Clinical Psychologists in relation to sexual and physical contact with patients, as well as to estimate the prevalence of therapist-patient sexual contact in the UK. This information will be central in developing an understanding of the phenomenon.

I enclose a questionnaire which I would be grateful if you would complete at your earliest convenience. Your name has been selected at random by the British Psychological Society from the membership list of the Division of Clinical Psychology.

I apologise for being unable to send a stamped envelope for you to return the questionnaire, but funding restrictions prevented this, as I am sure you will appreciate. However, I have provided an envelope with the return address and I hope that the lack of a stamp will not prevent you from returning the questionnaire. Also, by not providing a stamped envelope, I have been able to increase the sample size.

The questionnaire is to be returned to the University of Warwick. You will see that the questionnaire is completely anonymous, and no specific identifying information is requested. All returned questionnaires will be opened by a secretary and the envelopes discarded, but if you are concerned about the possibility of postmarks identifying you in any way, perhaps you could post the questionnaire on your next visit to another town. I have made every attempt to ensure that there will be no means of identifying the origin of questionnaires, and will be making no attempt to ascertain respondents' identities from their questionnaires. I hope that in view of this you will feel able to be as frank as possible in your responses. However, if you are concerned that your response to a certain item(s) could identify you, please feel free not to respond to that particular item(s).

Please respond to the questionnaire even if you are not currently in clinical practice, but have practiced in the past.

I understand that you will be very busy, but would appreciate your time in completing this questionnaire, since a good return rate is vital in research such as this. I hope that you will agree to complete the questionnaire, which I have attempted to make as short and easy to complete as possible. Please don't bury this questionnaire in your pending file - it would be helpful if you could let me have it back within the next 2 weeks if possible.

Thank you for your co-operation.

Tanya Garrett  
**Chartered Clinical Psychologist**



APPENDIX 2

QUESTIONNAIRE



Today's date.....

Please attempt to answer **all** questions (but see covering letter)

**SECTION ONE**

1. Please give your sex (Tick one box) MALE  FEMALE

2. Please give your age .....YEARS

3. Are you (Tick as many boxes as apply)

- SINGLE  
 IN A STABLE RELATIONSHIP  
 MARRIED  
 SEPARATED/DIVORCED  
 WIDOWED

4. How would you identify your sexual orientation?  HETEROSEXUAL  
 (Tick one box)  HOMOSEXUAL  
 BISEXUAL

5. In **total**, how many years have you practised as a Clinical Psychologist since qualifying? .....YEARS

6. How would you describe your therapeutic orientation? (Please indicate the 3 orientations which **most influence** your practice, where 1=most influence, 2=moderate influence, 3= least influence, by numbering 3 boxes).

- BEHAVIOURAL  
 COGNITIVE  
 PSYCHODYNAMIC/ANALYTIC  
 SYSTEMIC  
 HUMANISTIC  
 OTHER (Please specify).....

7. What is your **main** area of clinical work?  
 (Tick one box)

- ADULTS  
 CHILDREN AND YOUNG PEOPLE  
 LEARNING DIFFICULTIES  
 ELDERLY  
 PHYSICAL HEALTH  
 NEUROPSYCHOLOGY  
 OTHER (Please specify).....

8. How many hours per week on average do you spend in face to face patient contact?  
 .....hrs

9. With what proportion of your patients do you have **long term** therapeutic contact (ie over 50 sessions)? .....%

10. With what proportion of your patients do you have **brief** therapeutic contact (ie less than 20 sessions)? .....%

11. What is your **main** work setting? (Tick one box)

- NATIONAL HEALTH SERVICE
- PRIVATE PRACTICE
- SOCIAL SERVICES
- VOLUNTARY AGENCY
- OTHER (Please specify).....

12. Have you in the past undertaken, or are you currently undertaking, personal therapy? (Tick one box) YES  NO

### **SECTION TWO**

1. Have you ever engaged in the following types of physical contact with any of your patients? (Tick as many boxes as apply)

#### **MALE PATIENTS**

- HANDSHAKE
- PATTING ON ARM
- HOLDING HAND(S)
- TOUCHING ARM/SHOULDER ETC
- HUGGING
- OTHER (Please specify).....

#### **FEMALE PATIENTS**

- HANDSHAKE
- PATTING ON ARM
- HOLDING HAND(S)
- TOUCHING ARM/SHOULDER ETC
- HUGGING
- OTHER (Please specify).....

2. Have you ever felt sexually attracted to one of your patients? (Tick one box) YES  NO

3. If YES, go to Q4.

If NO, why not?.....

Now go to **SECTION THREE**

**4. PLEASE RECALL THE LAST OCCASION WHEN YOU WERE SEXUALLY ATTRACTED TO ONE OF YOUR PATIENTS.**

a) How do you feel **NOW** about this attraction? (Tick one box)  
 CONCERNED  UNCONCERNED

b) How, if at all, do you think this attraction affected/is affecting the therapy process ?  
 (Tick one box)  MAINLY ADVERSE EFFECTS  
 LITTLE OR NO EFFECT  
 MAINLY POSITIVE EFFECTS

**SECTION THREE**

1. Do you believe that patients can ever benefit from sexual contact with a therapist ?  
 (Tick one box) YES  NO

2. Have you ever had what you regard as sexual contact with one of your patients, no matter whether **current** or **discharged** ? (Tick one box)  
 YES  NO

3. If YES, go to Q4

If no, what has stopped you?

.....  
 .....

Now go to **SECTION FOUR**

4. a) With approximately how many patients have you had sexual contact?  
 .....

b) Aggregating all the patients with whom you have had sexual contact (if more than one), please estimate the total number of occasions on which you have had sexual contact with patients in your lifetime.....OCCASIONS

c) With how many patients have you had sexual contact that commenced after you had discharged the patient?.....

d) With how many patients have you had sexual contact that commenced while the patient was in therapy with you?.....

e) When have sexual contacts with patients who were/are **current** occurred? (Tick one box)

- ONLY WITHIN THERAPY SESSIONS  
 ONLY OUTSIDE THERAPY SESSIONS  
 BOTH WITHIN AND OUTSIDE THERAPY SESSIONS  
 NO SUCH CONTACTS

f) Prior to completing this questionnaire, have you ever disclosed a sexual contact with a patient to any of the following? (Tick as many boxes as apply)

- COLLEAGUE
- MANAGER
- SUPERVISOR
- FRIEND/PARTNER
- ANOTHER PATIENT
- PERSONAL THERAPIST
- OTHER (Please specify).....
- NO SUCH DISCLOSURE

g) PLEASE CONSIDER YOUR MOST RECENT SEXUAL CONTACT WITH A PATIENT (IF THERE HAS BEEN MORE THAN ONE).

i) Please specify this patient's sex (Tick one box) MALE  FEMALE

ii) Please specify this patient's age .....YRS

iii) Please specify what forms of sexual contact have occurred between you and the patient (Tick as many boxes as apply)

- KISSING
- NON-GENITAL TOUCHING/HOLDING/FONDLING
- HAND-GENITAL CONTACT
- VAGINAL INTERCOURSE
- ORAL-GENITAL CONTACT
- ANAL PENETRATION
- OTHER (Please specify).....

iv) Did/does the patient give full consent to these contacts? (Tick one box)  
YES  NO  SOMETIMES

v) Did/does the contact involve an aim of inflicting physical pain on the patient? (Tick one box) YES  NO  SOMETIMES

vi) Please specify the length of your sexual involvement with this patient (Tick one box)

- ONE SEXUAL ENCOUNTER
- LESS THAN 3 MONTHS
- 3-11 MONTHS
- 1-5 YEARS
- MORE THAN 5 YEARS

vii) What is the current status of your involvement with this patient ? (Tick one box)

- NO CONTACT WHATSOEVER
- CONTINUED THERAPEUTIC CONTACT, NO SEXUAL CONTACT
- CONTINUED SEXUAL CONTACT, NO THERAPEUTIC CONTACT

- CONTINUED SOCIAL CONTACT, BUT NO SEXUAL OR THERAPEUTIC CONTACT
- CONTINUED THERAPEUTIC AND SEXUAL CONTACT WITH THE PATIENT
- MARRIED TO, OR IN A COMMITTED RELATIONSHIP WITH THE PATIENT

viii) How did you come to be sexually involved with this patient ?

.....

.....

.....

.....

ix) What effects do you think this sexual involvement had/is having on the patient?

.....

.....

.....

.....

x) How do you feel **NOW** about this sexual involvement? (Tick one box)  
 CONCERNED  UNCONCERNED

xi) Who initiated this sexual involvement? (Tick one box)  
 SELF  PATIENT  MUTUAL

xii) What steps, if any, did you take to dissuade this patient from reporting or disclosing their sexual contact with you?

.....

.....

.....

.....

#### **SECTION FOUR**

1. Do you believe that a student/trainee psychologist can ever benefit from sexual contact with a lecturer/supervisor? (Tick one box) YES  NO
2. During your **undergraduate training**, did you ever have sexual contact with a lecturer/tutor? (Tick one box) YES  NO
3. During your **postgraduate clinical training**, did you ever have sexual contact with a lecturer/tutor/supervisor? (Tick one box) YES  NO
4. If you have had/are currently having **personal therapy**, have you ever had sexual contact with your therapist(s)? (Tick one box) YES  NO  NOT APPLICABLE
5. If you are a lecturer/supervisor, have you ever had sexual contact with one of your student/trainee psychologists (including undergraduates)? (Tick one box) YES  NO  NOT APPLICABLE

**SECTION FIVE**

1. To your knowledge, have you ever treated any patients who have had sexual contact with previous therapists? (Tick one box) YES  NO

If NO, go to **SECTION SIX**

2. What was/were the profession(s) of the previous therapist(s)? (Tick as many boxes as apply)

- CLINICAL PSYCHOLOGIST
- PSYCHIATRIST
- SOCIAL WORKER
- NURSE
- VOLUNTARY AGENCY THERAPIST
- PRIVATE SECTOR PSYCHOTHERAPIST
- COUNSELLOR
- OTHER (Please specify).....
- DO NOT KNOW

3. Overall, how would you rate the effects of the sexual contact(s) on the patient(s)? (Tick one box) POSITIVE  MIXED  NEGATIVE

4. Approximately how many of the therapists were reported to their employer, professional body, official agency, etc?

NUMBER REPORTED.....  
 NUMBER NOT REPORTED.....  
 NUMBER UNCERTAIN.....

**SECTION SIX**

1. Do you know through sources other than your own patients, of Clinical Psychologists who have been sexually involved with their patients? (Tick one box) YES  NO

If NO, go to **SECTION SEVEN**

2. How many such Clinical Psychologists do you know of? .....

3. Was/were the Psychologist(s) reported to their employer, BPS, official agency, etc?

NUMBER REPORTED.....  
 NUMBER NOT REPORTED.....  
 NUMBER UNCERTAIN.....

4. a) To your knowledge, how many Psychologists were sexually involved with only one patient? .....

b) To your knowledge, how many Psychologists were sexually involved with more than one patient? .....

5. Have you taken any action to prevent the continuation of such contacts, for example to report a contact or to discuss the matter with the Psychologist concerned? (Tick one box) YES  NO

If NO, why not ?

.....  
.....  
.....

**SECTION SEVEN**

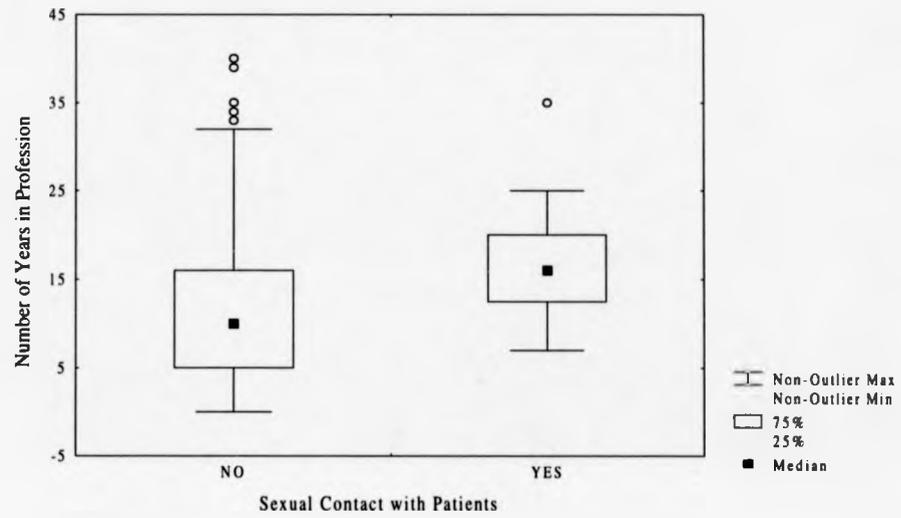
1. Any further comments.



APPENDIX 3

BOX AND WHISKER DIAGRAM FOR  
YEARS IN PROFESSION AND SEXUAL  
CONTACT WITH PATIENTS





**Figure 2. Number of years in profession and sexual contact with patients: Box and whisker plot.**



**APPENDIX 4**

**DEFINITIONS MANUAL FOR  
QUALITATIVE DATA**



**DEFINITION MANUAL: QUALITATIVE DATA****Coding instructions:**

Assign the entire response of each respondent for each question to one or more of the following categories. If a response to a question is assigned to more than one category, then indicate this at the end of the response **each time it appears** by inserting in brackets the number of times the response appears. Use the following four point rating scale for each response:

- Definitely applies (rate 1)
- Probably applies (rate 2)
- Possibly applies (rate 3)
- Does not apply (rate 4)

These categories were chosen by reading all responses to each question, and identifying themes among responses.

**1. Have you ever felt sexually attracted to one of your patients? If no, why not?****a) Ethical concerns**

The respondent cites reasons for not being attracted to a patient, which would involve ethical concerns about the inappropriateness of attraction to a patient, including such matters as abuse of power, the importance of professionalism, concern for the adverse effects upon the patient of such attraction, or other statements which convey or imply that attraction to patients would be antitherapeutic.

**b) Features of patient population**

The respondent makes an explicit or implicit statement that s/he works with children, those with learning disabilities, the elderly, same sex patients, or some other group that does not fall within the ambit of the psychologist's sexual orientation.

**c) Respondent experiences feelings for patients which preclude the sexual.**

The psychologist describes feelings such as maternal or protective feelings towards patients, which preclude sexual feelings.

**d) Traumatic experience**

The respondent mentions a negative personal/sexual experience with a patient, which exerted a traumatic effect and has resulted in an inhibition of any sexual feelings towards patients.

**e) Self-management**

The respondent mentions explicitly that his/her thoughts or assumptions are either aimed to avoid attraction to patients or would function in such a way as to exclude it.

**f) Don't know**

The respondent offers no explanation or understanding of his/her stated lack of sexual attraction towards patients, stating explicitly that s/he does not understand it. Alternatively, the respondent states that s/he is unable to answer the question.

**g) Nature of therapeutic relationship**

Contextual factors within therapy are mentioned by the psychologist which prevent attraction towards a patient from developing. This could include either factors relating to the concrete therapeutic environment, or because of aspects of the therapeutic relationship. For example, the respondent might view the therapeutic relationship or atmosphere in clinics, etc., as somehow excluding sexual attraction.

**h) Fortuitous**

The respondent explicitly states that s/he has not felt attracted to patients, either per se, or because, by chance, the respondent has not (yet) been attracted to a patient. The respondent gives no reason why attraction might not occur in the future. Statements giving little explanation such as "I just haven't" should be coded here. However, if the main rationale refers to ethical reasons for the lack of attraction, the response should be coded under a) ethical concerns. If the main reason given relates to situational factors, for example the roles of patient and psychologist precluding attraction, code the response under g) situational factors.

**i) Existing relationship**

The respondent states that the fact that s/he is already in a relationship has prevented him/her from becoming attracted to patients, for example, because of loyalty or being sexually satisfied. The implication should be that were the respondent not in that current relationship, it is possible that s/he would look at patients in a different way, which could include the possibility of sexual attraction.

**j) Taboo/repression**

The psychologist makes a statement that s/he has not been attracted to a patient because of a taboo upon it, or some form of repression/suppression/denial of sexual feelings for patients. If reference is made to conscious efforts to avoid experiencing such feelings, code as e) "Self management"

**k) Miscellaneous or uncodeable**

This category may include instances when the respondent has apparently misunderstood the question, or makes comments about the question itself which do not lend themselves to coding in other categories. Statements refusing explanation should be coded here.

**l) Other**

Any response which does not fit into the other categories

**2. Have you ever had what you regard as sexual contact with one of your patients, no matter whether current or discharged? If no, what has stopped you?**

**a) Boundary issues**

The respondent provides as a rationale for refraining from sexual contact with patients the notion that to do so would be to transgress boundaries of therapy and thus, by implication, have a therapeutically unhelpful effect upon the patient. The suggestion is, therefore, that sexual contact with patients falls outside of what constitutes a therapeutic relationship, and is incompatible with the role of therapist. There may be reference to the occurrence of sexual attraction by patients towards the therapist and to a theoretical understanding of this attraction (perhaps using concepts such as transference) leading to the use of the concept of boundaries to "contain" it. There may also be a suggestion in terms of personal boundaries, that is, that the psychologist implies that s/he endeavours to keep a distance between his/her personal and professional life, and that engaging in sexual behaviour with a patient would not maintain this separation.

The primary focus here should be upon **boundaries**: if the primary focus lies elsewhere, e.g. on the impact upon the patient of sexual contact, or ethical issues, then the statement should be coded under o) Impact upon the patient or c) Professional/ethical issues, respectively. If such behaviour is termed "inappropriate" by the respondent, and no elaboration is given, then the response should be coded here as rating 3, as well as in categories b) and c).

**b) Personal values/ethics in relation to therapeutic practice**

The respondent defines his/her own values as excluding sexual contact with patients: by implication, the rationale for this is related to the power issues in therapy and the potential negative effects upon the patient. Thus, there is a personal moral element to this reason. The personal rather than professional nature of this rationale should form the primary emphasis, and in addition, a concern for potential damage to the patient rather than factors related to the respondent's personal relationship. If professional/ethical reasons are given priority, the response should be coded under c) "Professional values/ethics. If such behaviour is termed "inappropriate" by the respondent, and no elaboration is given, then the response should be coded here as rating 3, as well as in categories a) and c).

**c) Professional values/ethics**

The respondent mentions purely professional and/or ethical reasons which relate to a code of practice rather than personal moral judgement for refraining from sexual contact with patients. If reasons mainly related to the **therapeutic relationship** are given, code under a) Boundary issues. Professional/ethical rationales such as misconduct should be classified here. Perceived illegality of sexual contact with patients should be coded here. If such behaviour is termed "inappropriate" by the respondent, and no elaboration is given, then the response should be coded here as rating 3, as well as in categories a) and b).

**d) Supervision**

The respondent cites the opportunity in supervision to discuss issues of attraction in therapy, as safeguarding the respondent from acting out sexual feelings with the patient.

**e) Don't know**

The respondent makes an explicit statement that s/he can provide no rationale for his/her failure to become sexually involved with patients.

**f) Negative professional consequences for self**

The psychologist provides as a reason for avoiding sexual contact with patients the potential negative consequences for him/herself professionally. If the respondent simply mentions the consequences for him/herself, without alluding to whether these consequences would be personal or professional, code here as rating 3 as well as in i).

**g) Lack of opportunity**

The respondent states that the reason for his/her lack of sexual contact with patients is because of lack of opportunity.

**h) Avoidance of sexual contact**

The respondent has deliberately avoided situations in which sexual contact with patients might occur.

**i) Negative personal consequences for self**

The psychologist states that there were personal reasons for refraining from sexual contact with patients. For example, s/he may make an explicit connection between his/her existing relationship and the fact that s/he has not engaged in sexual behaviour with patients. That is, the respondent may mention this issue in isolation, or a wish to remain faithful/belief in monogamy, etc. The possible threat to the existing relationship which a liaison with a patient might pose, may also be coded here. If the respondent simply mentions the consequences for him/herself, without alluding to whether these consequences would be personal or professional, code here as rating 3 as well as in f).

**j) Not having experienced any desire to engage in sexual contact**

The respondent explains that s/he has not engaged in sexual contact with patients because of a failure to find a patient, or patients as a category, or the particular client group with which they work, attractive. A statement that the therapist has not been "tempted" should be categorised here. Alternatively, the psychologist states that his/her lack of interest in the concept of sexual contact with patients, or lack of a wish to do so has precluded sexual contact with them. This lack of interest may not be elaborated and should not relate specifically to the psychologist's existing relationship: if it does, code under i) negative personal consequences for self. Respondents may state that they have never considered the possibility of sexual contact with patients before, and has not,

therefore, engaged in it. If the reference is primarily to the **situation** not having arisen, this should be coded under g) Lack of opportunity.

**k) Traumatic experience**

The respondent cites a traumatic/negative experience in relation to patients, as reason for failure to engage in/avoidance of sexual contact with them.

**l) Fear of potential negative consequences within the therapy relationship**

The respondent states that s/he lacks the confidence to approach a patient if s/he were attracted to one. Shyness could be categorised here, as well as fear of the potential negative consequences personally within the therapist-patient relationship such as rejection/anger.

**m) Impact upon the patient**

The potentially negative impact upon the patient of sexual contact with their psychologist, is put forward by the respondent as a reason for his/her avoidance of such behaviour. A number of reasons/negative effects upon the patient may be cited, e.g. harm, damage, etc.

**n) Miscellaneous or uncodeable**

This category may include instances when the respondent has apparently misunderstood the question, or makes comments about the question itself which do not lend themselves to coding in other categories. Statements refusing explanation should be coded here.

**o) Other**

Any response which does not fit into the other categories

**3. Do you know through sources other than your own patients, of clinical psychologists who have been sexually involved with their patients? Have you taken any action to prevent the continuation of such contacts? If no, why not?**

**a) Suspicion only**

The respondent only suspected that a clinical psychologist had engaged in sexual contact with a patient. This should be a **personal** suspicion, based on factors other than the suspicions/allegations of third parties, otherwise code under (b). This category will usually, but not necessarily, relate to a clinical psychologist who is known directly to the respondent. There should have been insufficient evidence/information to take any action.

**b) Hearsay only**

The respondent did not report a sexual contact between as therapist and patient because his/her knowledge of the contact was indirect. This category relates to the suspicions/allegations of third parties. For example, the respondent had seen media coverage of a case, or had been informed of a sexual contact by a third party or through the "grapevine".

**c) The sexual contact was not considered to be harmful to the patient**

The respondent implies or explicitly states that s/he believes that action was not warranted because there was, in his/her opinion, no harmful consequences for the patient. The reason for the perceived lack of harm should relate to the **actual** sexual contact rather than, for example the fact that time has passed since the sexual contact occurred. If the latter is their emphasis, then record under (c). Reasons for the perceived lack of harm could include the fact that psychologist and patient had married or were in a long term relationship, or that the respondent believes that the sexual contact was terminated without harm to the patient.

**d) The sexual contact was not current**

The respondent states that a sexual contact between a psychologist and patient had occurred in the past and had now ceased, thus suggesting that reporting was inappropriate **mainly** on the basis that the event had occurred in the past. If the emphasis is on issues of harm (or lack of it) in relation to the fact that the contact is not current, then record under (c) "The sexual contact was not considered harmful to the patient".

**e) The sexual contact occurred after termination of therapy**

A clear statement should be made by the respondent that because the sexual contact between psychologist and patient began after therapy had ended, there was no reason to consider it inappropriate, and therefore no reason to report it. Thus a view is implied or explicitly stated that post-termination sexual activity with patients is a legitimate activity.

**f) Action had already been taken**

The respondent felt that action was not warranted since other parties had taken relevant action regarding the sexual contact between the psychologist and patient, or another form of action had been taken. Respondents' statements that they are/were involved in an official capacity with a disciplinary investigation relating to the case should be coded here.

**g) No risk of reoffending**

The respondent states that s/he did not / does not believe that action is required or justified in relation to a case of sexual contact between psychologist and patient. For example, the respondent might believe there to be no risk of the psychologist reoffending because s/he had reformed or because s/he was in therapy. The respondent might also feel that action was not warranted because the psychologist who had been sexually involved with a patient was no longer practising, either because of retiring from clinical psychological practice, or through death. If the psychologist ceased to practice through dismissal relating directly to the sexual contact, this should be coded under (e) "Action had already been taken".

**h) Patient was to blame for the sexual contact**

The respondent puts forward the view that the sexual contact was not the fault of the psychologist, but that of the patient, and that therefore no action was warranted.

**i) The respondent did not believe it to be his/her responsibility to take action.**

The respondent has not reported a sexual contact between psychologist and patient because s/he felt that this was not his/her responsibility. For example, the respondent might cite lack of contact on the respondent's part with the offending psychologist. The primary reason for the lack of contact may be geographical or the respondent may simply have made a statement concerning the lack of contact, without giving explicit reasons for it. If a patient who has had sexual contact with a psychologist, reports this to the respondent, this should be coded here. If, by contrast, the respondent has been informed of such a sexual liaison by a colleague, this should be coded in (b) "Hearsay only".

**j) The respondent was a friend of the offending psychologist**

The respondent states explicitly or implies that s/he did not report the offending psychologist because of a personal relationship between him/herself and the psychologist.

**k) No understanding of the importance of taking action**

The respondent acknowledges that action should have been taken but recognises that at the time s/he did not understand that this was necessary.

**l) Fear of retribution/retaliation**

The respondent states or implies that no action was taken because of the offender's senior/power position in relation to him/her, or because of other reasons for fearing negative consequences to him/herself as a result of action.

**m) Miscellaneous or uncodeable**

This category may include instances when the respondent has apparently misunderstood the question, or makes comments about the question itself which do not lend themselves to coding in other categories. Statements refusing explanation should be coded here.

**n) Other**

Any response which does not fit into the other categories

#### **4. Any further comments**

##### **a) Suggestions for further research**

The respondent makes a specific suggestion for future research in this or a related field, or mentions an issue which s/he does not feel was covered by the research/questionnaire.

##### **b) Questioning whether respondents would answer the questionnaire truthfully**

The psychologist makes a statement about the possibility that respondents may not answer some of the questions honestly, possibly because of the delicate/sensitive nature of some of the questions. Reference may be made to the consequent potential inaccuracies in the data gathered/bias in the sample in view of this, and despite assurances of anonymity and confidentiality. The response may include a direct assertion from the respondent that were s/he to have been sexually involved with a patient, then s/he would not admit this.

##### **c) Power issues in therapy**

Comments are made about the salience of power issues in the area of sexual contact between therapist and patient. This may be a general or specific reference, for example, the respondent may refer to parallels with child sexual abuse.

##### **d) I had not thought about or experienced this before or tend not to consider patients in a sexual way**

The respondent states that s/he had not given consideration to the issues of sexual contact with patients, or had not been sexually attracted to patients, or had not been aware of the issues, prior to receiving the questionnaire. This would include respondents who state that they do not tend to think about patients in a sexual way, as well as respondents who state that they find the fact of therapist-patient sexual contact shocking or disturbing: whilst no personal statement is made here, the implication is that it is outside of the respondent's personal experience.

##### **e) Comments about theoretical orientation**

The respondent mentions the issue of theoretical orientation in relation to the issue of sexual contact between therapists and their patients. This may relate to personal theoretical orientation in terms of awareness of the issue being more or less problematic for certain theoretical orientations.

##### **f) Ethical issues**

The psychologist comments that therapist-patient sexual contact is an ethical issue, or makes remarks which carry this implication, for example that sexual contact with patients serves the therapist's rather than the patient's interests, is exploitative, etc.

**g) Disclosure of personal experience of sexual abuse or sexual dilemmas**

The respondent makes a disclosure not contained elsewhere in the questionnaire about personal experiences which are relevant, for example sexual harassment by a supervisor during training, or a patient, or knowledge through friends or family of abusive experiences in therapy. Additionally the respondent may disclose sexual abuse by a personal therapist.

**h) Some allegations of sexual abuse by therapists are false**

The respondent comments that some patients may make false allegations against their therapists of sexual abuse.

**i) Comments about the research methodology**

The psychologist makes comments about the research methodology, including the way in which the questionnaire is constructed or structured.

**j) Negative comments about the research**

Explicitly negative comments are made about the research topic or approach. Specifically negative comments about the questionnaire should be coded under i).

**k) I have felt tempted but I keep myself under control**

The respondent states explicitly that s/he has felt sexually attracted to patients but has consciously kept such impulses under control.

**l) Sexual contact with ex patients or ex trainees is acceptable**

The respondent makes an explicit statement that s/he believes that it is acceptable to have a sexual relationship with a discharged client or a former trainee.

**m) Comments about dealing with sexual impropriety**

The respondent makes comments about the issues involved in managing actual or suspected sexual impropriety either between therapist and patient or between psychologist and supervisor.

**n) Comments supporting the research**

Positive comments about the research are made by the psychologist, who may also offer help or resources to the author. If the comment relates to the research methodology, code as i) "Comments about the research methodology"

**o) Detail of colleagues who have had sexual contact/behaved sexually inappropriately with patients**

The respondent mentions other professionals who s/he knows to have behaved inappropriately in sexual terms with patients. This would not have been covered in the questionnaire since such patients are not on the respondent's caseload, and the therapist was not a clinical psychologist, or the profession was unknown. Alternatively the respondent gives further detail about clinical psychologists or his/her own patients, which s/he mentioned in the questionnaire.

**p) Gender issues**

The respondent mentions the relevance of gender issues to the subject of therapist-patient sexual contact. For example the respondent may be commenting upon the fact that male therapists are more likely to legitimise sexual contact with patients, or power issues related to gender.

**q) Organisational/professional responsibility**

A statement is made that the issue of sexual contact between therapist and patient is not the responsibility of the therapist, but of the profession or of the organisation, since preventative action is lacking, for example on clinical psychology training courses.

**r) Therapist-patient sexual contact can be damaging**

The respondent states that s/he believes that sexual contact (and perhaps other forms of intimacy such as friendship) between therapist and patient is unjustifiable because of its negative effects on the patient. Statements may also be made about the importance of avoiding the abuse of the relationship, because of such potential damage.

**s) Preventative suggestions**

The respondent makes suggestions for the prevention of sexual contact between therapists and trainees, such as compulsory supervision, encouraging patients to assume more power in therapy,

**t) Comments on sexual relationships between educators and trainees**

The psychologist offers some comments about the issue of sexual relationships between educators and trainees, either supporting the practice or not.

**u) Sexual contact with patients can be acceptable under some circumstances**

The respondent offers the view that there may be times or circumstances under which it can be acceptable for therapist and patient to have a sexual relationship, for example if both parties "consent".

**v) Comments on sexual attraction in therapy**

General comments are offered on the issue of sexual attraction in therapy, for example as an issue in its own right, which should be considered in depth. Comments may also expand on the questions in the survey on this topic.

**w) Hearsay only**

The respondent mentions that some of his/her responses to the questionnaire are based on hearsay only rather than direct experience.

**x) Miscellaneous or uncodeable**

This category may include instances when the respondent has apparently misunderstood the question, or makes comments about the question itself which do not lend themselves to coding in other categories. Statements refusing explanation should be coded here.

**y) Other**

Any response which does not fit into the other categories



APPENDIX 5

DSM-IV DIAGNOSTIC CRITERIA FOR  
BORDERLINE PERSONALITY DISORDER  
(AMERICAN PSYCHIATRIC  
ASSOCIATION, 1994)



**DIAGNOSTIC CRITERIA FOR BORDERLINE PERSONALITY DISORDER**

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- (1) frantic efforts to avoid real or imagined abandonment. **Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.
- (2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
- (3) identity disturbance: markedly and persistently unstable self-image or sense of self.
- (4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). **Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.
- (5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
- (6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
- (7) chronic feelings of emptiness.
- (8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
- (9) transient, stress-related paranoid ideation or severe dissociative symptoms.

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**TITLE**                    **AN EXPLORATION OF SEXUAL CONTACT  
BETWEEN CLINICAL PSYCHOLOGISTS AND  
PATIENTS**

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