How Clients Are Harmed by Sexual Contact with Mental Health Professionals: The Syndrome and Its Prevalence

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Research concerning the prevalence, varieties, contributing factors, and harmful consequences of sexual intimacies with clients (occurring either prior to or subsequent to termination) is reviewed. The sequelae of therapist-client sex may form a distinct syndrome, with similarities to Rape Response Syndrome, Battered Spouse Syndrome, reaction to incest, response to child abuse, and Post-Traumatic Stress Disorder. Aspects of Therapist-Patient Sex Syndrome include: (a) ambivalence, (b) a sense of guilt, (c) feelings of emptiness and isolation, (d) sexual confusion, (e) impaired ability to trust, (f) identity, boundary, and role confusion, (g) emotional lability (frequently involving severe depression and acute anxiety), (k) suppressed rage, (i) increased suicidal risk, and (j) cognitive dysfunction (especially in the areas of attention and concentration, frequently involving flashbacks, nightmares, intrusive thoughts, and unbidden images).

Sexual intimacies between mental health professionals and clients are inherently unethical, unprofessional, and severely damaging. Yet they continue to occur. Table 1 (adapted from Pope and Bouhoutsos, 1986, p. 34) presents the prevalence studies that have been published during the last fifteen years. The very different criteria for sample selection make it difficult to compare these data, but it is clear that male therapists engage in therapist-client sex at higher rates than female therapists do. The aggregate averages (unadjusted for sample size) are 8.3% for men and 1.7% for women.

There is an apparent decline for psychologists: The rate of the 1987 study is significantly below that of the previous three national studies of psychologists. However, the increasing attention to statutes in such states as Colorado, Minnesota, and Wisconsinn that make such activity a felony may have made the participants in the most recent study even less willing to acknowledge what is now construed as not only unethical and damaging but also possibly criminal behavior. It seems extremely unlikely that there would have been such a steep decline during the l-year period since the previous study. In any event, it is likely that such studies underestimate the prevalence of therapist-client sexual contact.

It is not only adult clients who are sexually exploited. Bajt and Pope (in press) found that a substantial amount of therapist-client sexual intimacies involve clients who are minors. Slightly more of these children (56%) were girls, with a mean age of 13, ranging between 3 and 17. The victims who were boys had an average age of 12, ranging from 7 to 16.

CONTRIBUTING FACTORS

Varieties of Sexual Involvement

The fact that so many mental health professionals become sexually intimate with their clients, that the mental health professions have yet to take adequate steps to prevent this sexual abuse, and that so many clients are damaged so deeply by such intimacies constitutes a major problem for the professions and consumers alike. One part of the problem may be that therapists are unaware of the variety of ways in which sexual intimacy with a client can occur. They may conceptualize the phenomenon as a scheming, malicious therapist overpowering—perhaps by physical force—a reluctant client. Thus they may be unprepared to recognize and handle safely and therapeutically a client who is experiencing an intense sexual transference or an attractive client who is expressing a need for nonerotic closeness. It is crucial that therapists be aware of the diverse paths to unethical intimacy. Table 2 (adapted from Pope and Bouhoutsos, 1986, p. 4) presents ten of the common scenarios. In every instance and without exception, *it is always the therapist's responsibility to ensure that sexual intimacies with a client do not occur.*

Training Issues

Another part of the problem seems to involve training programs, which spend relatively little time addressing issues of sexual contact with or even sexual attraction to clients (Pope and Bouhoutsos, 1986; Pope, Keith-Spiegel, & Tabachnick, 1986). The sexualization of the student-teacher and student-supervisor relationships in training programs tends to prohibit open and honest discussion of the sexual feelings that are a normal part of many therapies. About one fourth of recent female graduates of psychology training programs have been sexually involved with at least one professor (Pope, Levenson, & Schover, 1979). The research suggests that individuals who, as students, become sexually involved with faculty are more likely—at a statistically significant level—to become sexually intimate subsequently, as therapists, with their clients (Pope, Levenson, & Schover, 1979).

Denial

Still another part of the problem has been the massive denial of this problem among professionals. As late as 1977, therapist-client sexual intimacy was termed the "problem with no name" (Davidson, 1977), and various authors found that conventions and journals were reluctant to present material on this topic (Pope & Bouhoutsos, 1986). Dahlberg (1971), for example, wrote in his introduction to "Sexual Contact Between Patient and Therapist": "I have had trouble getting this paper accepted by larger organizations where I had less, but still not inconsiderable influence. I was told that it was too controversial" (p. 34).

The denial is complicated by the discomfort most therapists feel in response to a very common phenomenon: sexual attraction to clients. Research indicates that the vast majority (87%) of therapists experience attraction to some of their clients, but

TABLE 1

Frequency Studies of Therapist-Client Sexual Intimacy[a]

Ref. No.	Pub. Date	Profession	Location	Return Rate (%)	M	F
1	1973	Psychiatrists	LA County	46	10.0	n/a
2	1976	Psychiatrists	CA & NY	33	n/a	0.0
3	1977	Psychologists	National	70	12.1	2.6
4	1979	Psychologists	National	48	12.0	3.0
5	1985	Social Workers	National	54	3.8	0.0
6	1986	Psychologists	National	59	9.4	2.5
7	1986	Psychiatrists	National	26	7.1	3.1
8	1987	Psychologists	National	46	3.6	0.5

Reference key: 1, Kardener, Fuller, & Mensch; 2, Perry; 3, Holroyd & Brodsky; 4, Pope, Levenson, & Schover; 5, Gechtman & Bouhoutsos; 6, Pope, Keith-Soiegel, & Tabachnick: 7, Gartrell, Herman, Olarte, Feldstein, & Localio; 8, Pope, Tabachnick, & Keith-Spiegel.
[a]Adapted from Pope & Bouhoutsos, 1986, p. 34.

most (63%) feel guilty, anxious, or confused about the attraction (Pope, Keith-Spiegel, & Tabachnick, 1986). So troubling is the attraction that about 20% of the therapists do not acknowledge it or discuss it with anyone. Thus, therapists may experience difficulty in responding sensitively, professionally, and therapeutically to their own feelings of attraction to clients and may resist making use of resources developed to help therapists who feel overwhelmed by such attraction and tempted to act it out with the client (Pope, 1987). This strong and persistent denial enables a number of senior and apparently respected psychologists to use "client welfare" as a rationale for engaging in sex with the client (Pope and Bajt, 1988).

This denial can play a destructive role when-colleagues discover that a counselor has been sexually involved with a client. Shutting out awareness of the research findings that about 88% (Holyrod & Brodsky, 1977) of erotic practitioners become sexually involved with more than one client, of the specialized procedures that have been developed to assess and rehabilitate sexually exploitive therapists (Pope, in press a and b; Schoener, 1986), and of the need for assessment and rehabilitation to be carried out by professionals with expertise in this specialty (otherwise the counselor who is attempting to carry out the rehabilitation plan is functioning outside his or her area of competence), psychologists may formulate superficial or otherwise inadequate assessment and rehabilitation plans that actually enable the exploitive counselor to continue sexually abusing clients. When a counselor is discovered to have become sexually involved with a client, the counselor must not be permitted to resume practice until an adequate assessment and rehabilitation have been completed.

EVIDENCE AND VARIETIES OF DAMAGE

Yet perhaps the greatest part of the problem is the fact that most mental health professionals are unaware—in any specific and emotionally immediate way—of the damage that therapist-client sexual intimacy causes to the client. Counselors may be aware that they are violating ethical, legal, clinical, and professional standards—and are taking a personal risk—when they engage in sex with their clients. But they tend to be unaware of the devastating ways in which they are violating the client's welfare, trust, sense of identity, and potential for future development.

Counselors can educate themselves about the deep, diverse, lasting, and sometime permanent harm that sexual intimacies—prior to or subsequent to the termination—can do to clients. Durre (1980), for example, reviewed the prior research (e.g., Belote, 1974; Chesler, 1972; Dahlberg, 1971) and conducted an original study of female clients who had been sexually intimate with their therapist. She found

> many instances of suicide attempts, sever depressions (some lasting months), mental hospitalizations, shock treatment, and separations or divorces from husbands . . . Women reported being fired from or having to leave their jobs because of pressure and ineffectual working habits, because of their depression, crying spells, anger, and anxiety (p. 242).

She concluded that "amatory and sexual interaction between client and therapist dooms the potential for successful therapy and is detrimental if not devastating to the client" (p. 243). Her research on therapy more generally confirms Freud's (1915/1963) conclusion specifically about psychoanalytic treatment that sex-

TABLE 2

Ten Common Scenarios[a]

Scenario	Criterion
Role Trading	Therapist becomes the "patient," and the wants and needs of the therapist become the focus of the treatment.
Sex Therapy	Therapist fraudulently presents therapist-client sexual intimacy as a valid treatment for sexual or other kinds of difficulties.
As If . . .	Therapist treats positive transference as if it were not the result of the therapeutic situation.
Svengali	Therapist creates and exploits an exaggerated dependence on the part of the client.
Drugs	Therapist uses cocaine, alcohol, or other drugs as part of the seduction.
Rape	Therapist uses physical force, threats, and/or intimidation.
"True Love"	Therapist uses rationalizations that attempt to discount the professional nature of the relationship with its attendant responsibilities and dynamics.
It Just Got Out of Hand	Therapist fails to treat the emotional closeness that develops in therapy with sufficient attention, care, and respect.
Time Out	Therapist fails to acknowledge and take into account that the therapeutic relationship does not cease to exist between scheduled sessions or outside the therapist's office;
Hold Me	Therapist exploits client's desire for nonerotic physical contact and client's possible difficulties distinguishing between erotic and nonerotic contact.

[a]Adapted from Pope & Bouhoutsos, 1986, p. 4.

ual intimacies constitute "a complete overthrow for the cure" (p. 174).

Bouhoutsos, Holroyd, Lerman, Forer, and Greenberg (1983) conducted an elaborate study, in which subsequent clinicians provided their professional opinions about clients who had been sexually intimate with a prior therapist. In 90% of these cases, the subsequent therapist reported damage to the client. The range of harm included inability to trust, hesitation about seeking further help from professionals, severe depressions, hospitalizations, and suicide.

What of the 10% of the cases in which no harm was reported at the time of the study? It is likely that two major factors obscured the harm in these cases. First, the destructive effects of therapist-client sexual intimacies are sometimes delayed in a way that is similar to many cases of Post-Traumatic Stress Disorder, reaction to incest, and reaction to child sexual abuse. Second, Holroyd and Bouhoutsos (1985) subsequently conducted more detailed analyses of the data and discovered that in many of the cases in which "no harm" was reported, the therapists making the reports had themselves engaged in sexual intimacies with clients and thus could hardly be considered an unbiased group in making and reporting their evaluations.

References to the prohibition against and the harm that results from sexual intimacies with clients that occur *only after termination* are provided by Brodsky (1988), Dyer (1988), Ethics Committee (1988), Gabbard and Pope (1988), Gilbert and Scher (in press), Pope, Tabachnick, and Keith-Spiegel (1988), and Sell, Gottlieb, and Schoenfeld (1986). It is important for counselors and other mental health professionals to be knowledgeable about aspects of the therapeutic process that continue after termination—for example, the residual transference in successful therapies that tends to peak during the period from 5 to 10 years after termination, the ways in which clients form internal representations of their former therapists, the power differential that continues—which are presented in such references.

Yet another perspective on the damaging consequences of therapist-client sexual contact is provided by those who have developed counseling, therapy, mediation, advocacy, and related services for victims (Bouhoutsos & Brodsky, 1985; Pope & Gabbard, in press; Pope & Bouhoutsos, 1986; Schoener & Milgrom, 1984; Sonne, 1987; Sonne, Meyer, Borys, & Marshall, 1985).

THERAPIST-PATIENT SEX SYNDROME

The sequelae (for the client) of therapist-client sexual involvement may form a distinct clinical syndrome, which is similar in some ways to Rape Response Syndrome, Battered Spouse Syndrome, reaction to incest, response to child abuse, and Post-Traumatic Stress Disorder. Like many of these syndromes, the appearance of the damage may be considerably delayed. Incest victims, for example, may repress the sexual incidents for years, sometimes decades, and pull together an external facade or persona that enables them to cope with life's demands. Later, perhaps when some unexpected, triggering event catches the person off guard while in a particularly stressed and distressed state, the memories of the incestuous events may erupt into awareness and the person may decompensate severely. For example, a victim of sexual contact with a counselor may experience an emotional numbness for years but be quite functional. Five or ten years later, he or she might form a romantic-sexual relationship with someone. As the relationship becomes more intense and intimate, the victim may suddenly see flashbacks of the sexual contact with the counselor, may have difficulty distinguishing between the current lover and the counselor, and may lapse into a profound depression with psychotic features.

There are ten aspects commonly associated with Therapist-Patient Sex Syndrome (Pope, 1985, 1986).

Ambivalence

Victims of therapist-client sexual intimacy often experience a deep sense of ambivalence about the exploitive therapist. On one hand, clients may feel rage, abhorrence, fear, and other negative feelings in regard to the therapist. There may be a desperate longing to escape completely from his or her considerable power and influence. Some victims may feel that only suicide can truly separate them from the therapist's potential to cause them suffering and pain.

On the other hand, the client may fear any separation or alienation from the therapist. He or she may feel or believe that the therapist is the only one capable of loving them or healing them. Therapists tend to be skilled in identifying clients' vulnerabilities and knowing ways in which people can be influenced; thus they are in a position to take advantage of their clients' honesty, openness; and trust. Clients may fear that their own actions (in resisting sexual advances, in seeking second opinions, in disclosing the sexual abuse to third parties, or in filing complaints with the civil courts, the licensing boards, or the professional ethics committees) will destroy the therapist (e.g.,cause financial and professional ruin, end the therapist's marriage). Often such factors—until they are worked through in a subsequent therapy—can prevent clients from filing formal complaints for a number of years.

The ambivalence is similar to that which is experienced by many incest victims and battered spouses who alternately (or simultaneously) want to flee from the abuser and to cling to (and even protect) the abuser. At times the abusing counselor may be perceived through the distorted lenses of the exploitive relationship as a somehow "good" person who is, in this psychological framework, the victim's only source of love, protection, and perhaps even survival itself.

Feelings of Guilt

The guilt felt by victims of therapist-client sexual intimacy, though unfounded, tends to be pervasive and persistent. Such guilt is always and without exception unfounded: It is always the responsibility of the counselor to see that any sexual contact is avoided, despite any behaviors, requests, desires, or vulnerabilities of the client. And yet clients tend to feel as if they are to blame. Once again, Therapist-Patient Sex Syndrome is similar to reaction to rape, incest, child abuse, and spouse battering: The victims feel as if they are to blame. The rape victim, for example, may feel a completely unfounded guilt that she took the wrong route home, or did not get her keys out quickly enough, or did not struggle vigorously. She may grasp intellectually but not emotionally that the rape is always the responsibility of the rapist, that the victim of rape is never guilty of the rape.

Sense of Emptiness and Isolation

Victims of therapist-client sex often feel empty, hollow, without substance or worth, as if only the abusing therapist could fill them up. They also tend to experience a sense of isolation, as if they had been uniquely singled out for this fate and could never again make genuine contact with another human being. Here again the syndrome is similar to that experienced by rape, incest, and battering victims, who may know intellectually that others have endured such abuse but who emotionally feel completely alone, "weird," isolated, alienated, and cut off from other people and from "normal" human experience.

Sexual Confusion

Some clients—but by no means a majority—who are subsequently sexually abused by their therapists begin psychotherapy because of sexual dysfunctions or concerns. Regardless of the presenting complaint, however, most victims seem to manifest a profound confusion about sexuality as a result of the sexual

involvement with the therapist. Victims of therapist-client sex, in a manner similar to that of rape victims, incest victims, and victims of child sexual abuse, tend to suffer from a severe sexual trauma that affects their sense of identity. For some, any sexual activity or material may bring back traumatic memories that threaten their sense of self. Others may be trapped into ritualistic, compulsive, and/or self-destructive sexual encounters and activities as a result of their sexual victimization by a therapist.

Impaired Ability to Trust

Therapy involves an exceptional degree of trust. We share ourselves with our therapists, showing them private aspects of ourselves, letting them know our deepest secrets, our hopes, dreams, fears, shames, guilts, and vulnerabilities. The violation and exploitation of that trust has lifelong consequences for the victim. Victims become mistrustful and understandably so. They mistrust themselves for developing a trust for the therapist. They mistrust others, particularly professionals, most particularly therapists. The damage and hurt occur at such a deep level, that they reverberate outward, affecting almost all the less intense relationships.

Identity, Boundary, and Role Confusion

Therapists who engage in sexual intimacies with their clients violate the identity of the therapist (what the therapist "means" and who the therapist "is" for the client), the fundamental and necessary boundaries, and the roles of therapist and client. As a result, they exploit and harm the client's sense of identity, ability to establish and maintain appropriate boundaries, and capacity for participating in clear, nonself-destructive roles. In a number of cases the sexual intimacy is preceded by an inversion of roles and identities: The therapist begins more and more self-disclosure until the focus of the therapy is the therapist rather than the client. This is parallel to some forms of incest and child battering, in which the child appears to switch roles with the abusing parent: The child becomes responsible for "taking care of" the parent (not just sexually). Thus clients become extremely confused about maintaining safe and appropriate boundaries, about their sense of identity and worth (as more than instruments of sexual gratification for the counselor), and about the roles they adopt in social interactions.

Emotional Liability

Clients who have been sexually involved with a therapist often feel overwhelmed by their emotions. Just when they believe that they are on a solid road to recovery and healing, they experience a plunge into depression or anxiety, into a blind rage or an all-consuming terror, The surge of emotion may be all the more frightening and demoralizing because neither the deeper causes nor the more immidiate catalyst may be readily apparent. For example, a client may have been recovering in a subsequent therapy that has lasted 3 years. The client's emotional life is becoming more stabilized, less of a roller coaster. Improvement is seen by both client and counselor in virtually all phases of the client's life. The client then becomes involved—for the first time since the prior therapy—with a sexual partner. The increasing intimacy of this new relationship overwhelms the client, who then *temporarily* re-experiences the sense of being emotionally out of control, which he or she had not experienced since early in this subsequent therapy. Both counselor and client must work hard to put this setback into perspective so that the client does not lose all hope and perhaps terminate therapy.

Suppressed Rage

Like victims of other forms of sexual, physical, and emotional abuse, clients who have been sexually exploited by their therapist may respond with an understandable rage at the fact of the exploitation and at the person who exploits. But there are at least three major factors that serve to block this rage from awareness, let alone from appropriate acceptance and expression.

First, there is the force and influence—which may last many years after the final interaction—of the abusive therapist. Many abusive therapists discourage any negative expressions that their clients may try to direct toward them. Such therapists become adept at eliciting compliance and "hero worship." They use a wide range of methods, including threats, manipulation, and intimidation to brainwash their clients. Some clients are convinced that they can be involuntarily hospitalized, medicated, treated with ECT or psychosurgery, or otherwise "punished" by the exploitive therapist. Thus anger—let alone rage—becomes a very dangerous and unacceptable emotion to experience.

Second, there is the ambivalence described above. Clients may feel psychologically paralyzed and may experience a need or responsibility to protect the therapist from their own rage.

Third, there is the guilt. However much they may, intellectually know otherwise, emotionally clients may feel that the sexual contact was their fault and thus the rage may be turned back on themselves.

Increased Suicidal Risk

The suicidal risk may be aggravated by a variety of factors. The rage turned inward may reach a level of self-destruction. Clients may feel hopeless while trapped in their ambivalence. They may feel that taking their own life is the only way to expiate the sense of guilt that they feel or to protect the abusing therapist from their emerging rage. Many have described suicide as if it would be the only possible end to the pain that they feel.

Cognitive Dysfunction

So pervasive and profound is the trauma caused by sexual involvement with a therapist that it frequently impairs cognitive abilities, particularly in the areas of attention and concentration. For many clients, attention and concentration—as well as the more general state of awareness—are disrupted by unbidden images, intrusive thoughts, nightmares, memory fragments, and flashbacks. Not infrequently, these cognitions will seem virtually as if they were happening in the present. In this sense, Therapist-Patient Sex Syndrome bears similarity to Post-Traumatic Stress Disorder: Traumatic images from the past will be suddenly and unexpectedly replayed. Such cognitions may represent the mind's attempts to process or work through a trauma that was originally overwhelming.

CONCLUSION

Awareness of the scope and nature of the damages caused by sexual contact with clients is important to all of us as professionals. Such awareness can help each of us as individuals to avoid any temptation to act out a sexual attraction to a client, can prompt us as a profession to create and implement *effective* measures to ensure that clients are protected from such abuse and from exploitive therapists, and can enable us as subsequent therapists of the victims to recognize and respond sensitively and therapeutically to their distress.

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