Sexual Boundary Violations by Health Professionals – an overview of the published empirical literature

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EXECUTIVE SUMMARY

INTRODUCTION

Clinical and therapeutic interventions inevitably render individual patients and clients vulnerable, and trust relies on providing a safe and boundaried space in which these can be carried out without compromising the person's dignity and bodily integrity. Sexual boundary violations occur wherever a clinical or therapeutic relationship is turned into a sexual or sexualised encounter. It is always the responsibility of the practitioner to manage and maintain these boundaries.

A scoping of the existing literature was commissioned as one component of the Council for Healthcare Regulatory Excellence's (CHRE) national project on Clear Sexual Boundaries between health care professionals and patients. The objective was to scan and review current research on sexualised behaviour by health and social care workers towards patients. The review focuses on:

- Clarifying the **nature of sexual boundary violations**
- The **prevalence** of such violations
- The **impact** on patients and clients
- **Predictors** of sexual boundary crossing or violation by professionals with patients or clients.

METHOD

Three electronic databases were searched – Medline, PsycLit and Social Care Online, for all dates from 1970 to May 2006. Papers were only read in full and included in this report if they reported empirical data.

Limitations include difficulties around definitions of 'sexual boundary violation' and of 'professionals'. Also, the evidence base is also inherently problematic as sexual boundary violations are essentially covert.

KEY FINDINGS

Boundaries

Discomfort, attitudes and lack of clarity regarding boundary crossing

- The majority of responding health professionals view sexual contact with patients/clients as inappropriate and harmful
- Health professionals education and/or training on sexual ethics is widely perceived as inadequate
- There is a lack of consensus amongst health professionals regarding the definition of an '*ex* client/patient'
- Health professionals being able to openly discuss sexual attraction to patients/clients with a supervisor was supportive and increased professionals understanding
- Health professionals expressed confusion about whose responsibility it was to maintain sexual boundaries
- Professionals had scant knowledge about how to handle situations involving sexual boundary violations and many would not report colleagues.

Ways in which to decrease sexual boundary violations

- Professionals who have received education/training on sexual boundaries are less likely to 'offend'
- Factors to consider in training include communication skills, manner, explanations, sensitivity to patient's perceptions, use of chaperones, and avoidance of sexual humour
- Positive training environments promote healthier coping responses by professionals

Reported prevalence and incidence

- The majority of reported sexual boundary violations involve male health practitioners and female patients/clients
- Between 38 and 52% of health professionals report knowing of colleagues who have been sexually involved with patients, although several professionals may be citing the same case. Self-reporting rates are considerably lower
- Self-reporting by health professionals acknowledges high levels of patient attraction
- Greater awareness of professional guidelines and sanctions reduces prevalence.
- For therapists: Between 22 and 26% of patients report having been sexually involved with a previous therapist to another practitioner

Impact of boundary violations

- The impact on survivors of professional sexual boundary violations/abuse shows considerable and enduring harm
- Symptoms include post traumatic stress disorder, anger, a sense of betrayal and exploitation, guilt and self-blame
- High levels of dependency on the offending health professional, confusion and dissociation are found
- The negative impact of sexual abuse by professionals can be exacerbated by a patient/clients youth and a previous history of sexual abuse

Factors associated with boundary violation

- Difficulties in researching the subject, together with an understanding of systemic and organizational factors, leads to reluctance to rely on a predictive profile of offenders
- Rather than a simple 'bad apple' model, an alternative view is that *all* health professionals should be aware of their 'trouble spots' around sexual boundary issues
- A higher proportion of offenders are male, older than 'average' sex offenders, and suffer from a variety of psychopathologies
- Professionals who themselves had been severely sexually abused are more likely to have engaged sexually with patients/clients
- Women are the main victims of abuse
- A significant proportion of abused clients are previous victims of abuse.

SUMMARY and FURTHER RESEARCH

This report highlights the large empirical literature on sexual misconduct by health professionals. The studies show similar findings across different professional and semi-professional groups. Findings are similar across different countries.

Despite the methodological limitations of this review, it is possible to draw out a number of themes from the studies:

- Clear sexual boundaries are crucial to client safety of the patient/clients
- Specific education changes attitudes toward sexual contact with patients/clients but must be delivered in a conducive environment
- Sexual boundary violations commonly result in significant and enduring harm to patients/clients

- Reported incidence of abuse is low, but concentrated in general practice and psychological therapies
- Client vulnerability is associated with higher prevalence.

Further research is recommended as follows:

- UK based studies, within general practice, psychiatry and obstetrics and gynecology
- Research in other regulated professions
- Research in non-regulated professions, particularly psychotherapy, complementary medicine, and within social and long term care
- Research as to the effectiveness of different educational interventions.

1. INTRODUCTION

1.1 SEXUAL BOUNDARY VIOLATIONS

What are "sexual boundary violations"? The term is used to describe a range of situations in which professional boundaries are crossed and sexual actions and feelings are allowed to enter into a relationship which is supposed to operate in the interests of the patient/ client, and which, by virtue of the patient/client's vulnerability, is inherently unequal. The patient is, at least temporarily, dependent on the clinician and relatively needy in relation to him or her. Clinical interventions necessarily involve crossing ordinary social boundaries in order, for example, to do physical examinations or to explore difficult feelings and emotions. This can only be done if the patient/client can be sure that this is a safe and non-sexual space. Patients are not in a position to give valid consent to sexual involvement with health professionals as they are bound into the unequal relationship in which they have real need and which is either a fiduciary relationship (that is it is being paid for by them as individuals), or provided as part of a service level agreement or contract with a voluntary body or public service.

Sexualized behaviour was defined in the Independent Investigation into how the NHS handled allegations about the conduct of Clifford Ayling as behaviour that was:

"Over familiar to sensitive and intimate examinations which bordered on the unprofessional and was distressing to both the recipient and observer." (Para 2.26)

(Pauffley, 2004)

For the purposes of this literature review we have defined sexual boundary violations in the following terms:

Clinical and therapeutic interventions inevitably render individual patients and clients vulnerable, and trust relies on providing a safe and boundaried space in which these can be carried out without compromising the person's dignity and bodily integrity. Sexual boundary violations occur wherever a clinical or therapeutic relationship is turned into a sexual or sexualised encounter. It is always the responsibility of the practitioner to manage and maintain these boundaries.

As the literature demonstrates, the term is used to describe a number of situations and circumstances, for example:

- Clinical interventions of an intimate nature which are not warranted by the person's condition and/or are carried out inappropriately
- Clinical interventions such as intimate examinations which are wrongly framed in sexual terms or accompanied by sexual comments
- Clinical or therapeutic relationships in which the sexual gratification of the clinician takes precedence over the therapeutic goals and needs of the patient/ client
- Clinical or therapeutic relationships in which sexual attraction or emotional closeness is acted upon by the practitioner whose role it is to maintain boundaries in the interest of the clinical or therapeutic needs of the patient/ client
- The practitioner responding to sexual approaches made by a patient or client especially as these may be indicative of previous boundary violation or confusion
- Mutual attraction that is acted upon while a clinical or therapeutic relationship is still in operation or recently terminated.

Dual relationships, in which a social relationship occurs alongside a clinical responsibility, for example where a GP meets patients in other community settings, or in which a pastor/ counsellor becomes a friend in the context of other community activities, are not in themselves boundary violations. However, they may compromise the clinician's impartiality and/or make the

patient uncomfortable in the face of particular medical or therapeutic interventions and consideration should be given to re-assigning the patient to an alternative practitioner where this is feasible. A practitioner who deliberately fosters a dual relationship *in order to* initiate a sexual relationship would be considered to have violated a proper sexual boundary.

1.2 LITERATURE SCOPING FOR THE CHRE SEXUAL BOUNDARIES PROJECT

A scoping of the existing literature was commissioned as one component of the Council for Healthcare Regulatory Excellence's (CHRE) national project on Clear Sexual Boundaries between healthcare professionals and patients. The objective was to scan and review current research on sexual and sexualised behaviour by health and social care workers towards patients. The review is intended to inform the development and implementation of the other products of this project, including guidance for healthcare professionals, information for patients, guidance for health employers and future educational materials.

Sexual abuse of patients within professional relationships is not an easy subject to face up to. Many of us would prefer to turn away, to downplay the risks, to preserve the right of professionals to practise without scrutiny or safeguards, and to minimise the evidence that this behaviour causes lasting damage to some, already vulnerable, individuals. This review sets out the evidence for considered reflection, whether as individuals, as clinicians, as managers or as regulators; about our role in preventing such boundary violations and in ensuring that when they occur they are dealt with promptly, fairly and proportionately.

The review could not be strictly systematic, but aimed rather to balance a broad focus on four key areas:

- Clarifying the **nature of sexual boundary violations**
- The **prevalence** of such violations
- The **impact** on patients and clients
- **Predictors** of sexual boundary crossing or violation by health professionals with patients or clients.

These key areas are referred to in short throughout the report as boundaries, prevalence, impact and predictors. The review seeks to provide an overview of findings, to consider the limitations of published research in this area, and to suggest potential future research in this area.

1.3 KEY FINDINGS

The studies reveal a number of key themes, which will be examined in detail in the forthcoming chapters.

- The literature highlights issues of definition and difficulties acknowledging sexual boundary violations, which are usually covert
- Boundaries are crucial to client safety. A slippery slope of sexual violations can occur following other seemingly innocuous boundary crossings.
- Specific education changes professionals attitudes toward sexual contact with patients/clients, but must be delivered in a conducive environment. Professionals can continue to feel unprepared even after educational sessions.
- Sexual boundary violations commonly result in significant and enduring harm to abused patient/client's emotional wellbeing and functioning
- Reported incidence of abuse is low, but concentrated in general practice and psychological therapies
- Client vulnerability is associated with higher prevalence.

2. METHOD

2.1 SEARCH STRATEGY

Three electronic databases were searched – Medline, PsycLit and Social Care Online, for all dates from 1970 to May 2006.

The search strategy used the following MeSH terms and keywords, with the number of records located for each line in brackets:

Medline

1 Sexual Harassment/ (870)
2 Professional-Patient Relations/ (14046)
3 Trust/ (2150)
4 Ethics, Professional/ (5652)
5 Professional Misconduct/ (1812)
6 Boundar….. (With any word ending) (26798)
7 1 or 2 or 3 or 4 or 5 or 6 (50236)
8 Sex$ (462830)
9 7 and 8 (2803)

PsycInfo

1 Professional Client Sexual Relations (414)
2 Dual Relationships/(135)
3 Patient Abuse/(128)
4 4 1 or 2 or 3 (639)

Social Care Online

1 Sexual abuse and ethics
2 Vulnerable adults and sexual abuse

2.2 SELECTION AND CATEGORISATION OF PAPERS

As a first stage, all available abstracts were skimmed to gain an overview of the literature in the four areas of boundaries, prevalence, impact and predictors.

Papers were excluded in the further work if they referred only to sexual harassment of students or colleagues; sexual harassment/abuse of staff by patients; non-sexual boundary crossing and dual relationships; or professional misconduct, with no detail. All of these areas may be relevant in that they appear to provide 'evidence' of the following:

- That sexual boundaries are not infrequently crossed by regulated health professionals
- That patients sometimes initiate unwelcome sexual advances
- That boundaries in general are grey areas, with extensive debate as to their maintenance and management when they are crossed.

However, reviewing these papers in depth was outside the scope of this piece of work.

Some additional papers have been included to reflect work carried out about all abuse of vulnerable adults, within which abuse by health professionals is one subset. This enables reference to be made to the literature on sexual offending and models for understanding covert and abusive sexual encounters from other arenas including child sexual abuse and abuse by priests and clergy. Additional reference is made to Inquiry reports as a source of evidence and informed comment (see Matthews 2004; Pauffley 2004; Pleming 2005).

Papers selected were categorised as belonging mainly to one of the four headings of boundaries, prevalence, impact, or predictors, recognising that some papers provided evidence on all of these. Papers were also

categorised as predominantly an empirical study; literature review; or discursive review, commentary or opinion piece. Papers have only been read in full and included in this report if they reported empirical data.

2.3 ISSUES OF DEFINITION

All aspects of this topic create definitional problems. What, for example, is meant by "sexual"? How are we to distinguish appropriate, though intrusive, interventions, such as an intimate vaginal examination in pregnancy, from acts that are unrelated to clinical concerns or from sexually exploitative relationships that take advantage of the patient's vulnerability in relation to the practitioner? Terminology in itself sets, and limits, the tone of the discussion. It is important therefore to note at the outset that those boundary violations, especially sexual acts that involve individuals who are not able to give proper consent, and/or situations in which the perpetrator exploits a position of trust in relation to the patient/ client, which are against the law should be dealt with through the criminal justice system. This should pre-empt action taken under disciplinary or regulatory mechanisms. The literature referred to in this report has grown up in isolation from the growing evidence base on sexual offending amongst the general population, or of the dynamics of child sexual abuse with its processes of targeting and grooming of potential victims. This generic literature sheds light on the dynamics at work when powerful professionals use their position to sexually exploit their patients or clients.

The use of sanitized terminology, such as "boundary violation" should not obscure the fact that some of these encounters have more in common with other sexual offences than with ordinary clinical practice and are no less serious or culpable simply because they are couched in these terms.

What is meant by "professional" in this context is also open to debate. If the abuse of power is a key element of boundary violations, should non- or less

well regulated professions such as healthcare or social care assistants be included alongside higher status professions such as psychiatrists and gynecologists whose power base is more incontrovertible? Professions outside the health and social care fields, who also wield considerable personal as well as institutional power, are also prone to crossing sexual boundaries in ways that have been well documented. The literature relating to priests and teachers may therefore hold lessons for the health professions (see, for example Goode et al 2003). The literature included in this review tends to focus on those professions that engage in one-to-one encounters and treatment modes, whereas there is also considerable evidence that patients/clients are prone to sexual exploitation within congregate settings such as long stay wards, residential homes and in day care settings, even though the dynamics that pertain in institutional settings may be somewhat different.

The evidence base is also inherently problematic because sexual boundary violations are essentially covert and there are many reasons why individuals would not want to report them and/or might feel powerless to act in the face of them. **Abuses tend to come to light after the event, in spite of protestations from the perpetrator and often in the face of denial or barriers thrown up by institutional processes and defenses. Colleagues may not want to believe their eyes or ears when they see or hear of a fellow professional acting inappropriately. Critically, they may not feel confident enough to challenge or refer the matter to management or to their professional body**. An emerging literature focuses on the systems that exist to promote more systematic reporting and referral, including important interfaces with the systems coordinated by Social Services for safeguarding information about abuse of all vulnerable adults, and this is outlined towards the end of the review.

2.4 LITERATURE REPORT STRUCTURE

This report contains a chapter each on boundaries, prevalence, impact and predictors. Each chapter follows the same format. A brief introduction is followed by a summary of the key findings emerging within the topic area and an overview of findings and their limitations before listing in detail the results presented in each of the studies reviewed.

The report does not claim to be a comprehensive record of all the empirical work on this topic, and the discussion of all four sub-topics reflects this in its summary of emerging themes.

3. BOUNDARIES

3.1 INTRODUCTION

"Boundaries are key to establishing therapeutic relationships. They recognize the separateness of clients and therapists, validate their uniqueness, and foster the safety necessary for client disclosure. Since clients assume a position of vulnerability in therapy by disclosing intimate information and see therapists as expert… boundaries determine the context for power, authority, trust, and dependence. Ideally, the boundaries make it possible for the client to express anything, including feelings toward the therapist, knowing the therapist will not act on these.
Boundaries are derived from social, cultural, political, philosophical, clinical, ethical, legal and theoretical considerations, as well as the therapist's personal limitations and choices. They vary depending on the therapist, client, relationship, setting and time. The purpose of boundaries is to contain the therapy and do no harm. Nonetheless, there is disagreement about what constitutes appropriate boundaries."
(Harper & Steadman 2003)

Boundaries are widely discussed in the literature, much of which is discursive. These discussions are not reported on in depth, but the quote above seeks to place the empirical studies described below in a context – recognising that boundaries are problematic and complex. Definitions of appropriate sexual boundaries vary, for example some of the literature seeks to distinguish sexual boundary crossings from boundary violations. We can also see that definitions have changed over time, both in guidance from professional bodies and in classification of misdemeanors.

That said, the following quote from Norris, Gutheil, & Strasburger 2003 illustrates the consensus that sexualised relations between healthcare professionals and patients constitute a boundary violation, and are harmful and exploitative:

"A boundary is the edge of appropriate professional behaviour, a structure influenced by therapeutic ideology, contract, consent, and, most of all, context….

Boundary violations differ from boundary crossings, which are harmless deviations from traditional clinical practice, behaviour, or demeanour. Neither harm nor exploitation is involved. Boundary violations, in contrast, are typically harmful and are usually exploitative of patients' needs – erotic, affiliative, financial, dependency, or authority. Examples include having sex or sexualised relations with patients…"

The empirical studies in this area focus on a broad range of issues relating to sexual boundaries, both boundary crossings and violations. The following areas are covered:

- Discomfort, and a lack of clarity regarding sexual issues in general
- Variation in the way boundaries are viewed and the "exceptions" which are put forward to the "rule" of no sexual contact between health professional and patient
- Ways in which to decrease the likelihood of sexual boundary violation.

3.2 KEY FINDINGS

- The majority of health professional respondents view sexual contact with patients/clients as inappropriate and harmful, but there is significant variation in attitudes and beliefs about behaviour within the relationship, and about sexual contact after the professional relationship has come to a close
- Students who experienced a sexual attraction to patients/clients and discussed it with their supervisor were more likely to show an understanding that such attraction was potentially harmful to clients
- The majority of health professional respondents felt that they had not received adequate education or training on sexual ethics
- A lack of consensus amongst health professionals exists regarding the definition of an '*ex* client'

- Confusion was expressed by health professionals about who was responsible for maintaining boundaries
- Many health professionals reported that they would not know how to handle a situation involving sexual boundary violations and would not report colleagues
- Respondents rated their educational preparation for sexual boundary issues as inadequate
- Health professionals who have received education on the topic are less likely to 'offend'
- Factors to consider in training include communication, manner and dress, explanations about intimate inquiries/examinations, sensitivity to patient's perceptions, use of chaperones, 'special patients' and avoidance of sexual jokes/humour
- A correlation exists between positive training environments (tackling acceptance, safety, encouragement, openness, sensitivity, frankness, adequate understanding, respect, privacy, support) and healthy coping responses by health professionals regarding attraction to patients/clients.

3.3 DISCOMFORT, ATTITUDES AND LACK OF CLARITY REGARDING BOUNDARY CROSSING

3.3.1 Introduction

As stated above, much discursive material exists on this topic. What we also see in empirical studies on attitudes to sexual contact is an illustration that the boundaries espoused in professional guidelines do not necessarily fit with the stated attitudes and beliefs of those in the professions. Nor is there consensus across professions and settings about what constitutes an appropriate boundary, or what warrants an exception to this rule.

3.3.2 The studies in detail

3.3.2.1 Discomfort with sexual issues

Discussions of sexual boundaries are often confounded by reference to abuse of professionals *by* clients as well as of patients by professionals, as if these were equivalent risks that cancel each other out. Moreover there is **evidence that workers find all sexual issues difficult to talk about or face up to, even in areas of medicine where this is necessary and an everyday occurrence**. For example, Walfish 1983 surveyed 105 volunteer telephone counsellors at a life crisis centre, with 58 (55%) returns. The survey asked about how often 100 different situations arose and the participant's level of comfort with them. Of 32 areas rated as generally uncomfortable, these were grouped into seven problems areas, one of which was sexual. Under this heading respondents had included obscene calls and client positive affect toward the counsellor, as well as client reports of sexual abuse. Women were found to be significantly less comfortable with obscene calls, and these were reported as occurring more frequently to them. Older counsellors were significantly more comfortable with a client asking 'do you love me?' The authors suggest that these interactions are infrequent but suggest that the findings can be used to design specific training experiences.

Closely related to discomfort with this issue, is the concern raised in a study by Haas, Malouf, & Mayerson 1986 about **action a professional would take regarding ethical concerns**, although it is clear that sexual boundary issues were considered seriously. In their study they surveyed 500 randomly selected members of the American Psychological Association with 294 (59%) response, using 10 vignettes of ethical dilemmas to elicit views on action the therapist would take. One vignette pertained to professional sexual misconduct – learning of a colleague's sexual advances toward a

patient. 57% said they would encourage the patient to report the issue him or herself, and **only 17% stated they would contact the licensing board.** In this same study, however, respondents rated colleague's sexual conduct as 4.12 /5 for seriousness, higher than a number of other ethical areas of concern, including their own sexual impulses or conduct (3.21/5).

3.3.2.2 Attitudes to boundary violation

There is no one consensus about what constitutes an appropriate boundary and there are considerable areas of ambiguity and disagreement. Many of the studies of reported incidence and prevalence (to be discussed in the following chapter) asked respondents about the appropriateness of sexual contact with clients. **Although it is clear from these studies that the majority of respondents viewed sexual contact with a current client as inappropriate and harmful, there is considerable variation in attitudes and beliefs regarding sexual contact following termination of the professional relationship.**

Nor is this debate always neutral but may serve the interests of those who exploit such ambiguity, for example Herman, Gartrell, Olarte, Feldstein, & Localio 1987 found that **psychologists who have engaged in sexual contact with patients have a greater tolerance for this conduct, tend to under-rate its potential harm, and are more likely to oppose the idea of imposing sanctions.**

Goodyear & Shumate 1996 studied the perceptions of practising therapists with regard to a therapist disclosing attraction to a client, assuming the attraction would lead to sexual activity, with a particular focus on gender differences. Sixty male and sixty female therapists (psychiatrists, counsellors, social workers) listened to one of twelve versions of a simulated therapy session, using different gender and disclosure or non-disclosure of mutual attraction combinations. No differences were found in

the perception of the therapist's trustworthiness, but disclosing therapists were perceived as more attractive, and non-disclosing therapists were perceived as more expert, with women also seen as more expert regardless of the disclosure status. **Erotic disclosure was rated as less therapeutic than non-disclosure**.

Salisbury & Kinnier 1996 surveyed 200 counselors about attitudes and behaviors with a 48% response rate (n=80). Of these, **33% believed that a post-termination sexual relationship could be acceptable**, with 62 months being the mean amount of time before such a relationship could be considered. This was contrasted with 25 months for a friendship. When considering post-termination relationships, counselors were most concerned about potential harm to the client, the mental health of the client, the ethical and legal repercussions, the possibility that counseling may be reactivated and counter transference issues.

Coverdale, Bayer, Chiang, & Moore 1996 surveyed 172 1st and 154 4th year students in a US medical school about sexual contact with patients. Of 141 (82%) and 98 (63.6%) responses for 1st and 4th years respectively, they found that **less than 20% thought that arranging a date or dating away from the clinical setting was appropriate and less than 14% thought that genital sexual contact actually during a treatment session was appropriate**. It was thought to be even less appropriate for psychiatrists than for internists or obstetricians and gynaecologists. **The majority of respondents thought that sexual contact could be appropriate after termination of treatment, with male respondents more likely to hold this view**. The majority also thought that hugging might be appropriate.

Herman, Gartrell, & Olarte, et al. 1987 surveyed 5574 psychiatrists from the American Medical Association file, probing attitudes toward sexual contact with patients in a range of contact and settings. 1423 (26%) responded,

with 98% believing sexual contact was always inappropriate during or concurrent with sessions and 97.4% believing it was usually or always harmful to the patient. 68% thought that hugging could be appropriate, 11% kissing and less than 5% genital contact. However, some **exceptions were given for 'romantic love'** where 4.1% felt it could be appropriate and another 4% reserved judgment. **29.6% thought that relationships after the professional relationship had come to a close could be appropriate.** The authors report a wide range of views, including respondents who distinguished between casual sex and serious relationships. **Amongst their sample were 84 respondents who acknowledged that they had had sexual contact with their patients, and these were found to differ in their attitudes, although the majority still conceded that such contact was inappropriate. 19% said that sexual contact could sometimes be beneficial to patients in the guise of therapy** versus 1% of non-offenders highlighting their capacity to provide post hoc rationalizations for their breach of boundaries. They also allowed more exceptions to the 'no contact' rule, particularly if the contact was post-termination of the therapeutic relationship (74.1% versus 27.4% non offenders). **In addition a distinct sub group of those who had offended with more than one client emerged, with 10/16 of these putting forward beliefs in the therapeutic value of sexual relations, and being more likely to describe the negative impact as being on them rather than on the patient, thereby confusing the issue of responsibility still further.** This type of projection has also been noted in relation to pastoral care where warnings were initially couched in terms of "predatory" women rather than exploitation of vulnerable parishioners.

Housman & Stake 1999 carried out a survey of directors of clinical psychology doctoral programmes assessing the amount of training on sexual ethics delivered, and sampled four of each respondent's 4th year students on their knowledge of sexual feelings for clients, relations with

current clients and relations with former clients. 84 (48%) of 176 programmes participated, with a total of 451 student participants. 88% of directors reported formal sexual ethics training in courses, and 94% of students reported some form of sexual ethics training. Students were significantly ($p<.0001$) less likely than directors to suggest comfort with discussing the issues (mean 3.58/7 versus 4.32, $p<.0001$), with their faculty being a safe environment (3.87 versus 5.23) and faculty providing adequate role models (4.97versus 5.84). 50% of those students who reported being attracted to a client discussed it with their supervisor, and men were statistically more likely to report an attraction. In regression analyses, **students who experienced a sexual attraction and discussed it with their supervisor were more likely to show knowledge of the (un) acceptability of acting upon attraction to clients**. No significant predictors were found for knowledge scores for relations with current clients, but programme atmosphere ratings and supervisor consultation were related to knowledge regarding the rules about relations with former clients. The authors suggest their findings highlight the **importance of addressing sexual issues in therapy early in training**.

Berkman, Turner, Cooper, Polnerow, & Swartz 2000 assessed master's level social workers' attitudes and educational preparation regarding sexual contact with clients using a survey of all 380 students on a field placement, with 349 (91.8%) responses. The majority of the students were women (84.5%) with a mean of 4.4 years of experience. The survey presented 11 circumstances in which hypothetical sexual contact might take place and asked the respondent to state their degree of approval, as well as addressing adequacy of education on the topic and willingness to report a colleague. Between 30 and 35% of respondents approved of sexual contact in circumstances in which professional relationships were terminated more than five years ago, were less than two sessions, or had involved only limited or concrete services, such as provision of advice or mobility aids.

Disapproval increased with each year of experience and those who thought class content on sexual ethics was inadequate were more likely to approve of sexual contact between social worker and client, although these variables only explained a small amount of variance in the model. Although 85% of students reported some education on this topic, **the majority felt that they had not received adequate education or training on sexual ethics**, and 35.2% reported not being trained to recognise their own sexual feelings toward a client, 45.6% to cope with the issue of sexual contact with clients and 61.7% to cope with sexual contact initiated by a client. 88% stated they would speak to a colleague who was considered to be having inappropriate sexual contact with a client, and 56% would report to the authorities.

Harris 2001 surveyed students on 27 of 43 Commission on Accreditation for Marriage and Family Therapy Education-accredited master's programmes, on their feeling regarding sexual attraction toward or from clients. The majority of the 259 respondents reported that they would feel cautious (85%) and uncomfortable (69%), and also nervous (53%), flattered (48%), respectful (44%), anxious (44%), embarrassed (22%), vulnerable (18%) or scared (15%) if a client expressed attraction to them. Students also reported discomfort with being with a client to whom they were attracted, but showed a willingness to discuss this with colleagues, although a minority feared being seen as unethical if they did so, and the **majority felt that the attraction would not affect the therapy**. The author suggests this is indication of the importance of addressing the issue of sexual attraction in therapy.

Mattison, Jayaratne, & Croxton 2002 identified a current **lack of consensus in the social work profession regarding the definition of an 'ex client'** and investigated whether the lack of a consistent definition had an effect on perceptions of appropriate behaviour, mailing a survey to 1200 randomly selected social workers in practice on the US register. 654 (57.2%)

responses were received, with 46.8% agreeing that a client is always a client, 40.9% that the client becomes an ex-client at the point of termination, and the remaining 12.1% giving their own specific time period ranging from six months to ten years. **Those working in private practice were more likely to suggest that once a client, always a client**. The majority of respondents considered that going out on a date with an ex-client (95.2%) and having sex with an ex-client (95.8%) was inappropriate, although this was significantly more so for those who saw a client as always a client. **The authors suggest a need exists to define the 'ex-client' in order to improve consistency of ethical standards.**

White 2003 surveyed medical students in an Australian university, using a questionnaire focused on boundaries, designed to collect both quantitative and qualitative data from medical students in all 6 years of the medical curriculum. Of the 293 students who participated (94.5% response rate), the overall majority (60%) thought it unacceptable to have sexual feelings for patients, though 57% of the year 6 students thought it acceptable. 79% reported that sexual contact with a patient was never appropriate. **Some confusion was expressed about who was responsible for maintaining boundaries. The response to case scenarios of boundary crossings suggests that many would not know how to handle the situation and would not report colleagues, particularly if they were senior. 87.4% respondents reported feeling unprepared by their education (mostly lacking) in this area.**

Shavit & Bucky 2004 interviewed six psychoanalytic psychologists who had been in practice for over 5 years and indicated, when asked by the researcher, that they had not engaged in sexual contact with a current or former therapy patient, and were heterosexual males. The participants showed almost universal agreement that termination of treatment did not resolve transference and counter transference issues and therefore

opposed the concept of terminating the therapeutic relationship in order to enter into a sexual relationship. They were also opposed to the concept of a minimum two years break prior to sexual contact – they **did not feel that an arbitrary time limit would resolve issues or avert potential harm**, that they perceived as possible (though they did not wish to make blanket statements about this) or know whether the rules should be varied if the sexual relationship resulted in a long term relationship / marriage, as the power differentials were perceived never to disappear.

3.4 ATTITUDES TOWARDS PREVENTION AND WAYS TO DECREASE SEXUAL BOUNDARY VIOLATIONS

3.4.1 Introduction

A number of studies are reported here, the vast majority of which focus on education of the professional, and a small number on empowering the client. **In many studies, respondents rated their educational preparation for sexual boundary issues as deficient, although the perception of its inadequacy has decreased over time.** A number of studies report on the impact of such educational interventions, usually localised, and with small groups of participants. The majority of studies report increased awareness of the issues following such interventions:

In addition, studies on reported prevalence and incidence suggest that **those who have received education on the topic are less likely to 'offend'** or report that boundary crossings might be appropriate.

These studies have been carried out, variously, with psychologists and medical students. **What none of these studies can do is discuss the longer-term impact of the training interventions** on trainee practitioners,

as they all evaluate attitudes after the intervention, rather than subsequent action in practice.

Two studies are found, one focused on learning groups with clients with learning disabilities, and the other using a consumer brochure in psychotherapy, which aims to empower the client. Both report positively on the **potential for patient education and advocacy to contribute to avoidance of abusive situations**. Focusing on patient education as opposed to professional awareness raising is an alternative strategy. This strategy carries risks especially if it implies that patients/clients have equivalent responsibility for avoiding sexualized encounters or assumes that they will be able to successfully challenge the behaviour through formal or informal channels. Such interventions should not minimize the power differentials involved especially if they are directed at client groups that are particularly vulnerable. Nevertheless, the evidence suggests that making explicit the non-sexual nature of the professional relationship both arms the patient and informs the practitioner, and lays the groundwork for clear expectations between them.

3.4.2 The studies in detail

3.4.2.1 Education provision

It appears from Samuel & Gorton's 1998 study that **sessions on sexual issues have only been relatively recently added to core curricula for psychologists in the USA**. They surveyed all directors of psychology internships accredited by the American Psychological Association (n=410) about the status of internship education related to prevention of psychologist-patient sexual exploitation, with a 56.9% (n=230) response rate. Virtually all responding directors (98.7%) reported that their programme provided at least one session on this topic and rated the topic as having high importance, and 96.9% indicated that such education should be part of the mandatory internship curriculum. Ninety-four percent of responding programs had instituted the reported training within the prior 10 years, with 60% within the previous 4 years and 29% within the previous two years only.

3.4.2.2 Impact of education

In medicine, three studies were found.

Robinson & Stewart 1996 describe a course developed to deliver to medical students, residents, fellows, faculty members and physicians in practice, and adapted for allied health professionals in Canada, focusing on sexual misconduct by physicians. The **course aimed for participants to be able to interact sensitively and warmly with patients and learners without sexualizing the relationship**. Of 392 attendees on the courses, 345 evaluated them. The course overall was rated highly and, of particular interest here, 130 (38%) stated they already practiced in a manner congruent with that presented**. A further 133 (39%) stated they would change their teaching or practice as a result of the course. The largest**

groupings of proposed change were to introduce more teaching on the topic (n=26), more formal manner and dress (n=15), more care with patients and students (n=14), improved explanations about intimate inquiries or examination (n=14), more sensitivity to patient's perceptions (n=12), more care in use of chaperones (n=10), more caution with 'special patients' (n=10) and a reluctance to tell sexual jokes to patients or students (n=10). While the majority of changes were constructive, some caused concern for the authors, and they also noted that follow up is required to see if actual behaviour change results.

Coverdale & Turbott 1997 assessed the impact of an educational intervention on medical students' attitudes toward social and sexual contact with patients by 211 (all) fifth year medical students in New Zealand, with four groups of students randomly allocated to control and five to intervention. Controls completed a questionnaire on appropriateness of hugging, dating and sexual contact with current and former clients for general practitioners, obstetrician/gynecologists and psychiatrists prior to the educational intervention and interventions one month after the session including discussion, literature summary and a video on harm. 141 questionnaires were completed (76 control, 65 intervention). As many as 14.5% of control group students thought it was (sometimes or usually) appropriate for general practitioners to date their own patients and at least 3% thought it appropriate for members of any of these 3 medical specialties to engage in sexual contact with their own patients. However, there were no significant differences in attitudes toward hugging, dating or sexual contact with current patients between those who had attended the seminar and the control groups. However, the intervention group was significantly less likely to endorse obstetrician/gynecologists and psychiatrists (when the groups were combined) hugging and having sexual contact with former patients. Despite this change, the relatively **high levels of endorsement,**

particularly with former patients, were discordant with professional ethical standards.

White 2004 used an action research method to design, implement and evaluate a programme focused on assisting medical students in setting and maintaining social and sexual boundaries, within their training and in future medical practice. Pre-education questionnaires were given to all six years of medical students at an Australian medical school and the programme delivered to 46 year 6 students who also had clinical experience and who then completed a post education questionnaire. The programme used individual reading, brainstorming, discussion, group work and role-play, video clips, and information on prevalence. **The material on sexual misconduct was reported to have made an impact, particularly by highlighting similarities between psychiatry and general practice. Pre- and post- programme surveys showed an increase in beliefs that boundaries are essential and of awareness that violations can amount to sexual misconduct. Participants in the programme articulated a continuing belief that sexual contact with current patients is never acceptable but expressed more ambiguity about former patients; and said that the programme had influenced their knowledge and attitudes. However, 7 of the students reported still feeling inadequately prepared for doctor-patient sexual relationships.**

In psychiatry, two studies were considered.

Gorton, Samuel, & Zebrowski 1996 evaluated the impact of a 6-session pilot course (background, ethical issues, video material, case material, and therapist predisposing factors) on sexual feelings and boundary maintenance in the treatment setting with nine 4th year psychiatry residents, using a pre and post questionnaire and comparing this with similar residents from another institution who did not receive the course. **Residents showed**

significantly increased knowledge (79% vs. 63%) **regarding boundary and counter-transference issues after the course as compared to controls.** Comfort with counter-transference situations in which strong feelings of sexual attraction were expressed toward different groups of patients increased, particularly for men. The authors suggest that such training should be mandatory in the residency programs.

Meek, McMinn, Burnett, Mazzarella, & Voytenko 2004 evaluated the perceived effectiveness of Christian and secular graduate training programs in preparing Christian psychologists to deal with experiences of sexual attraction by surveying 200 graduates from secular programmes and 192 from Christian programmes, about the training environment and coping styles. A response rate of 68% was achieved (n= 258). **A positive correlation was found between a reported positive training environment (acceptance, safety, encouragement, openness, sensitivity, frankness, adequate understanding, respect, privacy, support) and healthy coping responses when faced with feelings of sexual attraction.** Graduates of Christian programmes reported higher satisfaction with training programmes regarding handling sexual intimacies than those of secular programmes. The authors suggest that the training environment relates to willingness to discuss sexual attraction to clients, and that there was no reservation regarding this in these Christian programmes.

3.4.2.3 Empowering the client

Singer 1996 evaluated a self-protection group for seven people with learning disabilities living in a residential group home. Although not exclusively targeted toward sexual behaviour, the course covered 'good and bad touches' and included role-play regarding verbal, physical and sexual abuse. The home manager made assessments of the participants before and after the course, and course trainers interviewed the clients before the

course about how they would respond to different situations and this was compared to their behaviour in role-play. Overall most **participants showed an increase in social interaction and assertiveness scores with friends, staff and strangers but not with authority figures**. The author recognizes the study's small scale but suggests that the programme was successful in that participants learned to respond more assertively in role plays of situations involving verbal, physical, and sexual abuse.

Thorn, Shealy, & Briggs 1993 gathered feedback from 54 psychotherapy clients and 52 therapists in response to a brochure on sexual misconduct in psychotherapy using questionnaires. Mean scores of between 5.02 and 5.90 (on a scale of 1 to 7) were found on various items associated with the brochure's ability to enable clients' trust, understanding of appropriate behaviour, assertiveness, and confidence to face sexual misconduct. **The majority of both clients (67%) and therapists (69%) felt the brochure should be made available before or during the first session.** The authors also surveyed 139 college students considered to be potential psychotherapy clients, before and after reading a brochure on client-therapist intimacy or a 'control' brochure. For all items – trust, understanding, assertiveness, therapist discussion of sexual life, sexual contact, touch and self-disclosure, subjects who read the intimacy brochure had higher post test scores (increased negative attitudes to sexual misconduct) than the group reading the control brochure, indicating **that openly stated values do cut across the propensity for sexual boundary violations and remove the potential space for self-serving rationalizations.**

4. REPORTED PREVALENCE AND INCIDENCE

4.1 INTRODUCTION

"The term *prevalence* refers to the proportion of persons affected with a particular condition in a specified population at a designated point in time (Gordis 2000). This proportion is typically presented as a percentage." (Horner Johnson & Drum 2006). He continues: "Prevalence is often confused with incidence, which refers to the number of new cases of a condition or experience occurring during a particular time period within a population at risk (Gordis 2000). **Thus, *incidence* refers to the rate at which something occurs."**

Empirical studies in this chapter cover both reported incidence and prevalence. The studies vary vastly in the time period covered, and also in the source of the incidence or prevalence data. They have been grouped as follows:

- Analysis of complaints or disciplinary via administrative data
- Reports from professionals of sexual violations by other professionals
- Self reports of sexual contact with clients by professionals
- Sexual contact with professional reported by clients
- Literature reviews.

The majority of the studies are from psychiatry or psychology, and from the US, although many professional groups are represented, as are other countries in a small number of studies. Prevalence studies have been numerous since the 1970s with the majority concerning psychotherapy and psychiatry, and with later studies usually citing a number of landmark studies that brought the issue of sexual boundary violations to light quantitatively.

This literature needs to be read cautiously and critically because sexual boundary crossing is, by and large, a covert activity and there are many disincentives to disclosure, reporting and record-keeping. Most cases, even the minority that were challenged at the time, are not collated and tend to disappear from view and from the organization's history within a short period of time (Brown 1994). Many organizations, including the NHS, do not have the mechanisms to support those making this type of complaint (see for example the three recent Inquiries undertaken by the Department of Health - Matthews 2004; Pauffley 2004; Pleming 2005) and there are many organizational barriers and defenses that impede investigations and disciplinary action. It is therefore important to read between the lines and make an educated guess about which professional groups and which patients/ clients are likely to be under-represented in reported figures. For a patient to persist in their complaint, especially if met with initial denial or prevarication, they need to bring considerable personal resources in terms of their awareness, credibility, status and perseverance; patients who do not have these characteristics are both more likely to have been abused and less likely to have reported it.

Not all reports have the same status, as will be seen in the ensuing discussion. Some studies are based on unproven allegations about colleagues, others are reports by patients, which have not necessarily been corroborated, or subject to due process, and others are "admissions" by the professionals involved. Some reports will refer to single incidents, which may vary from sexualized comments through to coercive sexual acts, while others may refer to relationships occurring over a considerable period of time.

Moreover, some professional groups have been more focused upon than others. 'Semi-professions', such as care workers and nursing assistants,

tend to have been the focus of fewer studies and/or did not show up in our searches. **The literature on abuse of vulnerable groups, especially people with intellectual disabilities, suggests that such violations are relatively common in residential settings (see for example reports of abuse in homes in Sutton reported in The Guardian 17/1/07). The settings, which are the focus of the following studies, tend to be those characterized by one-to-one personal encounters masking the endemic nature of boundary violations in these even more under-resourced and less scrutinized areas of health and social care.**

Probably, the most realistic way of reading these reports is therefore to regard them as studies of reporting behaviour, more than studies of actual incidence or prevalence of boundary violations. This in no sense weakens the picture that can be gleaned from the studies below, but merely acknowledges that it these represent a partial view and probably a considerable under-estimate of the actual occurrence of these behaviors.

4.2 KEY FINDINGS

- Between 38 and 52% of professionals report knowing of colleagues who have been sexually involved with patients.
- Self-reporting rates by health professionals are considerably lower, but high levels of patient attraction are acknowledged
- A proportion of professionals violate boundaries with multiple patients
- Between 22 and 26% of patients report to another practitioner that they have been sexually involved with a previous therapist
- Greater awareness of guidelines and sanctions reduces prevalence.

4.3 PREVALENCE REPORTS FROM PROFESSIONALS OF KNOWN SEXUAL CONTACT WITH CLIENTS

4.3.1 Overview and limitations

Partly to overcome the methodological limitations several studies have approached the issue by asking professionals if they have treated clients who have reported sexual contact with previous 'therapists', covering the **US, UK, Switzerland and Australia**. These **studies show a reported prevalence of between 22 and 26% of clinicians treating patients who reported having been sexually involved with a previous therapist. Between 38 and 52% of these professionals also reported that they knew of colleagues who had been sexually involved with their patients**. These are all reasonably sized surveys, with variable response rates, and have similar reported rates. It is difficult to judge if the surveys were comparable, or to quantify the results in terms of prevalence. It is difficult to know if many professionals are reporting acquaintance with the same case, or to ascertain details such as the length of time that has elapsed since the sexual boundary violation took place.

4.3.2 The studies in detail

Gartrell, Herman, Olarte, Feldstein, & Localio 1987 surveyed 5574 randomly selected (every fifth member) US psychiatrists on the American Medical Association's register on their attitudes and practices regarding sexual misconduct. Of the 1423 **(26%) respondents,** 65% (n=290) **reported treating patients who had been sexually involved with previous therapists.** This sexual involvement was reported with 3031 patients, 2760 of whom were women.

Garrett 1998 carried out a national, anonymous survey of 1000 randomly selected members of the Division of Clinical Psychology of the British Psychological Society in relation to their experiences of sexual contact with patients, both personal (see below) and at second hand, with a response rate of 58.1%. Of respondents, **22.7% reported having treated patients who had been sexually involved with other therapists, most commonly psychiatrists, private sector psychotherapists, nurses and social workers.** Additionally, 38% of the respondents reported knowing of clinical psychologists who had been sexually involved with their patients, through sources other than their own patients.

Leggett 1994 surveyed 500 Fellows of the Australia and New Zealand Royal College of Psychiatrists, being every third member on the list. In addition to questions about their own sexual contact with patients (see section below), **68.7% (of 344) respondents reported that a patient had given a history of sexual contact with a previous therapist, and 50.3% had at least two patients who had given such a history**.

Parsons & Wincze 1995 surveyed all 678 licensed therapists in Rhode Island and about client-therapist sexual involvement in terms of having treated a client who reported previous sexual involvement with a therapist between 1989 and 1991, with a 49% (n=331) response rate. **26%** (n=86) **of the respondents reported having treated clients previously involved with a therapist**. A wide range of sexual behaviour was reported. In addition, the treating therapists reported 120 incidents of other boundary violations. **The majority (85%) of perpetrators reported were male and the majority of victims were female (87%).**

Wincze, Richards, Parsons, & Bailey 1996 compared this study with a comparable survey of therapist sexual misconduct in an Australian state. In addition to the survey of the licensed psychologists in the state of Rhode

Island (n=678) they also surveyed all psychologists, psychiatrists, social workers, therapists and counselors (n=1057) in the state of Western Australia, using the same method as the (Parsons & Wincze 1995) paper cited above. Their Western Australia response rate was **48%** (n=479) with 81 (22%) respondents **reporting treating previously abused clients**. The majority of therapists who had been reported by clients as sexually involved were male (81%) and functioning as psychiatrists or psychologists, and the majority of victims were women (90%). The authors therefore report that **despite some very distinct cultural and training differences between the two professional psychology populations, there was remarkable similarity in the percentage of respondents who reported having treated victims of therapist sexual abuse. This study is stated to be the first to provide survey data on this phenomenon in Australia and the first cross-cultural comparison.**

Kullgren, Jacobsson, Lynoe, Kohn, & Levav 1996 surveyed a random sample of 328 members of the Swedish Psychiatric Association using three clinical vignettes covering sexual relationships with a patient. Of the 214 (65%) respondents, **41% stated they believed there were abuses of psychiatry in Sweden, with 38% of these respondents reporting abuse of a sexual nature.** Twenty-six respondents provided detail of sexual abuse cases, 10 involving psychiatrists, five other staff, two psychotherapists and nine not specified.

Bachmann, Bossi, Moggi, Stirnemann-Lewis, Sommer, & Brenner 2000 surveyed all nurses at two Swiss psychiatric hospitals (n=714) with a 39% (n=279) response rate, about sexual contact between therapists and patients, noting the lack of prior data on nurses. As well as reporting their own sexual contact with patients (see below), **52% of respondents reported knowing of at least one colleague who had had sexual contact with patients**.

4.4 PREVALENCE REPORTS FROM PROFESSIONALS CONCERNING THEIR OWN SEXUAL CONTACT WITH CLIENTS

4.4.1 Overview and limitations

The majority of the studies concerning prevalence have been conducted using professional self-reporting in postal surveys. Two early studies – Kardener, Fuller, & Mensh 1973 and Holroyd & Brodsky 1977 - are referred to by the vast majority of subsequent authors, and have clearly been instrumental in bringing these issues out into the open.

Numerous studies are found under this heading, and several use similar survey tools, methods and populations, allowing some indication of change over time and some comparability. Several key limitations are also noted, and often acknowledged by the authors themselves, detailed below. In the studies, definitions of sexual contact vary, response rates are variable and representativeness of the eventual sample is not always examined. **The studies rely upon self-reporting with prevalence rates decreasing over time coterminous with increasing guidelines and awareness of the penalties associated with discovery of such relationships.** The issue of contact during or after termination of the relationship can be muddled as the time for 'after termination' varies by study. Williams 1990, commenting on Pope's 1990a review of the literature in this area, claims that research on this topic cannot meet minimal standards for survey research and may have insurmountable validity problems, an issue not disputed by Pope 1990b in his reply.

Nevertheless, the advantage of these prevalence papers is that they highlight the extent to which sexual boundary violations *do* occur, and

that, although the majority of practitioners do not breach professional codes of conduct, cases are not limited to a few extreme individual cases (a finding supported by CHRE's examination of all UK regulators' fitness to practice cases as part of its statutory function). The studies also reveal that amongst practitioners who breach boundaries, a proportion do so serially or with multiple patients.

Broadly, Carr, Robinson, Stewart, & Kussin 1991, in their review of existing literature, concluded that **7.1% to 10.9% of male therapists and 1.9% to 3.5% of female therapists admitted to engaging in intimate contact with patients.** Seto 1995, when reviewing the literature, suggested that the true base rate of prevalence was unknown - **although estimates from self-reporting were consistent, these were probably an underestimate.**

This is likely to be an under-report rather than an over-estimate as there are many reasons why a professional would not admit such breaches and no reason for owning behaviour that had not occurred. As the papers below indicate, these figures have decreased more recently, with papers now citing rates as low as 2% (Lamb, Catanzaro, & Moorman 2003) but it is difficult to infer whether this reflects an actual decrease in the incidence of boundary violations, or an increased awareness of the need to be secretive about it for fear of censure or sanctions. This confirms the view of these studies as studies of reporting behaviour rather than actual incidence and prevalence.

4.4.2 The studies in detail

The vast majority of studies examine psychiatry, psychology or other 'talking therapies', and most of the studies are from the US. They are presented chronologically.

Kardener, Fuller, & Mensh, et al. 1973 surveyed male Los Angeles Medical Society psychiatrists, with a return rate of 46%. Respondents **reported 5% sexual coital contact amongst psychiatrists, obstetricians and gynecologists, and medical doctors with their clients, and 13% erotic non-coital contact**.

Holroyd & Brodsky 1977 used the same method as Kardener, Fuller, & Mensh, et al. 1973 but sampled 1000 of 27,000 PhD psychologists, of whom 666 practicing psychologists returned the survey. 609 **(4%) respondents reported erotic contact with patients (6% of males and 1% of females), 2% including sexual intercourse**. Regarding intercourse with a former client within three months of termination of therapy, 4.1% of respondents reported this.

Pope, Levenson, & Schover 1979 found that **7% of their sample of psychologists conducting psychotherapy reported engaging in sexual intimacies with their clients**.

Gartrell, Herman, Olarte, Feldstein, & Localio 1986, in a US nationwide survey, surveyed 5574 psychiatrists (every fifth name from the American Medical Association register), and gained 1423 valid responses. Of respondents, 84 **(6.4%) reported sexual contact with their own patients**, involving a total of 144 patients, with **multiple occurrences for some respondents**. This is important because it demonstrates the potentially serial nature of the behaviour and hints at a model for understanding it as a

compulsion rather than as an isolated lapse in otherwise appropriate relationships with patients. The prevalence was 7.1% (n = 1,057) of the male and 3.1% (n = 257) of the female respondents. **Eighty-eight percent of the sexual contacts occurred between male psychiatrists and female patients**.

Akamatsu 1988 also surveyed a random sample of 1000 psychotherapists from the APA register about involvement in intimate relationships with former clients. Of the 395 (39.5%) usable responses, **11% said they had been involved with a former client, including 14.2% of male and 4.7% of female respondents**, with an average interval of 15.6 months between the termination of therapy and the beginning of the relationship. Respondents also reported such relationships during therapy at a rate of 3.5% of men and 2.3% of women.

Ladany, O'Brien, Hill, Melincoff, Knox, & Petersen 1997 approached 77 psychology trainees for interview about an experience of sexual attraction toward a client, use of supervision to address the sexual attraction, and prior training regarding how to manage sexual attraction. Twenty-two trainees responded and 13 who reported having experiences sexual attraction toward a client were interviewed. None of these trainees reported sexual activity with a client.

Gartrell, Herman, Olarte, Localio, & Feldstein 1988 used the same method as her 1986 study (above) with a national survey of all 1113 psychiatric residents on the AMA register, and a 5.4% (n=548) response rate. **Although 72.1% reported having experienced sexual attraction to a client (with this significantly more likely in men), only 0.9% of respondents reported that they had been sexually involved with patients**.

In 1992 Gartrell, Milliken, Goodson, Thiemann, & Lo 1992 again used a similar method to her 1986 and 1988 studies, this time surveying 10,000 physicians (3000 family practitioners, 2000 internists, 2000 obstetrician-gynecologists and 3000 surgeons). Of the 1,891 (19%) respondents, **9% (n=176) acknowledged sexual contact with one or more patients, 42% being with more than one patient, up to 11 patients in one case**. When asked about their most recent cases, 28% indicated they were involved with a former patient, and 72% of contact was with a current patient.

Leggett 1994 surveyed 500 Fellows of the Australia and New Zealand Royal College of Psychiatrists, being every third member on the list. Of the 344 (68%) respondents, 12 **(3.5%) stated that erotic contact sometimes occurred, and another four (1.2%) reported intercourse during treatment**. All of these respondents were male. Fourteen respondents (13 male) reported sexual intercourse post-treatment. Overall then 26 cases were reported.

Lamb, Strand, Woodburn, & Buchko 1994 surveyed 1000 US psychologists, randomly selected from the American Psychological Association register, with 327 score-able responses. Of these, **21 (6.5%) reported being involved in a post-termination sexual relationship, with the majority (70%) reporting this occurring once, 19% twice, 5% five times and 5% ten times**.

Rodolfa, Hall, Holms, & Davena 1994 examined sexual attraction between psychologists and clients through a survey to 908 American Psychological Association member psychologists who work in university counseling centers. Of their 386 (43%) respondents, **only 12% (n=47) reported never having been attracted to any client**, but sexual intimacies were reported as having occurred rarely, that is, once or twice, for 4% of the sample. More of these were men, but this was not statistically significant.

Thoreson, Shaughnessy, & Frazier 1995 surveyed 1000 randomly selected **women members** of the American Counselling Association, with a 38% (n=377) response rate. **Only 0.7% reported sexual contact during and 2.6% following termination** of the professional relationship.

Nickell, Hecker, Ray, & Bercik 1995 surveyed 400 clinical members of the American Association for Marriage and Family Therapy, randomly selected from the directory. Of the 189 respondents, **34% of men and 14% of women stated they were sometimes attracted to clients; 16 and 3% of men and women respectively sometimes had sexual fantasies about clients; and 46 and 78% sometimes hug clients**. Nine percent reported having kissed a client, but none of the respondents reported sexual relations in the last two years, although 5% of men and 2% of women had contemplated this.

St Germaine 1996 surveyed 1000 certified alcohol and drug counselors, on behaviour in therapeutic practice. Of these, 396 questionnaires were returned. No reports of sexual activity with a current client were given, but 2.8% reported sexual activity with a client after termination of treatment.

Lamb & Catanzaro 1998 repeated their 1994 survey, with another 1000 randomly selected subjects from the 18500 strong APA register. This time with a **60% (n=596) response rate, eight percent respondents reported a sexual boundary violation with at least one client, the majority of these (69%) being after the professional relationship ended**. More men and those who were older reported such violations.

Bachmann, Bossi, Moggi, Stirnemann-Lewis, Sommer, & Brenner 2000 determined the frequency of nurse-patient sexual relationships in two Swiss psychiatric hospitals through a survey of 714 nurses with 279 respondents.

Seventeen percent (n=18) of the male and 11% (n=18) of the female responding nurses reported having had such contacts with patients. Only 25 of these answered all the additional questions on the nature of the contact and their own characteristics. **Eight reported sexual encounters with more than one client**, with none of the men but four of the women reporting sexual intercourse. Twelve respondents stated that they would repeat the sexual contact.

Harris 2001 surveyed 375 psychotherapists and social workers in Alaska, achieving 151 completed and useable (43.5%) responses. Sexual contact was reported by 4% with current clients and 6% with former clients. They questioned whether the lower rates than those previously reported are due to a real decrease or to sampling differences.

In 2000, Lamb, Catanzaro, & Moorman, et al. 2003 repeated their 1994 and 1998 studies, using similar methodology, with another 1000 randomly selected psychologists. Amongst the 38% (n=368) of respondents, **3.5% (n=13) participants reported at least one sexual boundary violation** as a professional psychologist, three of which were ongoing. Seven (2% of the 368) were with a client, the remainder with a student or supervisee. Fifty seven percent of these were reported as occurring after termination of the therapy. The authors note the lower rate than those found in previous studies, including their own.

The one study examining other professionals, in this case, doctors is that of Wilbers, Veenstra, van de Wiel, & Weijmar Schultz 1992 who surveyed all members of the Society for Obstetricians (n=595) and Gynecologists and the Society for Ear Nose and Throat specialists (n=380) in the Netherlands. The Society of General Practitioners withheld approval for the study. Valid responses were received from 656 (67%). **Of obstetricians and gynecologists, 84% of men and 14% of women reported ever having**

been sexually attracted to patients; and 12% of men and 2% of women reported having had sexual contact. Of ENT specialists, 81% reported ever having been sexually attracted, but only 3% having had sexual contact.

4.5 PREVALENCE REPORTS FROM CLIENTS OF SEXUAL CONTACT WITH PROFESSIONALS

4.5.1 Overview and limitations

The six papers (including one review) considered here use a subset of clients within the specialty of client group they are considering, and possibly unsurprisingly report different rates. Horner-Johnson 2006 points out that many studies are not recent and are based on convenience samples and therefore lack generalisability.

4.5.2 Key findings

- Reported rates of sexual boundary violations within the client groups studied vary enormously between 3 and 81%, probably due to different inclusion criteria
- Violations are reported in a range of settings, from the client's home to in-patient facilities.

4.5.3 The studies in detail

Jacobson & Richardson 1987 obtained complete histories of all experiences of being physically or sexually assaulted from 100 psychiatric inpatients, using a structured interview. The majority (81%) of patients interviewed reported experiencing sexual assault. Sexual abuse is a significant predisposing factor in the development of mental ill health, especially for women so this figure might be expected (see for example Rose, Peabody, & Stratigeas 1991).

Armsworth 1989 examined the self-report (in interviews) of 30 adult women who reported experiencing incest in childhood or adolescence and had sought professional help from a counselor, psychiatrist, psychologist, social worker or minister). Of these 30, **seven (23%) reported being sexually intimate or being harassed over time to become sexually involved with the helper**.

Webb & Opdahl 1996 surveyed 350 women in two family medicine practices about gynecological examinations. Of the 336 respondents, 70% reported usually or often having a male examiner. In **8% (n=25) respondents reported unprofessional behaviour, defined as being examined in a peculiar way, or having comments made that made the woman feel uncomfortable), with an over exposed body (n=10), inappropriate comments (n=10), an unusual position (n=4) or inappropriate gesture/ facial expression (n=1**).

Lamb & Catanzaro 1998, when surveying members of the APA (as described above) for sexual contact with their clients, also asked how many members had had sexual contact with their own therapist, supervisor or educator. Of the 596 respondents, **12% (n=81) reported such contact, with 12 being with their own therapist. The majority (85%) were women**.

Frueh, Knapp, & Cusack, et al. 2005 examined the frequency and associated distress of potentially traumatic or harmful experiences occurring within psychiatric settings among persons with severe mental illness who were served by a public-sector mental health system. Participants were 142 randomly selected adult psychiatric patients who were recruited through a day hospital programme. Participants completed a battery of self-report measures to assess traumatic and harmful events that occurred during the course of their mental health care. Sexual assault was the least reported

harmful experience in the list studied but assault by another patient was still reported by eight percent of participants, and assault by a staff member by 3%. Additionally, 5% of participants reported witnessing sexual assault by a staff member. It is not clear in this paper whether this was always by professionals/ caregivers.

Brown, Stein, & Turk 1995 conducted a comprehensive survey of statutory service providers **for people with intellectual disabilities across the south east of England. They reported incidence figures for proven or strongly corroborated allegations of sexual abuse across two, two-year periods, from which they were able to extrapolate a figure of 12-1500 cases per annum across England and Wales, about one sixth of which were perpetrated by paid workers.** A similar pattern emerged from a retrospective study of case files carried out in Ireland by McCormack et al in 1995. A further window onto the issues, as they concern vulnerable victims, can be seen in **studies of cases of sexual abuse reported under Adult Protection Procedures** (Brown and Stein 1998). These refer to adults who are afforded additional assistance when faced with abuse on account of disability, age or mental illness.

Horner Johnson & Drum 2006 reviewed research on the **maltreatment of people with intellectual disabilities**. There are several studies reported in this paper that consider sexual contact as a type of maltreatment, but it is not always clear whether the sexual contact reported was from professional. There are three studies where this is clear, as follows. **Powers, Curry, Oschwald, & Maley 2002 found that, among 169 women with physical disabilities who used personal assistance services, 32 of whom also had intellectual disabilities, 11% had been touched sexually in unwanted ways by personal assistants. Otkay & Tompkins 2004, in interviews with 84 people receiving personal assistance, report 3% abuse by their primary personal assistant and 8% by other assistants.**

Matthias & Benjamin 2003, in interviews with 1095 recipients of in-home care, found that 1.9% of providers had made sexual advances.

4.6 INCIDENCE, AS ASSESSED THROUGH COMPLAINTS OR DISCIPLINARY ACTION

4.6.1 Overview and study limitations

Several studies from the 1990s and 2000s have sought to quantify 'sexual misconduct' using available sources of data on allegations, complaints and/or disciplinary proceedings. Many of these have taken the earlier cited prevalence studies as their justification, but they appear to cover a broader range of disciplines than those discussing prevalence – psychotherapists and mental health professionals, all medicine, chiropractic doctors, pharmacists. The majority of studies are again from the US.

As will be noted from the study detail below, the cited incidence rates vary widely and it is not possible to synthesize studies as some papers present incident rates in the context of the number of licensed practitioners in the group they study, while others detail sexual offences as a proportion of all complaints or disciplinary action, and others simply describe the incidents encountered without reference to the quantitative context. The varying sources of data used, methods of data retrieval and inconsistent definitions within the umbrella of 'sexual boundary issues' also limit comparison.

There are clearly limitations in this method in terms of representativeness, and varying definitions of misconduct over time and across different settings. With these caveats, valuable lessons can nevertheless be learned. The studies do present a **picture of decreasing incidence over time, and of variation between disciplines, with higher rates in some**

specialties, that are relatively consistent with the prevalence studies. Broadly the studies indicate that allegations, complaints and/or disciplinary action are not isolated, rare events.

In the UK, valuable lessons can also be learned from detailed public Inquiries into serious sexual violations, such as those which prompted this study, and from inspection reports into services that have failed where sexual misconduct has been cited, for example in the Inquiry into abuses at Budock Hospital and other services in Cornwall in 2006 and the Healthcare Investigations into services in Sutton in 2007.

4.6.2 The studies in detail

Three studies consider psychotherapy or psychiatry, and each use very different methods.

In psychotherapy, Averill, Beale, & Benfer, et al. 1989 carried out a 'self study' of a US psychiatric hospital, with a group meeting monthly to discuss all known cases of sexual exploitation of patients by psychotherapists and other mental health professionals in their own in- hospital setting. As stated above this paper does not mention the number of cases reviewed, and cannot be further analyzed.

Berland & Guskin 1994 surveyed 255 directors of psychiatric units (sampling every fifth psychiatric unit across the US) to determine whether hospitals had experienced patient allegations of staff sexual abuse and the characteristics of the allegations, over the years 1985 to 1990. Of the 110 (43%) surveys returned, **36% of units reported such allegations including voyeurism, harassment, fondling and rape, and involving general psychiatric, adolescent and geriatric units, and with patients**

aged 14-68, the highest proportion in the 20-29 age group. Of 60 allegations described in detail by respondents, patients in 14 cases withdrew allegations, and sexual abuse was determined, on investigation, to have occurred in only 16 cases. However, 28 members of staff left as a result of allegations.

In one Australian state Dawson 1994 collected the published legal documents on complaints of sexual misconduct incidental to psychiatric treatment from the Medical Tribunal in the state of New South Wales, from 1989-1991. **Eight enquiries were held, for seven practitioners, all of whom were removed from the register**. The practitioners involved had a wide range of experience (median 26 years), were mainly male (6/7), had a median age of 53 and included two cases where severe early pathogenic trauma was noted. As there were only 17 removals from the register for all medical practitioners in this time period, the author suggests the seven is a significant number.

Four studies look at physicians in general. In the US, Enbom & Thomas 1997 evaluated all complaints of sexual misconduct brought to the Oregon Board of Medical Examiners, from 1991 (when a separate category for sexual misconduct was instituted) to 1995, to create a baseline on how the state compared with national data on boundary violations. The authors found 100 complaints of alleged sexual misconduct, including six complaints for one licensee and three each for three others, with the percentage of sexual complaints of all complaints not differing significantly over time (range 4.3 to 8.3%). Of these complaints, 31 (39%) were for sexual impropriety, 25 for sexual transgressions and 24 for sexual violations with five, 27 and 47% of these categories respectively resulting in a reportable disciplinary action. A significantly higher proportion of complaints were found regarding doctors in Oregon with degrees in osteopathy and of podiatric medicine, but **by specialty the highest incidence was found in**

family practice (2.6%), psychiatry (2.3%) and obstetrics & gynecology (2.2%) down to pediatrics (0.1%). Incidence was found to increase significantly with age, with it being 1.44 times more likely with each increasing decade of age. Of the 100 complaints, 53 resulted in some form of action ranging from a letter of concern through to surrender of license and revocation. Reportable disciplinary actions were highest (54%) where the complaint was classified as a sexual violation.

Enbom, Parshley, & Kollath 2004 repeated the above study, analyzing data from 1998 to 2002 in the same system and manner. Although data collection appeared similar, definitions of sexual misconduct had changed to incorporate both sexual transgression and sexual violation. Taken together, the number of sexual misconduct allegations (n =47 for 46 licensees) was a 3.1% (of all complaints) five year average, a statistically significant drop from the first study's 5.9% average, although they represented a statistically higher percentage of total closed complaints, rising from 11.3% in 1991-5 to 19.9% in 1998-2002. The proportion of reportable disciplinary action to total sexual misconduct complaints increased from studies one's 19% to 53.2% (p .001), or an odds ratio of 4.84. The authors note the particular changes in specialties previously highlighted as raising concern - psychiatry and obstetrics and gynecology - but the opposite pattern in family practice (although these are small numbers and the statistics yield a non significant result), and there were no multiple patient complaints regarding the same licensee.

Also in the US, Dehlendorf & Wolfe 1998 carried out a national study, analyzing the frequency and severity of disciplinary actions taken against physicians for sex-related offences and determining the characteristics of the disciplined physicians. In 1989, the Public Citizen's Health Research Group began requesting information on all disciplinary orders that state medical boards and federal agencies had taken out against physicians. The

study found that the number and rate of disciplinary orders for sex-related offences increased over time, from 42 orders (2.1% of all orders) in 1989 to 147 orders (4.4% of all orders) in 1996, and that **disciplinary actions were more severe for sex-related offences than for non-sex-related offences. Of the physicians disciplined, 44.4% had their license revoked or had surrendered them, and another 26.3% were suspended.** Of 761 physicians disciplined, 567 (75%) were disciplined for sexual offences involving their own patients, including sexual intercourse, sexual contact, sexual assault and sexual favours for drugs. Prior to 1995 the disciplines of psychiatry, child psychiatry, obstetrics and gynecology, and family and general practice were over-represented when compared to the number of doctors of medicine registered to that specialty. However, while the rate of complaints against psychiatrists decreased significantly over time, the rate for family medicine increased significantly. Physicians subject to disciplinary procedures also tended to be older than the national physician population (58.1% disciplined versus 34.5% nationally aged 45 to 64).

In the UK, Donaldson 1994 described the incidence, nature, and implications of serious disciplinary problems among the medical staff of the Northern Health Region of the NHS, an administrative area within the NHS covering a population of three million. Between 1986 and 1991 concerns serious enough to warrant the consideration of disciplinary action were raised about 6% (49/850) of all senior medical staff. Seven of these concerned sexual behaviour, described as sexual overtones in dealing with patients or staff or both. Two cases are described in more detail, involving inappropriate pelvic and breast examinations, involving both patients and nursing staff. This paper does not give further breakdown of these cases by action resulting from the complaint.

In chiropractic medicine in particular, Foreman & Stahl 2004 studied disciplined doctors in this specialty in California and compared them with disciplined medical physicians through retrospective reviews of publicly available data from the California Board of Chiropractic Examiners from 1997 to 2001. **Sexual boundary offences constituted 22% of offences (49 of 216) for chiropractic doctors and 10% (37 of 375) for medical doctors.** The authors relate this to an incidence rate of 1.01 per 1000 chiropractic doctors versus 0.23 per 1000 for medical doctors. Both groups in this study use the same judicial system and pool of judges so the comparison was considered valid.

In pharmacy, Tullett, Rutter, & Brown 2003 conducted a longitudinal study of United Kingdom pharmacists' misdemeanors in order to define trends and identify areas where remedial or preventative support could be focused. Case analysis of reports of individuals' misdemeanors published in the British Pharmaceutical Journal over a 12-year period (September 1988-October 2000) was carried out. Wide ranges of personal (n=162) and professional (n=590) misdemeanors were found, with eight (4.9%) of the personal misdemeanor category being for sexual offences. This is presented in the context of 34,657 registered pharmacists at the study's mid point of 1994. As the numbers are small, a breakdown of characteristics and resultant action is not provided for each type of complaint.

4.7 OTHER AREAS OF SEXUAL BOUNDARY VIOLATION

Several studies also present data on the prevalence of sexual contact between educators or supervisors and their trainees or supervisees. These studies have not been reviewed in detail here, but the potential consequences of such contact are considered in the next chapter on factors associated with prevalence.

4.8 CONCLUDING REMARKS

A number of patterns can be discerned from these diverse studies. Firstly, it can be seen that although this is fortunately a rare occurrence, boundary violations are reported on a regular basis. **Complaints systems should be prepared to support complainants through what can be a challenging process**. **Offenders are predominantly men, and their behaviour is primarily directed at women,** suggesting that gendered patterns of power and control are perpetuated in professional encounters. **All professions have members who are implicated in sexual offending, however boundary violations appear to be a particular hazard in those specialties that involve one-to-one encounters and which necessitate intimate touch or confidential dialogue and which take place in settings in which privacy/ secrecy is afforded. Professions which need to pay particular attention to these factors include obstetrics and gynecology, general practice, psychiatry, psychology and other talking therapies, and those working in long term care settings.**

5. THE IMPACT OF SEXUAL BOUNDARY VIOLATIONS ON CLIENTS

5.1 INTRODUCTION

As noted, most professionals surveyed express a general consensus that sexual boundary violations are unacceptable and there is a widespread acknowledgment that they are damaging. A number of, mainly qualitative, studies have been carried out, to explore the impact of sexual boundary violations on different groups of survivors and the message is clear that these **sexualized encounters do give rise to considerable and long-lived harm.** There is a risk that these studies may present a biased view in that their sampling and responses might be biased towards those who had experienced the encounter negatively. Moreover, no systematic studies were found where the focus had been on what some continue to refer to as "consensual" relationships within the professional-client context, so these are not represented as a potential counterweight, although evidence suggests that consensual relationships in a pastoral context may later come to be seen as exploitative (Kennedy 2002). In addition, these qualitative studies do not claim to be representative or generalisable, but rather to give a deeper understanding of the issues.

5.2 KEY FINDINGS

- The impact on survivors shows harm of professional abuse is considerable and enduring
- Symptoms include post traumatic stress disorder, anger, a sense of betrayal and exploitation, guilt and self-blame
- High levels of dependency on the offending therapist, confusion and dissociation are found

- Youth and a previous history of sexual abuse in the patient/client can exacerbate the negative impact of abuse by professionals.

5.3 THE STUDIES IN DETAIL

Grunebaum 1986 interviewed 47 psychiatrists, psychologists or social workers that had been patients in a harmful therapy. Interviewees first used a questionnaire to rate the degree of harm they had experienced, and the author also rated this independently, with subjects tending to rate themselves as having been less harmed than the researchers had thought. Eight therapies were reported as 'emotionally seductive' and three as 'explicitly sexual'. Of these three, one interviewee stated she was not hurt by it, but the other two blamed themselves and felt taken advantage of.

Benowitz 1994 compared the experiences of women clients sexually exploited by female rather than male psychotherapists, using interviews and symptom check lists with 15 women who reported having verbal or physical sexual contact with women therapists. The participants reported increased isolation through fear of heterosexist judgments, and the harmful impact was clear. Eleven had displayed symptoms of post-traumatic stress disorder (PTSD), with four currently experiencing these symptoms, on average seven years after the ending of the sexualized therapy. Ten reported continuing anger and betrayal; eleven decreased trust, nine depression, and six guilt and shame. Respondents also reported coexisting positive effects with 20% stating they felt more attractive and 33% that they had learnt more about boundary issues in general relationships.

Luepker 1999 carried out a survey of 87 women presenting with problems related to practitioner sexual misconduct, with a 63% (n=55) response. The effects of the misconduct were measured by comparing recollections of problems before and following the misconduct. **95% of respondents met**

the criteria for post-traumatic stress disorder; the incidence of major depressive disorder went from 40 to 93% following sexual contact, and suicide ideation and suicide planning from 38 to 80% and 24 to 58% respectively. They also reported multiple disruptions to significant relationships and in daily functioning, with 87% reporting negative effects on feelings about themselves as sexual partners and 46% on feelings about their sexual orientation. 55% said it contributed significantly to a change in residence, 87% experienced self-blame and 90% were ashamed. In addition, 67% described harm to people close to them, particularly children who had also suffered as a result of the relationship. The authors concluded that, by comparing conditions in the respondents' lives before as opposed to after the practitioner misconduct, there was evidence of devastating and enduring effects.

Disch & Avery 2001 surveyed 300 self selected survivors of abuse by medical, mental health, and religious practitioners, receiving 149 useable responses, with 90 reporting a sexualized relationship with a mental health professional, 38 with clergy and 21 with a medical health care provider. **They suggested that vulnerability to the negative effects of these relationships might have been heightened by the young age and previous sexual abuse history of some of the survivors.** Although 75.2% reported at some point having felt special, 47% loved, 53.7% excited, 46.3% in love, a large majority reported negative feelings – confusion (81%), having to go along with it (57%) and that it was inappropriate (54.4%). 40.8% reported feeling worse about themselves once the sexual phase began. On 'impact of event scales', intrusion of the professional's abuse had occurred in the previous seven days on average between rarely and sometimes (mean score 2.91 with four meaning 'often') and avoidance, particularly not being able to remember the abuse (mean score 2.47). Responses to trauma constellation identification scores suggested high stress, particularly seen in the scales relating to **loss, emotional turmoil,**

isolation, shame, fear, rage, self-blame and trust. The data, not detailed in this synopsis, indicated that greater harm was experienced in clients who had been abused in medical contexts (although no statistical tests were presented to support this).

Somer & Nachmanil 2005 interviewed 24 participants who reported actual sexual contacts with their psychotherapists, for whom an average of eight years had elapsed since the experience, allowing them to recount their experience and complete questionnaires rating their pre-, peri- and post treatment experiences. Narratives revealed two constructs of the relationship – romantic or abusive, with more positive perceptions reported by those who perceived it as romantic. All respondents indicated **high levels of dependency on the offending therapist, together with confusion and dissociation.** In the 'abuse' group, participants thought that the therapists did not listen to them and were more concerned with their own needs, and they experienced negative perceptions during the liaison. **For the 'romance' group, emotional well being deteriorated later, after the sexual exploitation ceased. Post treatment psychological well being fell to levels below pre-treatment, and all had felt exploited and betrayed by the therapist.** The sample, however, reported fairly good levels of current emotional well being eight years after the event.

6. FACTORS ASSOCIATED WITH SEXUAL BOUNDARY VIOLATION

6.1 INTRODUCTION

A number of studies have been found that have been considered to fall loosely under the heading of "predictors" or indicators, as described in this literature scan's objectives. Clearly, the term 'predictors' is problematic in an area of study where trials cannot be conducted and it is fairer to suggest that the studies explore factors that may be associated with sexual boundary violation. In fact **many of the authors caution against the use of a predictive profile** (e.g. Celenza 1998)**, partly because their studies are not controlled, and partly because some of the characteristics or situations found are not uncommon and may result in numerous false positive predictions of potential sexual boundary violations if used in a predictive manner.**

Celenza 1998 suggests:

"Although it is possible to describe factors that may increase the risk for the loss of boundary between fantasy and action, the question of what accounts for the breakdown of controls can be answered only in the context of a particular case. For any one individual, risk factors may increase the internal pressure to act, but these risk factors are not predictive if viewed outside the context of the individual's particular psychic organization. Although vulnerabilities may be observed, these factors do not necessarily outstrip the capacity for containment or control, even in the face of intensified pressure toward action."

Russell 2003 elaborates, suggesting that **sexual violations may be more likely where other boundaries are allowed to become blurred**, masking the real inequality inherent in the professional encounter. She writes:

"… Some of my research into how therapists construe the therapeutic relationship indicates that many see it as a relationship of two-way intimacy…. I find it to be an extraordinary

claim, and one which invites huge potential for the intentional or non-intentional violation of boundaries. While I have no doubts of the depth of emotion or issue which might be shared in a therapeutic relationship, or the specialness of taking life's journey alongside someone, I am quite clear that what I offer to one client I offer to all; I do not divulge some areas of my selfhood to them; and I am there for a specific purpose which although always personalized is not unique to them. My relationship with them is professionally monitored, discussed in supervision, considered and reflected upon so that I guide it according to desired client outcomes. The genuineness of our relationship is real, but I am not as intimate with them as they are with me. When therapists begin to believe that they really are offering two-way intimacy, there is more scope for poor practice and the exposure of therapist needs and vulnerabilities."

Nevertheless, a number of useful models have been derived from a growing empirical evidence base and provide ways of understanding sexual boundary violations in terms of the professional's issues, the patient's characteristics, and the dynamic set up by, and within, the professional relationship and setting.

The studies present a complex picture of factors that have been found to be associated with sexual boundary violations that have been grouped into the following headings:

- *Characteristics in the professional*, focusing on gender, age, life situations and personality traits
- *Characteristics in the patient or client*, focussing on an overall concept of vulnerability, for example in women, those who have been previously sexually abused and those with intellectual disability
- *The nature of the interaction itself*, in the power differential and in particular forms of practice such as hypnotherapy, intimate physical examinations, one-to-one talking therapies, and ongoing care situations
- *The patient/client's expectations* about the encounter, and cues that create confusion with ordinary situations such as holding a meeting in

a café, which sets up similarities with dating or home-visiting and which blurs the nature of the relationship

- *Blurred boundaries* in the relationship short of sexual boundary violations, for example self-disclosure, or sharing of other activities, as carried out for example by social care workers, or Community Psychiatric Nurses
- *Ambiguity about the length or extent of contact that constitutes a "professional relationship"* and about when such a relationship can be properly considered ended and immaterial
- *Images portrayed in the media* which portray sexual boundary violations as common occurrences and may set up contradictory expectations
- *Combinations of these and other factors*.

In addition, it could be argued that failure to implement activities that have been found to impact positively on attitudes towards sexual boundary violations, as detailed in the previous chapters, actually contribute to a further risk of violation.

Several studies discuss a combination of these factors, and there is not agreement in the literature within these groupings. These issues serve to highlight the potential dangers of presenting a single profile of victim, perpetrator or structure that will result in sexual exploitation of a client by a professional.

In related fields, specifically in the fields of sexual offending and of child sexual abuse, the empirical data has been used to construct explanatory and predictive models. These models, for example Finkelhor 1984, Sobsey 1994 and Tomita 1990, attempt to demonstrate the interaction between intra- and inter-personal issues and link these to cultural values and social structures, service settings and the moving boundaries between public and

private space. **These models allow the focus to move away from viewing the victim and the abuser as isolated individuals and invite the active involvement of managers and regulators and of those who bear a more amorphous responsibility for creating and sustaining the professional cultures within which boundary violations occur.** For example, in the Inquiry into the abuses perpetrated by Clifford Ayling (Department of Health 1994), it was acknowledged that nurses had concerns that they referred to informally but felt unable to turn into formal complaints. **Inquiries have also found that when complaints were made in different parts of the NHS, these were not joined up to make a complete picture. These systemic factors, that is the structural and gendered relationship between doctors and nurses (see Davies 1995), and the failure of NHS management to take these concerns seriously are as important to understand as the particular make-up of Ayling himself as a serial sexual offender with unique and legitimised access to potential victims (Pauffley 2004).**

What the **studies almost unanimously call for is an open discussion of the issues at all levels**.

6.2 KEY FINDINGS

- Difficulties in researching the subject, and recognition of systemic and organizational factors, lead to reluctance to rely on a predictive profile of offenders
- Managers and regulators bear a responsibility for creating and sustaining the professional cultures within which boundary violations occur
- Rather than a simple 'bad apple' model, an alternative view is that *all* therapists should be aware of their 'trouble spots' around boundary issues

- A higher proportion of offenders are male, older than average sex offenders, and suffering from a variety of psychopathologies
- Professionals who themselves had been severely sexually abused were more likely to have engaged sexually with clients
- Women are the main victims of abuse
- A significant proportion of abused clients are previous victims of abuse.

6.3 CHARACTERISTICS IN THE PROFESSIONAL

6.3.1 Introduction

The previous chapter on reported incidence and prevalence of sexual boundary issues has introduced us to the concept that different levels of boundary transgression are reported in different groups who have been studied with differences reported particularly by gender, specialty and age. These differences form part of the evidence for characteristics in the professional and are summarised below. These studies have already been critiqued as a whole in the previous chapter, but in relation to their 'evidence' on factors associated with reported incidence and prevalence; there are additional concerns with some studies that we do not know the make-up of the population from which the sample belongs. Therefore, we cannot discount the suggestion that different groups may report differently. Additionally, the majority of these studies have not sought to examine any interaction between the factors for which they cite differences, such as length of experience, age, gender and specialty.

In addition to the above factors, another body of literature has examined the personality characteristics of offending individuals. These studies are all observational and mainly study offending groups only, although some do seek a comparison or control group.

It is important to note that **there is no agreement in the literature about which characteristics in the professional are predictive of sexual boundary violation** and Norris, Gutheil, & Strasburger 2003, as one example, **caution against use of what they describe as the 'bad apple' model, preferring to suggest that therapists should be aware of 'trouble spots' in their own practice and across the trajectory of their**

working lives in order to avoid boundary violations, as discussed in detail below.

6.3.2 The studies in detail

6.3.2.1 Differences reported in the studies focussing on reported incidence and prevalence

The most commonly reported difference is that of gender, with **male therapists being more widely reported as perpetrators and female clients as victims, although homosexual boundary violations are also reported.** These reports span the time scale studied and across the specialties (Parsons & Wincze 1995; Wincze, Richards, & Parsons, et al. 1996; Pope, Levenson, & Schover 1979; Akamatsu 1988; Ladany, O'Brien, Hill, Melincoff, Knox, & Petersen 1997; Gartrell, Milliken, & Goodson, et al. 1992; Leggett 1994; Lamb, Strand, & Woodburn, et al. 1994, Lamb & Catanzaro 1998; Thoreson, Shaughnessy, & Frazier, et al. 1995; Rodolfa, Hall, & Holms, et al. 1994; Nickell, Hecker, & Ray, et al. 1995; Wilbers, Veenstra, & van de Wiel, et al. 1992; Tullett, Rutter, & Brown, et al. 2003.

In addition, Abramowitz, Abramowitz, Roback, Corney, & McKee 1976 tested the impact of sex-role prescriptions on psychotherapists' treatment decisions about opposite sex persons, reviewing the records of 160 clients seen by 23 male and 11 female clinical and counseling psychology trainees at one psychiatric and one psychologically orientated university facility. They report that male therapists see women clients for significantly longer than male clients, and have a higher proportion of female clients. Female therapists who were married saw more male clients than single female therapists did and saw younger men of higher socioeconomic status for a shorter time. Although this study did not collect data on sexual boundary

violations *per se*, the authors suggest that voyeurism is almost exclusively male and that sex-role primed counter transference is fairly widespread.

In relation to abusive priests, conference papers from Ireland's Rape Crisis/ MACSAS 2003 drew on a study by Benson in which three common patterns in the lives of the transgressors were identified:

- **A chronic and pervasive lack of emotionally intimate non-work relationships**
- **They reported that they had been abused, emotionally abandoned, or exploited by a parent or parent surrogate**
- **They assumed a grandiose care-taking role in their relationships, with most perceiving their sexual behaviour as salvific for their counselees.**

Some authors also report that prevalence has been found to increase with age (Enbom & Thomas 1997; Dehlendorf & Wolfe 1998).

6.3.2.2 Situations in which the professionals find themselves

Bridging the gap between the studies looking at demographic characteristics and those considering personality attributes is the work of Epstein, Simon, & Kay 1992 who designed an Exploitation Index (EI), a self administered educational inventory intended to assist psychotherapists in evaluating their potential for violating boundaries in the course of treating patients. The EI was not correlated *per se* to sexual misconduct but a cutting score was estimated that might define individuals at highest risk of boundary violations. 535 survey responses were received from the 2500 mailed to every fifth

member of the US listing for psychiatrists. Respondents reported an average of 1.5 alerts to an activity that could have been counterproductive for psychotherapy with a patient in the previous two years. Factor analysis elicited 8 factors explaining half the variance, one of which was labeled eroticism. Middle-aged psychiatrists (45-52 year olds) had the highest scores. Those who were in the top decile of EI scores were male, in suburban practice and in solo private practice. However, these factors only explained 16% of the variance and the authors warn against demographics alone being used as predictors of boundary violations. This study provides a link to others considering personality or psychiatric associations.

Norris, Gutheil, & Strasburger, et al. 2003 used a case vignette of a psychiatrist who crossed several boundaries (though not sexual in their presentation) to discuss **'therapist' risk factors** for developing boundary difficulties, drawing upon other empirical literature. The factors they highlighted were: **therapist's life crises; transitions such as retirement or job change; illness; loneliness and an impulse to confide; seeing a patient as 'special'; pride particularly in experienced practitioners resulting in not seeking supervision or help; working in a small or (en) closed community; and denial.**

6.3.2.3 Personality / psychiatric evaluations

Studies in this section have focussed on **personality traits of offending therapists**. However, these are **not agreed upon by all authors**, and indeed they do report differently. Again an issue is that different samples are used, drawn from very different populations at times. Garfinkel, Bagby, Waring, & Dorian 1997 questioned whether these scores can be used predictively to assess those suitable for a particular career and several studies explore the usefulness of personality testing as a screening tool for people entering into the helping professions.

Langevin, Glancy, Curnoe, & Bain 1999 is the first to make a direct comparison between professionals who violate sexual boundaries and "ordinary" sexual offenders. He compared 19 physicians charged with sexual offences (14 within practice and five without) with other sex offenders, using standard assessment tests of sexual history and preference, substance abuse, mental illness, crime history, neuro-psychological impairment and biological factors. The authors had some difficulties matching the groups, as the physician offenders were considerably older and better educated than the typical sex offender. Physicians reported significantly less substance abuse than controls, and showed a trend toward lower antisocial personality disorder, but more neuro-cognitive impairment. Six of 14 physicians returning results showed endocrine disorders. 10 physicians and nine controls showed sexual deviance. Overall the **physicians and other offenders showed few differences on variables considered significant in the commission of sexual offences, leading the authors to question previous work portraying physician sex offenders as simply normal depressed men, rather than as men fitting a sex offender typical profile**.

Celenza 1998 used the therapies, evaluations or supervisions of 17 offenders (14 male and three female) who were mental health professionals and were sexually involved with a patient. All male offenders had heterosexual relationships, and all women homosexual relationships, in other words all the victims were women. Data included interviews, psychological tests, and consultation with supervisors, colleagues and the victim. The author presents **common themes, with qualitative descriptions from cases, of long-standing neediness and unresolved problems with self-esteem and a sense of powerlessness (although clients viewed them as powerful); a childhood history of sexualization of pregenital needs; restricted awareness of fantasy, resulting in**

taking feelings at face value rather than understanding multiple levels of meaning; covert and sanctioned boundary transgressions by a parental figure, such as affairs; unresolved anger toward authority figures, such as licensing boards; intolerance of negative transference, with sexual acting out often with hostile or angry patients; and defensive transformation of counter transference hate, avoiding any perception of the self as negative, into counter transference love.

Hetherington 2000 reviewed literature pertaining to therapists who sexually exploit their clients, with a view to describing some of the common characteristics that have been identified in therapists who abuse, and the psychosexual factors in their background. It is suggested that therapists who exploit their role will only do so if they are in some way dysfunctional and, **therapists who abuse are found to have severe problems with their own sexual identities and experience a considerable amount of sexual anxiety and guilt in their personal relationships. It is suggested that their own unresolved conflicts take precedence over those of their clients and unconsciously they harbour a deep antipathy towards the practice of psychotherapy.**

Other studies have identified psychological issues in this group but suggest that they are either more likely situational or linked to organisational factors, or are also found in some non-offending professionals, making discussion of the implications difficult.

Garfinkel, Bagby, & Waring, et al. 1997 carried out a longitudinal study of psychiatrists originally recruited when on US residency programmes. This study contacted them between 13 and 17 years after completion of residency training and included 52 (40 men and 12 women) of the total population of 120 who were all originally approached. The participants

completed a series of personality tests, and the authors report here on the one measuring psychopathology: the Minnesota Multiphasic personality inventory. At the time of study, two of the 52 had had their licenses revoked due to repeated sexual boundary violations, and their results are compared with the remaining 38 male participants. **The two participants who had been 'caught' for boundary violations were found to show psychopathology, with a combination of scores representing individuals with antisocial attitudes and behaviour, and a defensive cognitive-perceptual style. However, four (11%) of the remaining 38 participants also showed similar styles, and 5% were classified as sociopath. Garfinkel concludes that the stakes (harm to the client) are so high with sexual boundary transgressions that an acceptance of some restrictive criteria based on personality tests may be needed.**

Celenza & Hilsenroth 1997 carried out an empirical investigation of the psychological characteristics of 20 mental health professionals who have sexualised dual relationships, using a standardised tool, and comparing this to scores obtained by 700 non-patient adults. **They found that the professionals had no distinct coping style, showed inefficiency in managing and adapting to stressors, had high levels of distress, were depressed (sometimes related to the current stressful situation but also showing as higher than the norm once the recent stress had been adjusted for). They were found to have a normal capacity for impulse control but showed some tendency for affective constriction and obsessive-compulsive behaviour. They showed a primitive stance to sexuality and a tendency toward activity rather than fantasy. Overall scores indicated that the participants were not grossly impaired but did show acute distress, mostly attributed to situational factors, and some disturbance**. The authors suggest that these results challenge the easy comparison with sociopath repeat offenders, suggesting that this analogue may be overstated on the basis of a few well-known cases. They

accept these cases exist but that they were not found in their own sample, so they should be seen as an atypical subset and not taken as the norm.

Spickard, Swiggart, Manley, & Dodd 2002 describes a course delivered over three days to 38 physicians referred for sexual boundary violations with patients or staff under their supervision, in which didactic and discussion sessions were used. They use a composite case study to illustrate the type of sexual boundary violations and physician issues under consideration. Participants completed a range of screening tests for sexual addiction, and, of the 30 who agreed for their data to be reported, 23 (77%) scored below the cut-off point for sexual addiction. The remaining seven were referred for further treatment. The authors report that **all of the referred physicians were uninformed and poorly trained in medical school or residency about sexual boundary issues, with no idea how to apply principles of counter transference in practice and with little awareness of their own or their clients' vulnerability. They were also unaware of guidelines and policies** and reported being astounded when angry patients file complaints. The authors report their own surprise at the general reports of common boundary violations, and **recommend education, support for discussion of feelings, screening tests, and visible displays of ethical codes.**

Jackson & Nuttall 2001 surveyed 323 mental health professionals, including psychologists, social workers, paediatricians and psychiatrists to determine the relationship between childhood sexual abuse of the therapist and subsequent sexual boundary violations with clients. **Of the 29 men in their sample who had been sexually abused as children, six (21%) had engaged in sex with their clients compared to seven of the 109 (6%) who did not report such a history (p=.019). Those who had been severely sexually abused were found to be four times more likely to have engaged sexually with clients. Psychological distress in the**

therapist was also associated with sexual violation of clients, with paranoid ideation and somatisation present in those engaging in sex. The authors suggest then that some of these therapists were particularly vulnerable to acting out with clients, although they caution against the dangers and ethical issues of profiling high-risk therapists.

6.4 CHARACTERISTICS IN THE PATIENT OR CLIENT – CLIENT VULNERABILITY

6.4.1 Introduction

As noted above several of the studies of reported prevalence and incidence characterise the victims of these boundary violations. The majority of these focus on gender, with **women being the main victims in reported cases of sexual boundary violations, and on previous abuse or trauma.**

6.4.2 The studies in detail

Kluft 1990 described one male and 17 female incest victims with dissociative disorders who had been sexually exploited by psychotherapists. The author suggests that all **subjects suffered ongoing dissociative symptoms that disrupted their sense of mastery and control, and that they could be incapable of perceiving and reacting to actual danger situations appropriately**. **Many of the subjects became frozen or withdrawn under stress, met situations best avoided by decisive action with passive compliance and learned helplessness, had suffered a shattering of basic life assumptions, and decontextualised traumatic experiences**. **The author suggests that a resultant chronic impairment may predispose those who suffer it to elicit repeated victimization. This is the reason why it is imperative that the**

professional always takes responsibility for managing and maintaining these boundaries.

Acknowledgment of the client's vulnerability is also noted in a study by Harper & Steadman 2003 who carried out seven interviews and focus groups with therapists involved in treating survivors of childhood sexual abuse, including social workers, youth workers, psychologists, and nurses, and focussing on situations where therapists maintained or extended boundaries, and how they make decisions regarding boundary change. Of particular relevance to this report is their **unanimous decision around refraining from the use of touch with survivors of sexual abuse, due to the knowledge that this could be readily misinterpreted as an invitation to sexual contact.** It was considered that the power differential and the client's desire to please mitigate against any suggestion that permission to touch could be sought.

Armsworth 1990 carried out a qualitative study with six women (aged 37-52 yrs) who had histories of incest and had been sexually involved with therapists, on average 19 years after this involvement. Three therapists were psychiatrists and three clergy, and all men. Summaries of the cases and thematic analysis yielded **three overall themes that appeared most salient in understanding the development and maintenance of abusive therapy: the early environment destroying or prohibiting personhood, reinforcement of depersonalisation in therapist rationalisations of the need for sex, and a surrender pattern (helplessness and loss of control) to cope with violations**. All women reported harm.

Somer & Saadon 1999 interviewed twenty-two women in Israel who reported that they had been involved in a sexual relationship within psychotherapy or counselling, using standard stress and clinical interviews and comparing these with 26 women attending the institute for stress. An

average of 7.7 years had elapsed since the sexual involvement. Offenders were clinical psychologists, psychiatrists, social workers, counsellors and an art therapist. The majority of therapists had a good reputation or were recommended. **In 59% other boundary crossing, particularly self-disclosure, and 70% reporting other seductive behaviour preceded the sexual misdemeanours.** Retrospective self-descriptions of the condition that motivated them to seek help revealed a number of conditions including eight respondents who may have met posttraumatic stress criteria, seven depression, four eating disorders, three sexual dysfunction, three sleep disorder, three somatoform disturbances and two hypochondriasis. **These women were more likely than controls to have been traumatised in the past, including emotional neglect and sexual abuse in childhood**. They suggest that this provides **evidence of a heightened vulnerability to sexual exploitation that may be picked up by potential abusers.**

Disch & Avery 2001 found that **62.4%** (n=93) **of the sample they were surveying regarding the impact of professional abuse (see boundaries chapter) reported having also been sexually abused outside the professional relationship.**

BenAri & Somer 2004 carried out in-depth interview with 14 women who were sexually involved with their therapist, the relationship having terminated at least 2 years previously, with 13 male therapists and one woman. Thematic analysis focussed on memories of past experiences and on present experiences. In the former, they were found to question what is was about themselves that made a sexual liaison with the therapist possible, and focused on **emotional deprivation or crisis, problem saturation, neediness and low self-esteem, often reporting difficult relationships with mainly fathers and male partners, and focussing on the lack of a satisfying sexual relationship.**

Frueh, Knapp, & Cusack, et al. 2005 demonstrated the prevalence of traumatic or harmful experiences within the psychiatric setting. They note previous studies showing that high prevalence rates of traumatic victimisation and posttraumatic stress disorder have been found amongst **persons with severe mental illness** and that these persons **may be vulnerable to further harmful experiences within the psychiatric setting.** In their own study they found that those patients (n=24) with a lifetime history of sexual assault as an adult compared with those without such a history (n=110), were more likely to report unwanted sexual advances in a psychiatric setting overall and sexual assault by a staff member (17% versus none), even after adjustment for age.

6.5 THE NATURE OF THE INTERACTION

6.5.1 Introduction

Studies in this section question the personal characteristics models and focus on the power differential, including in hypnotherapy.

6.5.2 The studies in detail

Gabbard 1997 suggests that focussing on trying to find an essential difference between those who engage in sexual misconduct and those who do not, and suggesting psychopathy, leaves little space to learn about vulnerability to boundary violations, and **disallows the concept of a continuum between transgressors and others.** Based upon his personal

experience of treating 70 – 80 therapists who have engaged in sexual misconduct with clients, the author discusses cases that illustrate several issues: **that counter-transference is subconscious and therefore it is difficult to separate conscious and unconscious intent; that boundary violations often grow out of misguided beliefs from the therapist and client that love can heal previous harm; that confusions engendered by the concept of therapy as predominantly supportive has been confused with the need to remove boundaries, thereby starting a slippery slope from self disclosure to other boundary crossings; that secrecy can seep into supervision and is perhaps encouraged by telling students that love and sexual desire are not allowed, rather than encouraging open discussion of the struggles many have with such feelings; and the need for self care, aiming to prevent the seeking of personal gratification in the therapeutic relationship.**

Twemlow 1997 presents a largely theoretical paper on the interplay of therapist and client characteristics and the nature of the interaction itself, using case vignettes as illustrative evidence. The suggestion here is that no single profile of the therapist or client open to boundary violation exists, rather that a continuum exists from boundary attention to boundary crossing and on to boundary violation where harm results. The paper describes in some detail the interplay between the therapist's lack of ability to see counter transference due to psychopathology and how this leads to an increasingly dominant and submissive split between the roles taken on by the perpetrator and the victim, resulting in boundary violation. To avoid boundary violation, all treatment should focus exclusively on the benefit and best interests of the patient. The therapists should not be involved in the work for their own gratification other than to receive a fee for the session.

In a similar vein Gartrell & Sanderson 1994 explore four cases of sexual exploitation of women by women therapists. They suggest the cases

highlight **different pathways to the exploitation**, one being a *slippery slope* with a lack of supervision and colleague collusion; the second being *a refusal of the clergy therapist to identify with her own sexuality*; the third in a refuge where *hugging was presented as healing* and an anti-psychotherapy approach was advocated; and the last a psychotherapist who *advocated sexual contact, claiming that feminist therapy was not hierarchical.* In this paper the authors discuss how the particular environment of women exploitating women proved difficult to address for the victims and colleagues of the exploiters due to fears of a sexist or homophobic backlash, and concerns about withdrawal of funding for services. They suggest that the cases also illustrate that **factors contributing to the suspension of therapeutic boundaries included claims of mutual attraction and rationalising away the professional inequality by stressing that clients are consenting adults**, both of which mirror male abuse. In addition they found a denial that women can be abusive, as they are not seen to have patriarchal power.

On the same topic of the nature of the interaction, but considering hypnotherapy in particular, Hoencamp 1990 describes a case of a 40 yr-old male lay hypnotist in the Netherlands who was accused of sexually abusing nine women (aged 17-48 yrs), to illustrate the client's reported state of powerlessness and coercion resulting from the abuse. The nine detailed patient accounts led to several themes: an authoritarian approach, using the same strategy with all women, linking the presenting complaint to a sexual theme, and terminating the relationship when the patient spoke to their family about the sexual contact. The author suggests **several mechanisms that may have been involved in the coercion**, including the concern that an unequal relationship had increased the patient's vulnerability; the expectation that hypnosis makes you powerless; non volition in hypnotherapy; hypnotherapy as an excuse to behave and feel as one would not usually do; changes in self-perception during hypnosis; and post-

hypnotic suggestion. While the author notes that hypnosis *per se* cannot put a person into state of powerlessness, it is recognised that a person's state of mind can be influenced by it.

6.6 CLIENT EXPECTATIONS

6.6.1 Introduction

In the discussion above, the idea of the therapeutic relationship and the power differential within it has been depicted to be a factor that may predispose to sexual exploitation, amongst other boundary crossings. Added to this, a small body of literature indicates that a public perception of the role of the professional – particularly psychiatry or therapy exists regarding sexual boundaries. Although the studies make no claim that media or public representations are directly associated with sexual boundary violations, they do suggest that such images are influential.

6.6.2 The studies in detail

Gharaibeh 2005 explored quantitatively how American movies portray psychiatrists/therapist, reviewing 106 movies regarding the psychiatrist's or therapist's sex, age, clinical competence and knowledge, boundary violations, attitude toward the patient, influence in the movie's events, treatment modality or modalities used, intervention's outcome, and therapeutic setting. **The therapists were portrayed as mainly male (71.2%), and middle-aged (50.8%). In this study of fictional psychiatrists/therapists, 23.7% of therapists/psychiatrists violated sexual boundaries**. This is a startling misrepresentation, creating a set of very false expectations in that the image of psychiatrists/therapists portrayed in commercially available movies was that almost a quarter committed a sexual boundary violation.

Schill, Harsch, & Ritter 1990 enrolled 57 male and 57 female volunteers from a psychology undergraduate course to view a movie in which the psychoanalyst acts out counter transference feelings. A pre- and post-movie survey on beliefs regarding therapist-client relations was conducted. Significantly **more erroneous beliefs were expressed after viewing the movie** in relation to the following statements:

- "The sexual feelings of the analyst to the patient is real love"
- "The relationship is not damaging"
- "Consulting another professional is standard procedures in these circumstances for the analyst"
- "It is cruel for the analyst to abandon the patient"
- "Sexual relationships are prohibited mainly because it tarnished reputation of the profession"
- "Forbidding sex is outmoded".

Few believed that such occurrences were rare or that psychiatrists can't help themselves after the movie. Splitting the respondents by their level of distress (as measured on a psychiatric impairment scale) found that the less distressed group showed increased ambivalence after the movie but the more distressed group had reduced reservations after the movie, suggesting perhaps that they considered the prospect of a personalized relationship desirable, which should perhaps be linked back to the previously discussed studies highlighting client vulnerability.

6.7 COMBINED FACTORS

6.7.1 Introduction

As stated above, not all authors see a clear message regarding any one factor associated with boundary crossing. To capture that essence, one study of the clergy is drawn out, highlighting personal, organisational and situational factors.

6.7.2 The study in detail

Birchard 2000 reports on a study of the UK clergy, searching for causation of sexual misconduct, using interviews with two clergy specialists in recruitment and training, three focus groups comprising sixteen clergy members, and a survey sent to 100 clergy with 43 returns. The interviews revealed concerns about boundary ambiguity, power, and the reinvigorating power of a new relationship, with one interviewee associating this with male mid-life crisis. Focus groups variously raised issues of blurred boundaries, abuse of power, a false stereotype of women as "predatory females", loneliness, the connection of sexuality/love with spirituality, and the lack of safeguards within the ecclesiastical structure. The survey's open-ended question on perceived causes of sexual misconduct revealed four themes: loneliness, unresolved sexual and personal problems, the human condition (sin, sex), and a bad marriage. **The quantitative results combined to show several views on causation: Boundary ambiguity (n=58), absence of institutional attention (n=40), individual personal and sexual problems (n=30), power and charisma of the role (n=28). Loneliness (n=26), stress (n=23), role as an object of projection (attractiveness to women) (n=23), absence of awareness** training (n=21), the male libido (n=18), and a bad marriage (n=17). Overall then respondents primarily locate the problem in neediness of the cleric, in the

ambiguity of the boundaries that are bound up in the role, and in the inattentiveness of the organizational structure to these issues and to the personal welfare of individual clergy at crisis points.

7. MAIN THEMES AND POTENTIAL FOR FURTHER RESEARCH

7.1 MAIN THEMES

This report highlights the large empirical literature on sexual misconduct by health professionals in the areas related to boundaries, reported incidence and prevalence, and factors that may be associated with such misconduct.

The studies are, in the majority, carried out in the psychological therapies and in the United States, but, importantly, those that are carried out in other areas of medicine and allied health professions, and in other parts of the world, do not find dissimilar results.

Despite the methodological limitations of this review, it is possible to draw out a number of themes from the studies:

- **Boundaries are crucial to client safety. A slippery slope towards sexual violations can occur following other seemingly innocuous boundary crossings.**
- **Specific education changes attitudes toward sexual contact but must be delivered in a conducive environment. Professionals can continue to feel unprepared even after educational sessions. The impact of education on subsequent practice is not known.**
- **Sexual boundary violations commonly result in significant and enduring harm to abused client's emotional wellbeing and functioning**
- **Reported incidence of abuse is low, but concentrated in general practice and psychological therapies**
- **Client vulnerability is associated with higher prevalence**

In addition, a somewhat separate literature exists in relation to abuses of the most vulnerable. **People living in congregate and institutional settings are not included in these studies despite evidence that they are at heightened risk of a whole range of boundary violations at the hands of paid workers and other residents** (Brown, Stein, & Turk, et al. 1995). Other paid, but not "professional" groups of workers tend not to have been included in these studies, despite the fact that they also wield considerable power over vulnerable patients and clients.

The following quote, although focused on psychotherapy, sums up the issues highlighted in this review of the evidence and is clear about where responsibility lies:

"The critical issue in abuse is not so much whether abuse occurs with children or with women or with members of certain ethnic groups, but that the potential for abuse occurs in any relationship in which one party or their role is empowered…..Psychotherapists, like parents, are empowered by the nature of their role and are accountable for the responsible handling of the accompanying inherent power differential."
DeLozier 1994

An overview of the characteristics of the studies referred to in this report is given in the Appendix, and may be used as a guide to structure critical reading of new reports.

7.2 FURTHER RESEARCH NEEDED

- UK based studies of regulated health professions, within general practice, psychiatry and obstetrics and gynecology, but potentially looking at other specialties as controls
- Research in non-regulated professions, particularly psychotherapy and complementary and alternative medicine
- Prevalence of boundary violations by non-professional employees (e.g. hospital porters, drivers)
- Research as to effectiveness of different educational interventions.

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APPENDIX

A GUIDE FOR CRITICAL READING OF STUDIES REGARDING SEXUAL BOUNDARY VIOLATIONS BY PROFESSIONALS

The following tabulation provides an overview of characteristics of the studies referred to in this report, that can be used as a guide to structure critical reading of new reports.

Nature of boundary violation

- discomfort of the patient/client
- individual incident of sexualized verbal behaviour
- inappropriately sexualized clinical intervention
- sexual act, consensual or non-consensual
- ongoing sexual relationship
- romantic sexual relationship
- ongoing sexual partnership

Professional group(s)

- all paid workers
- several professional groups
- medical profession, specific specialties or all specialties
- all mental health workers
- social workers and social care workers
- priests and pastoral counselors
- counselors and psychotherapists

Nature of informants/ point of data retrieval

- clients and patients
- professionals reporting their own behaviour
- professionals reporting on colleagues
- case reports reviewed retrospectively
- service managers or regulators
- disciplinary boards and professional regulators
- criminal justice system, allegations or prosecutions

Status of reports

- allegations
- some corroboration
- proven in accordance with disciplinary procedures, i.e. on balance of probabilities
- proven in criminal court, beyond reasonable doubt.