Patient-Therapist Sexual Involvement: A Review of Clinical and Research Data

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Core concepts and selected research addressing the issue of patient-therapist sexual involvement (PTSI) are examined. Topics covered include the prevalence of PTSI, its suspected causes, the seduction process employed by offending therapists, the factors involved in patient's vulnerability, the mechanisms by which patients are damaged by PTSI, the types of harm caused to patients, the treatment of patients after PTSI, and the prevention of PTSI. The need to expand empirical research in all aspects of PTSI from the patient as well as from the therapists' perspective is strongly emphasized.

Sexual contact between physicians and their patients is prohibited in the Hippocratic oath: "In every house where I come, I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction, and specially from the pleasures of love with women and men."[1] The relationship between the doctor and patient is considered a "sacred" trust deriving from the traditional attribution of priestly features to the physician role.[2] As Simon[3] has emphasized, in legal tradition the doctor-patient relationship is, by definition, a fiduciary relationship, with the implication that a professional in holding the trust of a client enjoys a distinct power advantage over that client. This fact opens the possibility of a significant degree of manipulation and exploitation of the client-patient by the professional-physician. Simon,[4] referred to the fundamental ethical consideration underlying this central aspect of the relationship as the principle of abstinence which requires that professionals abstain from using clients for their personal gratification.

In Simon's view[4] breaches of the abstinence principle constitute boundary violations which, whether sexual or nonsexual in nature, are always potentially traumatic to the patient and may produce harm. The concept of personal boundary is central to all discussion of patient-therapist sexual involvement (PTSI). Rutter[5] defined boundaries as a complex set of physical and psychological barriers which together define who

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we are, the self from the not-self, what is ours and not ours, and what is intimate as opposed to separate. Gutheil and Gabbard[6] define sexual misconduct in the therapy relationship as an "extreme boundary violation" but believe that if structural aspects of the patient-therapist relationship such as time, space, money, clothing, language, are violated, its crossing in itself may represent an ethical violation. Since it is generally assumed that there is no practical method of policing boundary violations by external means, the expectation is that the patient will be protected by a code of ethical standards which explicitly forbids such exploitation.

The doctor-patient relationship may be viewed as prototype of all fiduciary relationships including those involving pastors, priests, teachers, attorneys, and psychotherapists. The ethical duty of physicians to refrain from sexual exploitation of their patients clearly extends to all health professionals involved as psychotherapists. Indeed, it has been suggested that psychotherapy patients are most vulnerable to sexual exploitation due to the intimate nature of the exchange involved and the longevity of the relationships that typically develop.[7]

Although some authors argue that the attribution of damage to patients from PTSI has been exaggerated,[8] the clinical literature on the topic strongly supports Simon's views about the prevalence and seriousness of PTSI, which is typically regarded as the most flagrant form of patient abuse. Admonitions regarding the dangers and destructiveness of PTSI have been published by leaders of psychoanalytic thought,[9,10] and explicit prohibitions against sexual exploitation are now incorporated into the ethical codes of all major psychotherapy-related professional organizations.[11]

This paper examines selected issues in the literature and research concerning PTSI from the patient's perspective, including the prevalence and suspected causes of PTSI, the seduction process employed by offending therapists, patient vulnerabilities, the mechanisms by which patients are harmed, and the consequences of PTSI. The treatment of patients post-PTSI and the prevention of PTSI are considered in light of this review.

This work draws heavily on recently published monographs that have offered valuable insights into the complex issues of PTSI[12–15] and on empirical data. It is important to note that many writers have criticized the PTSI literature on both conceptual and methodological grounds.[12,13] Further, existing studies have been criticized for the use of small, self-selected samples, lack of appropriate controls, and almost exclusive use of self-report measures. Thus, research results on PTSI must be viewed as tentative, especially in the area of consequences for patients.

The Prevalence of PTSI*

Reliable data on the incidence of PTSI are not available to this date. Current

* We refer to the patient/victim as "she" and to the therapist/offender as "he" because this is the most frequent distribution of gender, although there are many male patients/victims and female therapist/offenders.

prevalence estimates derive from a series of investigations measuring the percentage of therapists who endorse survey items indicating current or past sexual involvement with at least one patient. While estimates vary across studies, it is widely held that 7 to 10 percent of male and 1 to 3 percent of female therapists report having had sexual intercourse with one or more patients.[11, 14–18] Those therapists who report having sex with their patients are often repeat offenders with some surveys noting over 50 percent of male therapists reporting sexual involvement with more than one patient. While male therapists are more likely to have sex with their patients than female therapists, no such distinctions have yet been identified among professional groups. Psychoanalysts and board-certified psychiatrists are as likely as psychologists or social workers to be sexually involved with their patients.

Comparable prevalence figures for patient samples are not available. Bouhoutsos *et al.*[19] noted that 70 percent of the therapists in their sample reported being aware of at least one patient who had been sexually involved with a previous therapist. Rutter[5] projected from available surveys that in the United States alone there may be 400,000 to 1,200,000 female victims of sexual abuse in relationships of trust, including psychotherapy. Based on his interviews with hundreds of women, Rutter[5] commented:

> Remarkably, once invited to talk about it, women were not at all reticent in sharing their stories. Almost 80 percent of women I spoke with had an incident to recount about having been approached sexually by a man who was her doctor, therapist, pastor, lawyer, or teacher. In half of these cases, an actual sexual relationship took place, with disastrous results. . . . The 20 percent of women to whom this had never happened all knew of two or three other women to whom it had (p. 14).

It is surprising that in spite of numerous indications of the magnitude of the PTSI phenomenon, systematic research has not yet been undertaken to estimate incidence and prevalence rates for patients experiencing this form of sexual abuse.

Although such data on the prevalence of PTSI are equivocal and indirect, reliable and valid data have shown dramatic increases in the incidence of PTSI-related malpractice suits against therapists, the number of referrals of therapists to impaired professional programs, and the rate of disciplinary actions initiated by professional regulatory boards for sexual misconduct of psychotherapists have also soared.[20–22] It is assumed that only a small proportion of all PTSI cases result in such formal actions. These data may reflect increased public awareness of the problem and a decline in the professions' tolerance for such ethical misconduct rather than an increase in the incidence of PTSI.

The Seduction Process and The Problem of Vulnerability to PTSI: Causal Considerations

Speculation on the causes of PTSI fall into three general categories: cultural, situational-interpersonal, and intrapersonal. It is reasonable to assume that multiple factors along these three dimensions come into play and that con-

siderable variability exists across individual instances of PTSI.

Feminist writers have emphasized cultural causes of PTSI. Chesler[23] purported that the therapy situation mirrors that of society in general. Therapists regardless of their theoretical orientation share and act upon traditional myths about "abnormality," sex-role stereotypes, and female inferiority, thus perpetuating misogynistic views and exploitation of women in a patriarchal society. In this view, both therapists and patients are acting out societal scripts that are far more powerful motivators than any prohibitions of sexual involvement proclaimed in professional codes of ethics. Chesler believes that PTSI events are as common as sexual encounters between the female secretaries and their bosses, housekeepers and their employers, or any other situation where older males in positions of power employ allures of "love," "wisdom," and "protection" to exploit women under their influence. This cultural perspective regards all therapists to be at risk of becoming offenders.

Rutter[5] used a similar strategy in addressing the causes of PTSI, but his style is less cynical and more empathic to the male actor in the drama. In his view both the therapist and patient bring culturally inflicted wounds into the therapy relationship. He grouped the wounds which render women vulnerable to sexual-boundary violations into four categories: (1) overt sexual and psychological invasion in childhood leading the women to repeat these familiar roles in current relationships; (2) profound childhood aloneness and psychological abandonment arising out of the cultural devaluation of both children and women; (3) exploited female compassion where women are given the role of healer for the wounds of their parents and siblings in keeping with traditional sex-role stereotypes; and (4) devalued potential of women who are "told" they belong in the home, as the center of the family, and not out in the world. Rutter appears to believe that all women in this patriarchal society are wounded in these ways differing only by degree; all are at risk for PTSI. The wounds of men in this society are addressed by Rutter in great detail, but a discussion of them is beyond the scope of this current effort. It suffices to say that in his opinion all male psychotherapists who become involved in PTSI are also wounded differing only by degree. When they seek to heal their wounds, in the face of the powerful allure of forbidden sexual relations with a patient, the foundation for boundary violations in the therapeutic relationship is in place.

Another cultural explanation for a perceived increase in the incidence of PTSI in recent decades is the so-called sexual revolution of the 1960s. Schoener[24] noted that within the development of psychotherapy this time corresponded to the emergence of the human potential movement with the practice of sensitivity groups and public advocacy of the use of touch in individual therapy. Schoener[24] notes:

> In private conversations, a number of therapists linked their erotic contact with clients to experimentation with touch in the 1960's or

> 1970's. Some cited demonstrations seen at workshops, others, their personal experiences in encounter or sensitivity groups or marathons, as the initial source of the idea to attempt more physical contact with clients (p. 13).

In keeping with this perspective, it is likely that psychotherapy patients' attitudes and values concerning sexual boundaries also underwent a dramatic shift during the 1960s. It may be suggested that some patients may have assumed that in an era of openness and challenge of traditional sexual standards, sex with a therapist was now acceptable behavior. In the absence of empirical support this notion is purely speculative.

The cultural rationalizations of PTSI may be criticized on several grounds. They do not address the actual process which leads to sexual involvement between the therapist and the patient, an understanding of which would seem to be essential to addressing individual instances of PTSI and the development of prevention strategies. Further, explanations within the cultural context do not account for the apparent wide variation in patient and therapist vulnerability to PTSI and the variability in damage from such involvement.

The situational-interpersonal theories of PTSI put emphasis on the context of psychotherapy. It is clear that therapists and patients spend many hours alone in a closed room discussing intimate topics, and such interaction inexorably leads to the development of powerful transference and countertransference responses. While originally confined to psychoanalytic therapies, the concepts of transference and countertransference apply to virtually all therapies, and set the stage for boundary violations by the therapist. The seduction process may begin when the therapist breaks the traditional rules governing psychotherapy and engages in nonsexual boundary violations; for example, failing to bill for services, scheduling extra-therapy meetings, treating outside their area of expertise, infantilizing the patient, or using medications improperly.[4, 6] These actions may ultimately lead to a sexual encounter. An important assumption of the interpersonal theories of PTSI is that the patient is an entirely naive, innocent, and passive participant who, due to unique features of the psychotherapy relationship has been rendered incompetent to make an informed decision about sexual involvement with the therapist, i.e., the patient is considered as a child. This paternalistic view of patients and therapy is clearly conveyed by Aldrich[25] in his introductory text on dynamic psychiatry:

> The therapist's interest, empathy, and wish to help, conveyed not so much verbally as in the subtleties of his attitude, make it possible for his patient to trust him in the same way that a child trusts his parent when he senses his love and interest. . . . No matter how much he loves his child, however, the wise parent sets constructive limits to his child's behavior; in the same way, the therapist's wish to help his patient, client, or parishioner should not keep him from setting constructive limits to the amount and kind of help he gives (p. 325).

This reasoning has lead many writers to equate PTSI with incest.[26] A review of published accounts of patients[27-31] reveals three striking parallels between PTSI and incest: (1) all therapists engaged in elaborate manipulations of the

therapeutic process to get the patient to engage in sex; (2) the relationships that resulted were extremely disturbed, shallow, and involved compulsive ritualized sexual behavior; and (3) once exposed, the offending therapists made elaborate efforts to avoid responsibility for their behavior, including blaming the patient. Such use of manipulation, blaming, and ritualized sexual behavior are often reported by incest victims.[32]

The tenets of the situational/interpersonal explanations of PTSI also need to be critically appraised. In previous research[16] health professionals report rates of sexual involvement with patients equal to or greater than the rates for psychotherapists, suggesting that the sexual involvement with patients cannot be fully explained by the uniqueness of the psychotherapy situation. In her published case reports Burgess[33] documented that nontherapists may employ the same seduction process as psychotherapists.

These situational-interpersonal theories are based upon three traditional assumptions about the therapy relationship, which may not be valid.[8] First, that transference phenomena are unique to the psychotherapy situation. In fact such phenomena are probably a feature of all relationships, and they are not necessarily any more intense or significant than in relationships involving clergy, lawyers, teachers, or physicians. Second, that during transference phenomena patients are rendered incompetent to make decisions about boundary issues in the relationship to the therapist. Besides being offensive to many patients, there is no empirical evidence that this assumption is generally true. Third, that as passive child-like recipients of therapy, patients bare no responsibility for the conduct of the therapy relationship. In their extreme form these assumptions may reveal more about professional narcissism than they do about the realities of the therapy relationship.

The intrapersonal theories of the causes of PTSI address the psychological and characterological traits and liabilities which the actors bring into the psychotherapy relationship. One can examine therapists' characteristics that place them at risk for violating this ethical taboo. Schoener and Gonsiorek[34] have classified therapists into six categories: Uninformed, Healthy or Mildly Neurotic, Severely Neurotic/Socially Impaired, Impulsive Character Disorder, Sociopathic/Narcissistic, and Psychotic/-Borderline Personality. Inherent in all but the first category, is the position that PTSI is due to characterological or personality variables. Some psychological theories have attributed PTSI to therapist-displaced hostility toward his mother, the need to control,[35] and/or to unresolved oedipal conflicts.[9] Others have characterized offending therapists more harshly as narcissistic individuals who need to be idealized by patients and possess an unconscious urge to devalue and harm others.[36] Both Gabbard[15] and Vaillant *et al.*[37] provide data suggesting that helping professionals feel as though they did not receive appropriate nurturing during childhood, and thus these individuals get such needs met through their patients. Current theory and re-

search suggest that characterological variables may interact with environmental stressors to predispose certain therapists to be at risk for having sex with their patients. Observations by Brodsky[21] support this position, inasmuch as many therapist offenders reported some type of significant environmental stressor, (e.g., parent dying, marital difficulties) during the time of the sexual contact with their patient. Additional risk factors for the therapist include dual relationships with patients, (e.g., engaging in business or social contacts outside the therapy hour); difficulties in relating to women, differential treatment of patients by gender, and professional isolationism.[12]

The analysis of the responses of 84 psychiatrists (offenders) who had admitted sexual contact with patients were compared with the responses of 1,228 psychiatrists who denied having such contact (nonoffenders) as to their ratings of factors which can make sexual contact with patients always or sometimes appropriate (Table 1). Focusing further on the cognitive set of offending therapists, Table 2 reveals a striking similarity between some typical rationales employed by offending psychiatrists to justify sex with patients and the cognitive distortions used by pedophiles to justify their behavior with children.[32]

Gutheil[38] in a recent review of the predisposition of patients to involvement in PTSI, proposes two axioms that address the issues of responsibility, culpability, and accountability for PTSI. The first axiom is a restatement of the principle of abstinence:

> . . . the clinician always bears the burden of clinical, ethical, and moral codes and constraints flowing from the professional role; the patient does not. Consequently, in an instance of sexual misconduct, it is the clinician and only the clinician who can be counted culpable, blameworthy, or—in certain circumstances—liable or criminal. The patient in the same situation simply cannot be any of these since the standard against which blame would be measured is lacking (pp. 661–2).

The second axiom adds the crucial concept of pragmatic responsibility:

> . . . both therapist and patient in sexual misconduct are competent adults—barring minority age, competence impairing major Axis I pathology, or intoxication that renders either party functionally incompetent. Hence, both are pragmatically responsible (in the sense of accountable) for their actions, as are all adults. In a dyad of adults, both contribute interactively to the behavior therein. Like all adults, they may be subject to various influences, but for the patient to be responsible for certain actions clearly cannot be translated into the patient being blameworthy (p. 662).

Thus, a discussion of factors in the patients which might contribute to PTSI should not be construed as an attempt to blame the patient for the ethical shortcomings of the therapist, but rather as an aid in understanding how these events take place. Gutheil[38] concluded from his review that it is not feasible to develop a profile of the "typical" patient who is vulnerable to PTSI. Wohlberg[39] has suggested that the common characteristic found among patients involved in PTSI is precisely their extreme vulnerability, especially if they have experienced concurrent losses, "marker events," e.g., incest, and/or significant developmental turmoil. Kluft[40] has referred to this pattern of vulnerability as the "sitting duck syndrome." Averill *et*

Table 1
Factors Justifying Sexual Involvement with Patients by Admitted Sexual Offender Status of Psychiatrist*

Factors	Percent Endorsing PTSI	
	Offenders (n = 84)	Nonoffenders (n = 1228)
Setting		
After termination	74.1	27.4
During treatment sessions	9.5	1.4
Concurrent with treatment	8.4	0.6
Activity		
Hugging	91.7	66.7
Kissing	31.0	10.7
Sitting on lap	16.7	3.1
Disrobing	9.5	1.6
Fondling	6.0	0.5
Genital contact	6.0	0.4
Rationale		
Therapist genuinely in love with patient	21.4	3.5
Treat patient sex problem	17.9	3.9
Enhance patient esteem	10.7	0.9
Correct past abuse/neglect	8.4	0.5
Correct sex orientation	7.1	0.7
Make patient happy/shorten grief	6.0	0.6

* Data adapted from Herman *et al.*, 1987, and reproduced here by permission of the authors.

al.[41] and Gutheil[42] discussed the possible role of borderline personality dynamics while other writers have commented on the prevalence of childhood sexual abuse in these patients.

Posttraumatic stress disorder (PTSD) has also received attention as a factor in patient vulnerability. Herman *et al.*[43] viewed the previously abused patients' apparent gravitation to current abusive situations as reflecting a conditioned need for high-intensity, endorphine-releasing experiences because only the latter seem to them to have emotional meaning and validity. Finally, Gutheil[38] reviewed a variety of other factors and intrapsychic dynamics that may come into play for some patients including chronic resentment toward males, preoedipal sexual urges, and impairments in self-esteem.

The intrapersonal explanations of PTSI have considerable appeal to clinicians. Nevertheless, the intrapersonal theories entirely ignore cultural, situational and interpersonal factors. Further, some of the constructs of the intrapersonal theories do not lend themselves to empirical investigation. Based on the above review, it can be argued that PTSI encompasses cultural, interpersonal, situational, and intrapersonal aspects. This multifactorial process is complex and varies widely from case to case.

Impact of PTSI on the Patient: Empirical Evidence

The first issue to address in this discussion is whether PTSI is damaging to the patient. Earlier writers such as McCartney[44] and Shepard[45] discussed the potential benefits of sexual relation-

Table 2
Cognitive Distortions of Pedophiles Rationalizing Sex with Children and Those of Therapists Rationalizing Sex with Patients

Cognitive Distortions of Pedophiles[32]	Cognitive Distortions of Offending Therapists
A child who does not physically resist really wants sex.	Patients who do not object or resist the therapist's sexual advances really want sex.
Having sex with a child is a good way to teach a child about sex.	Having sex teaches patients about love and intimacy; it corrects sexual identity problems.
A child doesn't tell anyone about having sex with an adult because he or she really enjoys it.	I have had patients before and they never complained to anyone so it must have been helpful and positive for the patient.
Society will someday condone sex with children.	I'm ahead of my time; some patients need to do more than just talk about their feelings toward their therapist; having sex with a patient is a progressive form of therapy.
An adult who fondles a child's genitals is not really sexually engaging the child, and so no harm is done.	It's not just sex, it's therapy; it's love; it's a "corrective emotional experience."
When a child asks about sex, it means that the child wants to see the adult's genitals, or to have sex with the older person.	The patient was very seductive; she seduced me; she loved me and showed me in many ways that she wanted to have sex with me.
The relationship between the child and the adult is enhanced by having sex.	Sex with the patient helped the transference, made the relationship more real, deepened the commitment to therapy, etc.

ships with patients, but to this date there is no credible evidence that this contact is in and of itself curative under any circumstance. While one would assume that most professionals today would reject the notion that patients benefit from sexual contact with their therapist, recent data on therapists' attitudes reveal that the beneficial or innocuous view of PTSI is still held by therapist offenders.[18] However, as documented below, there is clear evidence that PTSI may be extremely damaging for at least some patients. Since the therapist has no way of knowing in advance which patient is going to be severely hurt, PTSI can only be construed in part as a kind of ethical Russian roulette played by therapists for their private purposes.

Pope[46] addressed the issue of how patients are harmed by sexual contact by making an analogy between PTSI and PTSD. Noting the similarity of its clinical presentations he introduced the concept of therapist patient sex syndrome. The specific mechanism by which a major trauma produces the typical PTSD symptoms and dysfunctions is still a matter of intense debate and research.[47] However, substantive evidence exists that traumatic experiences may produce permanent alterations in mid-brain physiology which may be responsible for the classic PTSD triad of autonomic hy-

perarousal, reliving experiences, and emotional blunting.[48] Parallels of PTSI with incest attribute the harm of the patient to the betrayal of trust, psychological abandonment of the victim—when the sex begins, the therapy ends—and social isolation which results from the patient's shame and obsessive preoccupation with the therapist. Finally, those patients who make the decision to disclose the abuse and to pursue legal redress are subject to the disbelief, anger, rejection of others, and the rigors of an adversarial legal process.

One of the earliest attempts to document the damage of PTSI to the patient was undertaken by Durre.[49] Using information from four case histories, questionnaires completed by 65 women who had sex with a therapist, and detailed study of the literature, she concluded that, "...the sexual relationships the female subjects had with their male therapists were detrimental, if not devastating, to the personal growth of all four women....Research has proven almost invariably that amatory and sexual interactions between clients and therapist dooms the potential for successful therapy and is detrimental if not devastating to the client" (p. 240).

Burgess[33] examined the reactions of 16 women patients to sexual abuse by their gynecologist. The patients were interviewed and asked a standard set of questions regarding (1) prior physician services, (2) the nature of the abusive incident, and (3) the patient's initial reaction and subsequent behavior. All patients felt emotionally upset and confused and reported feeling "dirty, humiliated, degraded, embarrassed, and nauseated." Some women reported negative impact on their sexual functioning from short-term aversion to long-term major impairment. Twenty-five percent reported significant anger, an unspecified number reported self-blame, and many of the women developed an aversion for gynecologic health care.

Bouhoutsos *et al.*[19] mailed questionnaires to 4,385 licensed psychologists in California, 704 responded with 318 respondents providing information on 559 therapists, and 559 patients who had been sexually intimate with their psychotherapists. The impact on patients included the following: aggravation of personality problems—34 percent; persistent negative affects directly related to the sexual experience—29 percent; worsening of sexual, marital, or intimate relationships—26 percent; patient improved clinically—16 percent; and no effect on the patient—9 percent. Concerning the therapy relationship itself the results were as follows: sex ended therapy—37 percent; sex interfered with therapy—40 percent; no impact on therapy—5 percent; positive impact on therapy—6 percent. Although these outcomes are wide ranging, the preponderance of the patients (90%) experienced at least one significant negative effect.

Feldman-Summers and Jones[13] turned to the public media to solicit participants for their study on the effects of PTSI. They formed two experimental groups and one control group. One experimental group was integrated by patients who had been sexually involved with a psychotherapist while in therapy

and a second group consisted of patients who had been sexually involved with another health professional during active treatment. The control group consisted of closed cases from a psychology clinic matched for gender, ethnicity, age, education, and income. Detailed information was obtained on self-esteem, depression, attitudes toward health care professionals, beliefs about sexual contact with therapists, emotional effects of treatment, sexual attitudes, and psychosomatic and psychological symptoms. One-third of the 48 respondents were men.

The results revealed that 91 percent of the males who reported having had sex with a female therapist found it to be a positive experience. Unfortunately, the men of this sample agreed to a telephone interview but did not come forward for a personal interview. Of the female respondents who had been sexually involved with their therapists, 96 percent regarded the outcome of the experience as negative. These women expressed significantly more anger and mistrust of therapists and more psychosomatic symptoms one month after the therapy ended than women in the control group. The professional background of the therapists in this study was not significantly related to the impact of PTSI. The marital status of the health professional, patient vulnerability by past sexual victimization, and patient vulnerability by number of prior psychiatric symptoms all predicted a higher degree of negative impact of PTSI on the patient.

Sonne *et al.*[50] reported on the experience of eight patients who participated in a posttherapy group conducted at the University of California at Los Angeles (UCLA) Psychology Clinic. The authors commented on the difficulties encountered in working with these women and underscored the patients' conflicts over issues of trust, impaired self-concept, and the expression of anger. Pope[51] summarized the results of his experiences with patient-victims under the rubric therapist-patient sex syndrome. As noted previously, the range of the impact was found to be similar to that seen in individuals with PTSD and included feelings of ambivalence, guilt, emptiness and isolation, sexual confusion, impaired ability to trust, identity and role reversal with the therapist, emotional lability or dyscontrol, suppressed rage, increased suicidal risk, and cognitive impairments.

Schoener[52] reports on a study done by Vinson[53] who investigated 21 women who were treated after ending a sexual relationship with a therapist. His data revealed that large numbers of patients reported "classic" PTSD symptomatology including negative mood (86%), reexperience of the event (67%), loss of interest in previously enjoyed activities (67%), increased irritability (57%), concentration difficulties (67%), exaggerated startle response (33%), and disturbing dreams (14%). In a follow-up two years later, Vinson found that many of these issues remained unresolved.

The studies and case reports cited above suggest that both the seduction process and sexual acting-out of therapists can be damaging to some patients.

In several well-documented instances the damage has been both severe and chronic. Harm to the patient may result directly from substandard care, the stress of the seduction process, and/or the psychic trauma associated with overt sexual contact. Psychic trauma may be present clinically as aggravation of underlying psychopathology, stress-related psychosomatic disorders, posttraumatic stress disorder, suicide and homicide attempts, sexual dysfunction, disruption of support network, and vocational and educational impairment. Furthermore, the rigors of the adversarial legal process may prolong the adjustment process that follows PTSI, and requires longer psychiatric care.

The Treatment of Patients Following PTSI

Most of the published discussions of the treatment of patients following PTSI derive from two sources: the Post-Therapy Support Project of the Psychology Clinic at UCLA[54] and the Walk-In Counseling Center in Minneapolis.[11] As noted earlier, one of the principal ways PTSI damages patients is related to the complexity and difficulty of subsequent therapy. Leupker[55] reports that patients often experience a sense of distrust in themselves and their perception of reality as well as feelings of shame or responsibility for the PTSI. Not surprisingly many of these patients are fearful of seeking professional help and are distrustful of therapists.

The literature does not address the difficulty in finding a therapist to treat the patient after PTSI has been publicly exposed. This may be a problem in situations where the victim may be seen as blameworthy, and the professional community "closes ranks" against a patient who is perceived as a "threat." Therapists may reject the patient based on the perception that they may be prone to make accusations of undue familiarity. Furthermore, therapists may simply refuse to undertake the complexity and strain of working with such a patient following an episode of PTSI. These considerations are critical in small communities where treatment options are limited, and psychotherapists may not be experienced or feel qualified in this specialized area.

Apfel and Simon[56,57] have forewarned therapists working with the post-PTSI patient they may notice ambivalence toward the therapist and the therapy. These reactions may be manifest in the patient switching therapists and delaying needed treatment. Patients who are not ordinarily psychotic may question their sense of reality as a result of the offending therapist's cognitive manipulations during the seduction process. The manipulation and control exercised by the offending therapist over the patient may result in a "bondage" between them that may be explained by the physical commitment that took place in their relationship. Clearly, this situation of bondage can repeat and reinforce pathogenic childhood traumas (e.g., sexual abuse) as well as aggravate the original symptoms that brought the patient to therapy in the first place. The dramatic and abrupt ending of therapy, that is common in PTSI situations, often leaves

patients severely disorganized—struggling with intense rage, guilt, shame—and, severely constricted in their capacity to take risks in new relationships.

The above authors suggest that in working with PTSI patients, therapists and consultants should be aware of their inclination to be skeptical of the patient and/or horrified at the offending therapist's misconduct. It should also be kept in mind that very disturbed, compulsive behavior may be typical in PTSI, and the bizarreness of the patient's description of sexual practices with the previous therapist should tend to confirm rather than weaken the patient's credibility. The consultant's natural curiosity about the details of the history may also present a problem. Thus, it is necessary to keep in mind that overaggressive inquiry into the specifics of the sexual involvement with the therapist may scare the patient off, and questions focused on how the patient happened to go along with the sexual involvement may needlessly aggravate the patient's shame. Although probably vital to long-term recovery, a premature confrontation with the issue of the patient's pragmatic responsibility in the sexual relationship with the therapist should probably be avoided. It is essential that, initially, the consultant strongly condemn the impropriety, destructiveness, and unethical nature of what has happened to the patient. In considering the mode of treatment for the patient, another attempt at individual therapy should not be ruled out, and should be preferable with a female therapist. However, group therapy may be the treatment of choice given that a group made up of individuals with similar experiences may be extremely helpful and validating for the patient.

Two issues require emphasis in long-term recovery: (1) the therapeutic value of legal or administrative actions against the offending therapist; and (2) the question of the patient's pragmatic responsibility (accountability) for the sexual involvement. The formal action against the therapist affords the patient the opportunity to turn passivity into active self-assertion. However, it must be remembered that for those patients seeking legal redress, the court proceedings can seriously complicate recovery and should not be entered into naively. Patients should expect that the offending therapist's defense strategy may include intense and possibly vicious attempts to discredit them, expose their sexual history, attack their support network, and discredit the motives and professionalism of subsequent therapists.[31]

The potentially curative role of written and/or face-to-face amends by the offending therapist to the patient has not been addressed in the literature on PTSI. Ideally, this amend should be a part of the offending therapist's own rehabilitation, and should contain a frank statement of the therapist's motivation and a step-by-step account of the seduction methods he engaged in. After being cleared by the offender's treatment team, this letter could be sent to the patient's therapist for use in her new therapy situation. Furthermore, if believed appropriate by the patient's new therapist, the offender may also be mo-

tivated to make face-to-face amends to his former patient. This process may facilitate the addressing of critical issues in the patients' recovery: (1) to make the difficult distinction between ethical responsibility (culpability) and pragmatic responsibility (accountability); (2) to provide insight into the motives, thoughts, and improper behaviors of the therapist; (3) to accept responsibility for their behavior; and (4) to forgive both herself and the offender, given that chronic resentment toward the offender may be extremely toxic to the patient.

The parallel between incest and PTSI has been established in an earlier section, thus it is appropriate to support the suggestions to use face-to-face amends with the treatment approach for victims of incest and their families proposed by Madanes.[58] It is her conviction that all family members are in some degree implicated in the occurrence of incest, and therefore everyone should participate in the healing process. Her approach, as well as the one proposed above, regards repentance and reparation as an essential component of the offender's rehabilitation and of the victim's recovery from the abuse. One of the steps in her strategy requires from the offender a public expression of sorrow and repentance to the victim. Madanes believes that it is therapeutic for the victim and the offender to go through this ritual; however, she insists that the victim should not be pressured to forgive the perpetrator.

Prevention of PTSI from the Patient's Perspective

The prevention of sexual exploitation of patients by their therapist has been sparsely addressed in the literature. Rutter[5] is the only writer who explicitly addresses the education of patients as a component of a prevention approach. He provides excellent guidance for women regarding the maintenance of boundaries with men in positions of power. He points out that some women do not know that sex with a man who has administrative authority or power over them clearly violates established ethical, moral, and legal guidelines. Once this is recognized, monitoring of the boundary is possible by using intuitive skills and observation of the man's behavior. Taking responsibility for the "shaping" of the boundary on the part of patients moves them from a passive to an active mode. Rutter recommends that women explore these issues with family members, female peers, and support groups. Ideally, a discussion between a male in a power position and the woman in a subordinate position could be initiated by the woman provided that she takes special caution against being interpreted as seductive. If a man in power explicitly challenges a woman's sexual boundary, Rutter urges her to actively defend it both face-to-face with him and indirectly through administrative complaints and legal procedures. An important issue, not adequately addressed by Rutter, has to do with the emerging area of risk management procedures for both institutional settings and private practice to address the sexual abuse issue.[59, 60]

The concept of boundary and dimensions of risk management is thoroughly addressed by Gutheil and Gabbard[6] in

their recent article. In this very timely work these authors discuss extensively the notion of boundary and the obstacles in reaching a clear definition applicable to all psychotherapy situations. They contend that the structural aspects of therapy—such as the role of the therapist, time, place, money, gifts, services, clothing, language, self-disclosure, and sexual contact—represent possible areas of boundary violation. They regard sexual contact between patient and therapist as an extreme form of boundary trespassing, which is usually preceded by the violation of the structural aspects of the therapeutic relationship.

There is a consensus that the great variation exists in the therapeutic relationship from one clinician to the other, and even between patients of a same therapist. Thus, establishing a rigid set of norms about the structural aspects of therapy would not be helpful to the patient, or to the therapist. However, these authors agree with Gabbard and Gutheil[6] that psychotherapists must become educated about the complexity of the issue and must monitor their own behavior and avoid departing from what is considered "usual practice."

In support of the Gutheil and Gabbard position, it is proposed here that the prevention of patient-therapist sexual involvement should begin during the training of clinical practitioners. Issues regarding boundary violation should be incorporated in the curriculum and become part of the ongoing supervision of trainees. It is the responsibility of the mental health professional to observe the ethical norms of clinical practice and respect the right of their patients.

Conclusions

The available research data on the prevalence and consequences of PTSI are limited and of questionable validity. Despite these limitations some tentative conclusions based both on the empirical findings and conceptual considerations are possible:

1. At least 10 percent of male and 3 percent of female psychotherapists will acknowledge being sexually involved with patients, and a sizeable portion of these professionals are involved with multiple patients.

2. There is no clear evidence that the incidence of PTSI has increased over the last two decades, although a dramatic increase has been observed in the number of administrative and legal actions against psychotherapists resulting from PTSI.

3. The traditional concept that transference phenomena render patients incompetent to make informed decisions about boundaries with their therapists is not generally valid. Patients have pragmatic responsibility for any sexual behavior; nevertheless, ethical responsibility (culpability) for PTSI rests entirely with the therapist.

4. There is no credible evidence that sex in the therapy situation is of itself therapeutic or curative; however, there is a good deal of evidence that for an unknown proportion of patients PTSI is harmful.

5. There is no typical patient profile in cases of PTSI; however, patient vul-

nerability both to involvement in PTSI and to damage as a result of it probably varies widely. This vulnerability is probably a result of the interaction of multiple complex factors that cut across traditional diagnostic categories.

6. Damages resulting from PTSI range all the way from no apparent damage to severe damage. The symptom profile of PTSI shows general similarities to that of PTSD, with symptoms that may be relatively transient for some patients and lifelong and devastating for others.

7. The treatment of the patient post PTSI is often difficult and requires special training and abilities on the part of the therapist. Emphasis has been placed on the beneficial effects that group therapy, support groups, legal/administrative actions against the offending therapist, and written and/or face-to-face amends to the patient may have in the patient's recovery.

8. There is a great need for additional empirical research on the consequences of PTSI for the patient. Research suggests that abused patients may not be as inaccessible to be interviewed as it was previously assumed, and given the proper setting, women may readily talk about their sexual experiences with therapists.

9. There is urgency to gain further understanding of the dynamics and characteristics of the offender practitioners to prevent boundary violations in the future.

10. The prevention of PTSI involves both therapist education and risk management strategies implemented by the therapist.

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