Objectives

- Participants will
  - know the prevalence of sexual attraction and sexual contact in therapeutic relationships.
  - be familiar with ethical and legal guidelines regarding sexual contact in therapeutic relationships.
  - understand the dynamics that contribute to sexual attraction in therapeutic relationships.
  - be able to recognize common warning signs of sexual attraction.
  - be able to avoid inappropriate responses and apply appropriate responses when sexual attraction occurs.

Sexual Attraction in Therapy
Part I: Therapists in Love

Bill Finger, Ph.D.
TPA Convention
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Sexual Contact in Psychotherapy:
A Historical Perspective

Is it OK?

In a 1973 study, 20% of psychiatrists reported that sexual contact with patients might be beneficial in certain circumstances.

(Kardener, Fuller, & Mensh, 1973)

“Beneficial” Effects

- improve sexual maladjustments
- especially in the depressed, middle-aged female who feels undesirable
- to teach sexual anatomy
- disclosing areas of sexual blocking
- to relieve frustration in a widow or divorcee who hasn’t yet re-engaged in dating

(Kardener, Fuller, & Mensh, 1973)

More “Beneficial” Effects

- for specific sexual problems (by being a normal partner)
- to demonstrate that there is no physical cause for absence of libido
- in healthy patients by mutual consent making the therapy go faster, deeper, and increases dreams

(Kardener, Fuller, & Mensh, 1973)
Ill Effects for the Client

90% of clients suffered ill effects, including:
• increased depression,
• loss of motivation,
• significant emotional disturbance,
• suicidal feelings or behavior,
• increased drug or alcohol use.

(Bouhoutsos, 1983)

More Ill Effects

• 11% of the 559 cases were hospitalized,
• 1% committed suicide,
• Sexual, marital, or intimate relationships worsened for 26%,
• 48% were suspicious or mistrustful of therapists and had difficulty resuming therapy.

(Bouhoutsos, 1983)

Negative Consequences for the Therapist

• diversion of time and energy from the professional relationship
• loss of therapeutic effectiveness
• self-doubt, frustration, and reduced job satisfaction

Negative Consequences for the Therapist

• loss of job, livelihood, and career
• civil liability, and/or criminal prosecution
• civil liability for supervisors, consultants, and employing agencies

Professional Guidelines

Organizations Prohibiting Sex with Clients

• American Medical Association
• American Psychological Association
• American Psychiatric Association
• National Association of Social Workers
• American Association for Marriage and Family Therapy
• American Association of Sex Educators, Counselors, and Therapists

Bill Finger, Ph.D.
“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 especially from the pleasures of love with women or men, be they free or slaves.”

AMA Ethical Guidelines
- E8.14 - Sexual contact that occurs concurrent with the physician-patient relationship constitutes sexual misconduct. Sexual or romantic interactions between physicians and patients detract from the goals of the physician-patient relationship, may exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's health care, and ultimately may be detrimental to the patient's well-being.

(NASW Delegate Assembly, 1999)

NASW Ethical Guidelines
- Principle 1.09 - Social workers should under no circumstances engage in sexual activities or sexual contact with current clients, whether such contact is consensual or forced.

APA Ethical Guidelines
- Principle 4.05 - Sexual Intimacies With Current Patients or Clients:
  Psychologists do not engage in sexual intimacies with current patients or clients.

Therefore...
- Sexual activity with a current patient is unethical

(American Psychiatric Association, 1998)
**AASECT Ethical Guidelines**

- Principle 3(N) - The member shall not engage, attempt to engage, or offer to engage a consumer in sexual behavior whether the consumer consents to such behavior or not; sexual misconduct includes kissing, sexual intercourse, and/or the touching by either the member or the consumer of the other’s breasts or genitals.

**Sexual Contact in Psychotherapy**

**Sexual Contact with Clients**

- 10.9% of male psychologists and 1.9% of female psychologists reported erotic contact with clients,
- 5.5% and 0.6% acknowledged intercourse.
- 80% who acknowledge sexual intercourse had intercourse with more than one client.

(Holroyd & Brodsky, 1977)

**Reporting Rates**

- Only 4% of clients report sexual contact with therapists
  - Feel powerless
  - Guilt and shame
  - Assume complicity
  - Stigma of therapy
  - Angry with professionals don’t trust the system
  - Unresolved transference
  - Fear of consequences: divorce, custody

(Bouhoutsos, 1985)

**NASW Ethics Cases – 1982-92**

- 29.2% involved sexual misconduct
- Double the rate of the next most common offense
- 18.5% of malpractice cases

(NASW, 1995; Reamer, 1995)
### APA Ethics Cases - 2009

- 33% of ethics complaints resulted from sexual misconduct (5 out of 12)
- No other category accounted for more than three complaints (child custody and non-sexual dual relationships)
- Little change from 2005 (50% or 16 out of 32) or 2002 (53% or 18 out of 34)

### Therapist and Client Gender

- 80-89% male therapist-female client
- 6-13% female therapist-female client
- 4-5% male therapist-male client
- 1-2% female therapist-male client

(Gartrell, 1992; Gonsiorek, 1989)

### Therapist Characteristics

- Majority are older
- 70% maintained a dominant position
- 60% saw themselves in a fatherly role
- Likely to be in the midst of personal crisis
- 90% said they were vulnerable, needy, or lonely
- 55% were frightened by intimacy

(Bouhoutsos, 1983, 1985; Gartrell, 1986)

### Types of Therapist Vulnerability

- Sociopathic or narcissistic character disorder
- Psychotic or borderline personality
- Impulsive or compulsive character disorder
- Severely neurotic and/or socially isolated
- Uninformed/naive
- Healthy/situational breakdown

### Therapist Reactions

- 95% reported feeling conflict, fear and guilt
- 40% sought professional consultation
  - 50% of first time offenders
  - 22% of repeat offenders

(Butler, 1977; Gartrell et al., 1986)

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About half truly believe that they have fallen in love with the client, which is clearly a way to rationalize their loss of self control. Such a rationalization should not obscure the fact that whenever this happens, the psychotherapist has not been able to master his countertransference feelings.

(Marmor, 1972; Gartrell, 1986)
Why is this Happening?

We confuse the prohibition against sexual contact with a prohibition against sexual attraction.

Of 585 psychologists in clinical practice, 87% (97% of the men, 76% of the women) had at times felt sexually attracted to clients

(Pope, Keith-Spiegel, & Tabachnick, 1986)

- 63% felt guilty, anxious, or confused about the attraction,
- 50% believed that their training left them entirely without guidance in this area,
- only 9% considered their training or supervision adequate to this challenge
- 23% believed that such attraction was unethical (30% “unquestionably ethical”)

(Pope, Keith-Spiegel, & Tabachnick, 1986, 1987)

“If training programs, by their behavior and example, suggest that the issue of attraction is to be shunned and that feelings of attraction are to be treated as dangerous and antitherapeutic, it is not surprising that individual psychologists tend to experience feelings of attraction with wary suspicion and unsettling discomfort.”

(Pope, Keith-Spiegel, & Tabachnick, 1986)

Thoughts vs. Behavior

Feelings may be spontaneous, but the act is a choice.
The Slippery Slope

Sexual exploitation rarely comes out of the blue. Sexual misconduct usually begins with relatively minor boundary violations. A direct shift from talking to intercourse is rare; the “slippery slope” is the characteristic scenario.

(Guthell, 1990)

Therapist Warning Signs

- ambiguous verbal communications
- changing to first-name basis
- change from clinical to personal
- voyeurism
- feelings

(Simon, 1995)

Therapist Warning Signs

- ambiguous physical communications
- attire
- physical touch
- trips outside the office
- “chance” meetings

(Simon, 1995)

How to Handle Attraction

- DO control impulsiveness
- DO acknowledge your feelings
- DO confide in your supervisor, peer or professional consultant
- DO express non-sexual caring
- DON’T refer out
- DON’T terminate

More Warning Signs

- financial incentives
- scheduling signs
- isolation
- phone calls after office hours
- considering termination to engage socially
- considering referral to another professional for the same reason

Sex After Termination

- Additional 2.6% of males and 0.3% of the females had intercourse with former patients within 3 months of termination.

(Holroyd & Brodsky, 1977)
Sex After Termination

• Principle 1.09(d) - Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client. If social workers engage in conduct contrary to this prohibition or claim that an exception to this prohibition is warranted because of extraordinary circumstances, it is social workers—not their clients—who assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally.

(National Association of Social Workers, 1999)

Sex After Termination

• Principle 4.07 - Sexual Intimacies With Former Therapy Clients: Psychologists do not engage in sexual intimacies with a former therapy patient or client for at least two years after cessation or termination of professional services.

(American Psychological Association)

Sex After Termination

• Section 2.1 Annotations for Psychiatrists: Sexual activity with a current or former patient is unethical (emphasis added)

(American Psychiatric Association, 1998)

Sex after Termination

• Sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship.

(American Medical Association, 1992)

Sex After Termination

• Principle 3(N) - For purposes of determining the existence of sexual misconduct, the counseling or therapeutic relationship is deemed to continue in perpetuity.

(American Association of Sex Educators, Counselors, and Therapists)

Neither transference nor the real inequality in the power relationship ends with the termination of therapy. The notion that exceptions can be allowed in the name of love or marriage reveals either a naive romanticism or an insufficient understanding of the nature of the therapeutic relationship or both. Efforts to define a post-termination waiting period disregard both the continued inequality of the roles of the therapist and former patient and the timelessness of unconscious processes...

(Herman, Gartrell, Olarte, Felson, and Localio, 1987)
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Part II: Clients in Love  
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Only 6-31% of sexual contact in therapeutic relationships is initiated by the client (it depends on who you ask)  
(Bouhoutsos, 1983; Gartrell, 1986)

• 73% of practitioners were told by a client that he or she was sexually attracted to the therapist.  
(Pope and Tabachnick, 1993)

Why is this Happening?  

Here are two people who meet repeatedly, in some cases frequently, to discuss things that people usually talk about only with their most trusted intimates (if at all). They are alone together and may sit close to each other. The client tends to be in an emotionally vulnerable position, expressing needs for closeness, caring, nurturance, and love.

Why is this Happening?  
The client views the therapist as someone who is caring, non-judgmental, trustworthy, sincere and understanding. The client can easily confuse this caring with love, and with little context provided, the client can easily perceive the therapist as an ideal (sexual) partner.

Client Motivations  
• Special attention or nurturance  
• To divert attention from treatment issues  
• To establish an alliance  
• To restore balance  
• To gain strength through a more powerful person  
• To test for safety  
• Avoidance of termination  
(Alperstein, 1999)
Client Warning Signs

- Preference for therapist of one sex
- Edited self-presentation
- Voyeurism
- Extracurricular contacts
- Body language
- Spoken invitations
- Verbal exhibitionism

Client Seduction

- Some clients can be expected to act seductively, deceptively, and destructively because this is how they act in their everyday relationships. However, "it is no more reasonable for the therapist to respond to the seductive behavior than to join a violent patient in smashing windows."

More Client Warning Signs

- Modifying context:
  - Gifts
  - Requests for more time or different time
  - Requests for different setting
  - modifying environment
  - dual relationships

What shouldn’t you do?

- Ignore or avoid the attraction
- Exhibit shock or discomfort
- Belittle or criticize for vocalizing the attraction
- Shame, blame, or reject the client
- Equivocate in saying no

Responding to Client Attraction

- #1: Validation of Expression
  - Normalize sexual attraction as natural
  - Value the client’s honesty
  - Validate the client for fulfilling the contract
  - Reflect the client’s experience of therapy
  - Reassure the client of safety

- #2: Emphasize prohibition
  - State unambiguously
  - Explain it is for protection of client
  - Experiencing vs. acting
  - Redirect the sexual desire
## Responding to Client Attraction

### #3: Clarification and Interpretation
- Caring vs. sexuality
- Professional vs. personal
- Previous relationship patterns and current attraction
- Explain transference

### #4: Exploration of feelings
- Inquire about the client’s history
- Explore the timing of the emergence of sexual feelings
- Explore how these feelings can be addressed in future sessions