SEXUAL ABUSE BY THERAPISTS: MAINTAINING THE CONSPIRACY OF SILENCE

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ABSTRACT

The mental health professions are reluctant to admit, and quick to minimize or deny, therapist sexual abuse. Constructive action will be facilitated by understanding the ingredients of this "conspiracy of silence": the belief that it only happened in the '60s and '70s, a we-they attitude to abusers, professional protectionism, denial of sexual attraction to clients, trivialisation, idealization of therapist-client sexual contact, victim-blaming, and the myriad fears and other feelings that hinder client disclosure.

INTRODUCTION

Despite the Hippocratic Oath, Freud's dire warnings, codes of professional ethics and statements of professional organizations, studies of mental health professionals have indicated that a substantial number have sexually exploited their clients/patients. Masters and Johnson (1970) were the first to bring attention to this widespread problem. In 1973 an anonymous questionnaire survey of male physicians in California indicated that 20% of the psychiatrists responding believed that erotic contact with patients may sometimes be beneficial. Five percent of the psychiatrists admitted to sexual intercourse with patients (Kardener, Fuller, & Mensh, 1973). A random sampling of U.S. women physicians reported no sexual intercourse with patients, although 83% believed that non-erotic contact was sometimes appropriate (Perry, 1976). Studies of psychologists yielded similar results. Holroyd and Brodsky (1977) had a 70% return rate with a random sample of 1000 psychologists in 50 states. Sexual intercourse with patients was admitted by 5.5% of males and 0.6% of females. "Erotic practices" were acknowledged by 10% of males and 1% of females.

In the mid-'80s a survey of U.S. psychiatrists reported that 7.1% of males and 3.1% of females admitted sexual contact with their patients, and that 88% of the involvement was between male psychiatrists and female patients. All offenders involved with more than one patient were male (Gartrell, Herman, Olarte, Feldstein, & Localio, 1986). In a 1986 mail survey of U.S. psychologists in private practice 9.4% of males and 2.5% of females acknowledged sexual contact with clients (Pope, Keith-Speigel, & Tabachnick, 1986). A survey of U.S. social workers, done in 1984, indicated that 3.8% of male social workers had erotic contact with clients. Hypothesizing about the lower incidence in this profession, Gechtman (1989) notes that social workers are more likely to practice in institutional or agency settings, and that men in social work are more likely to possess

"feminine" characteristics of sensitivity, caring, and responsibility; thus being less likely to exploit clients.

The amount of sexual involvement of hospital staff with patients (Collins, 1989), and the abuse of the chronically mentally ill for "quickie" sex (Stone, 1976) is likely to be extensive but harder to document.

With a few exceptions professional concern about these findings has been minimal until public outcry, court cases, documentaries, magazine articles, books written by survivors, and pressure from consumer groups has forced professional organizations and licensing bodies to form task forces and committees and to reissue statements of professional ethics. At the same time a "backlash" can be discerned which argues that clients are fabricating and mountains being made of molehills. To understand the general lack of concern, and the mounting disbelief about the magnitude of the problem, it is necessary to understand factors contributing to the "conspiracy of silence"; issues which will be raised again and again to defuse the outcry and set the therapist-patient relationship back on its pedestal.

FACTORS MAINTAINING THE "CONSPIRACY OF SILENCE"

"It only happened in the '60s and '70s and we're still getting the fallout."

Those favouring this sentiment point out that only two publications expressly recommended sexual intercourse with patients and both stemmed from this time period (McCartney, 1966; Shepard, 1971). Sexual mores were changing and some mental health professionals became involved in a variety of "fringe" treatments such as nude marathons and other "human potential" therapies (Butler & Zelen, 1977; Forer, 1969; Stone, 1984).

This view is contraindicated by other writers such as Davidson (1977) who dates concern about male physician/woman patient relationships back to Mesmer, an 18th century Viennese physician and magnetist. He became permanently estranged from his wife while treating a blind woman pianist (Ellenberger, 1970). Some 100 years later the erotic attachment of his patient, Anna O., caused trouble in the marriage of another Viennese physician, Josef Breuer. The recent publication of Sabina Spielrein's papers has demonstrated that Jung seduced one of his first analytic patients (Carotenuto, 1982). According to McCartney (1966), Karpman, Boss, Alexander, Hadley, and Sullivan all allowed their patients to "act-out physically."

Freud (1915/1963) was well aware of the vicissitudes of "transference-love" and warned that the analyst "must recognize that the patient's falling in love is induced by the analytic situation and is not to be ascribed to the charms of his person, that he has no reason whatsoever therefore to be proud of such a 'conquest' as it would be called outside analysis" (p. 169). He stressed that the analyst's countertransference must never be acted out, emphasizing "If her advances were returned, it would be a great triumph for the patient, but a complete overthrow for the cure. . . . The love relationship actually destroys the influence of the analytic treatment on the patient: a combination of the two would be an inconceivable thing." Despite these warnings, Ferenczi, a disciple of Freud's,

believed that emotionally deprived patients needed nurturing and began to experiment with hugging and kissing his female patients. Freud warned him, prophetically, that others would use the same rationalization to go even further with their patients (Jones, 1967).

So it would appear that sexual attraction, and temptations to consummate the relationship, are not limited to the era of "sexual liberation."

Mental Health Professionals Who Abuse Are Total "Bad Apples" and Bear No Relationship to the Rest of Us

This convenient belief is fuelled by the few cases of repeated sadistic sexual abuse by therapists whose cruel and often bizarre behaviour seems far removed from that of a caring and compassionate therapist (Freeman & Roy, 1976; LeBourdais, 1991; Plasil, 1985). It is easy to write these people off as sociopaths and espouse a we-they philosophy, a contention that can be found in some of the literature (Bolker, 1990).

Various attempts have been made to develop typologies of abusers and to delineate underlying motivations. Butler and Zelen (1977), who interviewed 20 psychiatrists and psychologists who admitted to sexual intimacy with patients reported that 80% of those interviewed could not recall the events that led up to the sexual contact. At the time they felt vulnerable, needy, and lonely. Stone (1984) described six types of abusive therapists: middle-aged depressed, bad character, perverse sexual fixation, sexually liberated, grandiose, and withdrawn-introverted. In their book *Sexual Intimacy between Therapists and Patients*, Pope and Bouhoutsos (1986) developed 10 scenarios that lead to abuse.

In an earlier paper (Penfold, 1987) I argued that sexual abuse of women patients is merely the tip of the iceberg and is a product of a much more general and widespread problem. I contended that sexualization of the therapist-woman patient relationship is an expectable outcome of the therapist-patient power differential, the mystique within which the mental health professional functions, victim-blaming sentiments, prevailing stereotypes about expected behaviour for men and women, and the self-protective stance of the professions. These dimensions were derived from interviews with women patients and ex-patients who described experiences with therapists who were sexually abusive, flirtatious, or whose attitudes seemed to replicate male-female relationships in society.

Obstacles Created by Professional Bureaucracies and Societal Institutions

The barriers to reporting sexual abuse are daunting to client and professional alike. Patients are made to feel like criminals, and the mental health professional's attempts to report are made to seem unethical (Stone, 1984). In the documentary "My doctor, my lover," the victim's second psychiatrist, Dr. Martha Gay, providing treatment subsequent to the original abuse, was forced to leave the local ethics committee, and eventually, because of dwindling referrals, had to give up her practice in Denver and move to another city. One victim told me that the proceedings of the College of Physicians and Surgeons Board of Inquiry was "like another abuse." Other victims wrote letters of complaint, but

when invited to the college for an interview and faced with a male investigator, they were intimidated and decided not to proceed. The woman victim of a woman psychologist complained that the local ethics committee, all male, did not take her seriously. When complaining to such organizations women experience harassment, repeated challenges to their credibility, and humiliating interrogations about their past sexual relationships.

Within most sizable communities of mental health professionals there are tales of therapist-client marriages, elopements and "affairs," and carefully guarded "blacklists" of those who are known to sexually abuse clients. Vague rumours and gossip abound. It is easy to do nothing when a patient complains of abuse by a previous therapist, using the rationale of protecting a client's confidences (Stone, 1984).

Gartrell, Herman, Olarte, Feldstein, and Localio (1987) found that, of the 1,423 U.S. psychiatrists responding to a national survey, 65% reported they had treated patients who had been sexually involved with their previous therapists. The psychiatrists assessed these involvements as harmful for 87% of the patients, but reported only 8% of the cases. The reasons for not reporting included: viewing the information as "hearsay," disbelieving the patient, avoiding knowing the name of the abusive psychiatrist, and fearing retaliation by the offending psychiatrist. The researchers emphasized a disconcerting finding, that offenders appeared to be the most likely respondents to have treated previously sexually involved patients. This suggested that offenders might be referring patients with whom they had been sexually involved to colleagues who might be sympathetic because they too were sexually abusing patients.

The Myth that Mental Health Professionals Never Feel Sexually Attracted to Clients

Mental health professionals are sometimes visualized as benign, compassionate eunuchs far removed from the trials and tribulations of ordinary mortals. Conceived of, and indeed viewing themselves as, dedicated and nurturing parent figures, the thought of being sexually attracted to clients seems to bear no relation to their every day functioning. This belief is carried over into training programs where trainees describe little or no training about therapist-client sexual attraction (Carr, Robinson, Stewart, & Kussin, 1991; Gartrell, Herman, Olarte, Localio, & Feldstein, 1988; Pope et al., 1986).

Pope et al. (1986) relate this failure of training systems to acknowledge and examine the phenomenon of sexual attraction to clients to earlier negative views of countertransference. Viewed as a manifestation of therapist conflict, countertransference was thought to be an irrational or inappropriate response on the part of the therapist. Analysts strove to be "blank screens" and their attitudes toward patients were unnatural and stilted (Thompson, 1950). Trainees reporting erotic responses to patients were assumed to have countertransference problems or to have been seductive themselves.

Despite this attitude of moral righteousness, it seems likely that in some training institutions, as in incestuous families, a hotbed of sexual harassment and exploitation seethed below the surface (Pope, Levenson, & Schover, 1979). Educators' exhortations to behave in a correct professional manner with clients

may have been belied by their tendency to harass, proposition, and seduce their trainees. Over the last decade the once taboo topic of therapist-client attraction has begun to be discussed. Pope et al.'s (1986) survey of 575 psychotherapists demonstrated that 87% had felt sexually captivated by their clients. Of these respondents 63% reported feeling anxious, guilty, or confused about the attraction.

It seems likely that training institutions' failure to discuss educator-trainee sex and therapist-client sex are inter-related and that both represent society's tendency to ignore, trivialize, or minimize the abuse of power by those in positions of authority.

Trivialization

Several varieties of this occur. In one form therapist-client sex is conceptualized as a relationship between two consenting adults. For instance, in a column about doctor-patient sex in a recent issue of *The Medical Post*, psychiatrist Clements (1991) argues that the term "victim" is degrading to the patient. Clements says "taking money from clinical care to police the behaviour of two competent adults seems a very unethical choice" (p. 18). This view ignores the vast power differential between doctor and patient and the mystique of medicine that orchestrates patient compliance. When applied to psychiatrist-patient relationships, the added issue of transference and the expectation that patients will bare their most personal and hidden secrets make the relationship even more one-sided and the betrayal of trust even greater (Sreenivasan, 1988).

A related issue is the belief that a sexual relationship is acceptable if the client initiates it, or gives consent. This contention is sometimes raised by defence lawyers (Pope & Bouhoutsos, 1986). Clients often "fall in love" with their therapist, who, as a parent-figure and a repository of erotic transference, is the subject of child-like incestuous longings. Clients may try to induce the therapist to consummate their "love." As Freud warned, acting out the patient's erotic transference destroys the therapy. The client's sexual feelings, provocativeness, or outright propositions are all indicators of their self-concept, habitual patterns of interacting, problems in intimate relationships, and so on. As such they are grist for the therapeutic mill.

Jokes made about therapist-client sex allow us to understand important and ugly underlying dimensions. Cultural beliefs about women as sex objects and man's natural prey, and the depiction of women who assert themselves or pit themselves against male entitlement as nags, shrews, or frustrated, unfulfilled spinsters are laid bare. Davidson (1977) pointed out that the cultural perception that doctors avail themselves of female patients is reinforced by drug advertisements portraying scantily clad women. One woman psychologist told me that her male colleagues contended that the "real problem" about therapist-client sex is "women psychologists making a fuss." I personally overheard two male colleagues discussing a woman psychiatrist who was speaking out on the subject of doctor-patient sexual abuse. Noting that she was about to get married, they said "Now she'll stop hounding all those poor guys."

The Belief that Therapist-Client Sex Is Beneficial

Surveys show that, despite considerable public airing and reaffirming of codes of ethics, a few therapists persist in thinking that sexual involvement is helpful to the clients. In Kardener et al.'s (1973) survey 20 psychiatrists believed that erotic contact with patients may sometimes be beneficial. Explanations given included "improves sexual maladjustments," "especially in depressed middle-aged women who feel undesirable," and "in healthy patients by mutual consent making the therapy go faster, deeper and increases dreams" (p. 1079). Similarly the psychologists surveyed by Holroyd and Brodsky (1977) suggested erotic contact might be used to treat sexual problems, broaden experiences, enhance self-concept, and develop mutual positive regard.

In the 1980s few therapists maintained erotic contact could be beneficial. Only two percent of the U.S. survey of psychiatrists (Herman, Gartrell, Olarte, Feldstein, & Localio, 1987) thought sexual contact in therapy may be appropriate. The reasons given included "to enhance the patient's self-esteem," and "to provide a restitutive emotional experience" (p. 165). Examining such rationalizations Marmor (1976) noted that most erotic breaches of the relationship between therapist and patient occur with an older male therapist and a physically attractive female patient, and almost never with a patient who is ugly, aged, or infirm.

Beliefs that sexual contact is beneficial, or its effects similar to an involvement between two consenting adults is contradicted by studies that show victims are significantly damaged or even devastated. Of the 90% who describe damage, 11% require hospitalization, and 1% commit suicide (Bouhoutsos, Holroyd, Lerman, Forer, & Greenberg, 1983). Durre (1980) described many instances of mental hospitalization, ECT, marital breakdowns, being fired or having to leave jobs, crying spells, anger and anxiety. Pope (1989) has proposed a "Therapist-Patient Sex Syndrome" with at least 10 major damaging aspects: ambivalence, guilt, emptiness and isolation, sexual confusion, impaired ability to trust, identity and role reversal, emotional lability or dyscontrol, suppressed rage, increased suicidal risk, and cognitive dysfunction.

Victim Blaming

Our society has a long tradition of blaming victims (Ryan, 1976). With women this started with Eve. The old saying "Hell has no fury like a woman scorned" seems to underlie findings by courts and ethics committees that conclude that the woman complainant's "false allegations" were a vindictive retribution for her therapist's perceived disinterest or rejection. Or the complainant's descriptions are conceived of as hysterical fantasies, delusional ideas, or the manifestations of a borderline personality (Gutheil, 1989). Stating that "no women who consulted me were fabricating," psychiatrist Stone (1984) calls this preoccupation with false allegations "the professions' own wish fulfilling fantasy" (p. 192).

Even when the therapist's sexual violation is recognized, formulations tend to revolve around the supposed psychopathology and other characteristics of the victim, often giving the impression that the hapless therapist falls into the clutches of a borderline patient who is "particularly likely to evoke boundary violations,

including sexual acting out" (Gutheil, 1989), or a patient who "has a penchant for seducing professional men" (Medlicott, 1968). "Fatal attraction" (Carr & Robinson, 1990), the unfortunate title of one recent paper, conjures up visions of this popular movie's predatory, unbalanced, and ultimately murderous woman villain stalking her male victim, a very reasonable man who succumbed to a passing impulse.

While some authors describe victim risk types (Kluft, 1990; Pope & Bouhoutsos, 1986), Schoener, Milgrom, Gonsiorek, Luepker, and Conroe (1989), considered by most to be the North American authorities on this topic, state "There are no data in the literature to show that any client characteristic predicts sexual involvement with a therapist" (p. 45). Rather, they postulate, therapist characteristics are the main predictors.

Victims' Feelings

Like professionals and the general public, victims are also caught up in pervasive victim-blaming. As with rape, the victims of therapist sexual abuse may feel they are partly to blame, that they have done something to "cause" their seduction (Davidson, 1977). The perception of the therapist as a parent figure, secrecy, reframing of the sexual activity as "helpful," role reversal and focus on the therapist's needs, and the extreme inequality of the relationship are similar to parent-child incest. When the abusive "therapy" ends, many victims are left feeling grateful, nurtured, and special. Even when the realization that they have been duped and used (Bouhoutsos, 1985) begins to creep in, victims, still loyal to their therapist, tend to rationalize, compartmentalize the sexual involvement, and believe that most of their therapy experience was helpful. Eventually they realize their trust was betrayed (Marmor, 1976), that pre-existing problems were not solved, and a new set of difficulties were created (Feldman-Summers & Jones, 1984).

Some victims, particularly those who were not subjected to bizarre practices or where the sexual relationship may have seemed to be mutually desired, may take many years to reach this point. The problems created by the sexual abuse, including pervasive self-doubt about their own judgement, perceptions, and motives interdigitate with victim-blaming to make the next step very difficult. Quite rightly, victims fear the consequences of disclosure. They hear tales of husbands divorcing client-wives, of children being taken away, and of their humiliating sexual secrets being made public. They are afraid that they will be trivialized, demeaned and blamed; that their friends, relatives, and children will be shocked and horrified, and possibly reject them.

Some of these fears were made explicit in the recent U.S. documentary "My doctor, my lover" (U.S. Public Broadcasting Service, 1991). Psychiatrist Jason Richter and his lawyer subjected his ex-patient Melissa Roberts-Henry to an extremely demeaning and intrusive cross-examination about past sexual relationships, using confidential information that Richter had obtained during the therapy. Although Roberts-Henry was awarded a settlement, she was portrayed as using it all on legal costs and further therapy, and as barely hanging on to her marriage. Richter, whose costs and the settlement are all covered by insurance, is seen to escape with no consequences at all, while the woman psychiatrist Martha

Gay, Roberts-Henry's second therapist, is subjected to scapegoating by the psychiatric community and forced to move to another city.

In my own case, victim of sexual abuse by a Seattle psychiatrist from 1968-1972, I began to realize that I had been exploited by 1974 and wrote him an angry letter; later, in 1976, confronting him in his office. At that time I was afraid that public disclosure would affect my reputation and career far more than his, and also struggled with many feelings of self-blame, intense shame, and humiliation. It was nine more years before I started sharing my experiences with women's groups, and only during the last couple of years have I disclosed my abuse to the media and professional audiences and made a report to the Washington State Board of Medical Examiners.

CONCLUSION

The "conspiracy of silence" has reinforced and perpetuated the damage that has accrued to victims of sexual abuse by therapists. While Alan Stone (1984) has credited the women's movement with bringing this issue into the public eye, it must not be seen as a "women's issue" alone. Indeed several male researchers and authors, Stone himself, Gary Schoener, Kenneth Pope, and Judd Marmor have written forcefully about this widespread betrayal of trust, this abuse of women, some children, and a few men, which is taking place in the name of "therapy." When societal determinants, and issues of power and inequality are examined it becomes clear that sexual abuse by therapists is yet another form of violence toward women, children, and vulnerable adults. Like rape, wife battering, and child sexual abuse, it is papered over by mythology about how the victim "asked for it," "needed it," "provoked it," "was seductive," "deserved it," "liked it," "was sexually titillated by it," "was better off for it," and so on.

Awareness of the "conspiracy of silence" is a necessary prerequisite to constructive action by mental health professionals, our professional organizations, and training institutions. Sexual abuse of clients is rooted in the mystique of therapy, the power differential between therapist and client, society's penchant for blaming victims, taboos against the discussion of sexual attraction during training, the mental health professions' self-protective stance, and in cultural expectations for men and women. Training, for mental health professionals, must provide an understanding of this context. Issues of sexual attraction must be confronted and discussed. Professional organizations, on a national and provincial basis, need to develop comprehensive guidelines (e.g., Independent Task Force commissioned by the College of Physicians and Surgeons of Ontario, 1991) including continuing education, consumer education about clients' rights and expectations for therapy, reporting processes that facilitate complaints from victims and other professionals, support for victims, and appropriate sanctions for offenders. To ensure that consumers are being protected, monitoring of the professional organization by an outside body, such as a provincial Ministry of Health, is essential.

As therapists we must resist the tug of the "conspiracy of silence," and work on individual, community, and professional levels to ensure that therapy does not violate, and is a truly empowering, demystifying, and growth-promoting experience for those who seek our help.

RÉSUMÉ

Les professionnels de la santé mentale admettent difficilement l'existence d'abus sexuels de la part des thérapeutes, ils minimisent rapidement le fait ou le nient. On pourra plus facilement penser à une action constructive si l'on comprend les paramètres de cette «conspiration du silence» : la croyance que cela n'arrivait que dans les années 60 et 70, une attitude de distanciation (nous) face aux personnes abusées (elles), le protectionnisme professionnel, le déni d'une attirance sexuelle pour les clients, la banalisation, l'idéalisation du contact sexuel entre client(e) et thérapeute, l'imposition du blâme sur la victime, une multitude de craintes et de sentiments mélangés qui empêchent la divulgation des faits par les client(e)s.

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