Professional Psychology: Research and Practice
1999, Vol. 30, No. 5, 504-509

0735-7028/99/$3.00

Therapist–Client Sex: Clients' Retrospective Reports

Eli Somer
University of Haifa and Maytal—Israel Institute for Treatment and Study of Stress

Meir Saadon
Maytal—Israel Institute for Treatment and Study of Stress

Therapists will be more effective practitioners when they understand the factors that contribute to sexual boundary violations. The authors' interviews with former victims indicated that offending therapists were mostly reputable psychologists working alone, and that boundary violations developed gradually. The clients were often victims of child sexual abuse. Many reported pleasurable feelings during the affair but saw the experience as hurtful or exploitative in retrospect. The authors' findings imply that practitioners should minimize seemingly innocuous physical consolation or self-disclosure, especially with survivors of child abuse. They are encouraged to select offices with other professionals and to participate in peer-supervision activities.

Professional psychologists are cautioned, first in training and later throughout practice, against sexual involvement with clients. However, they are also not fully informed about how to avoid being drawn into such relationships because so little is known about the factors putting therapists, as well as clients, at risk.

Most previous studies of therapist–client sex focused on the beliefs and behaviors of psychotherapists (e.g., Gartrell, Herman, Olarte, Feldstein, & Localio, 1986). Despite wide agreement that such a relationship is never acceptable, the history of psychoanalysis and psychotherapy is laced with anecdotal, clinical, and empirical data attesting that the problem has always existed (e.g., Carotentuto, 1982; Grosskurth, 1991; Mahler, 1988). Since the early 1970s, the problem has received considerable attention in the United States (e.g., Chesler, 1972a; Pope, Sonne, & Holroyd, 1993). Early data indicated that approximately 10% of male respondents admitted that they had engaged in some form of sexual behavior with at least 1 patient (e.g., Holroyd & Brodsky, 1977), whereas later findings indicated that only 2–3% of the respondents engaged in sexual contact with patients (e.g., Pope, Tabachnick, & Keith-Spiegel, 1987).

No typical profile of patients who become sexually involved with their therapists (therapist–client sex; TCS) has been empirically established, and the process leading to this ultimate boundary violation in psychotherapy remains unclear. The meager research has searched for transference patterns gone awry. Robertiello (1975) described 8 TCS patients who were high-functioning, with a stable background of childhood and current family life, but Pope and Bouhoutsos (1986) suggested that TCS patients frequently entered therapy following a relationship trauma (p. 48). Such traumata can create a vulnerability that might be abused by erotic therapists. Other investigators of TCS patients have described some of the risk factors. Several feminist authors identified stereotypically feminine characteristics, such as other-directedness, little self-regard, and little acceptance of their own aggression (Belote, 1974; Chesler, 1972b).

Survivors of incest may be at especially high-risk of becoming TCS patients (Pope & Bouhoutsos, 1986), because they possess a limited repertoire of available adjustment patterns. Marmor (1972) likened therapist–patient sex to incest. Behavior patterns that served well for survival in childhood became less adaptive as adults: Incest victims learn to accept the blame for early abuse and later learn to exonerate the adult offender (Pope & Bouhoutsos, 1986, p. 53). Kluft (1990b) explored the circumstances of 12 female TCS patients and found that they all had experienced incest as children. In a separate study (1990a), Kluft investigated 18 cases of incest victims who developed dissociative disorders and had been sexually exploited by psychotherapists. Seventy-eight percent of these patients had also been raped as adults. All suffered ongoing dissociative symptomatology that interfered with their senses of control of their lives, and they ablated their memories in ways that rendered them incapable of accurate assessment and appropriate reaction to high-risk situations. Kluft (1990a) identified this pattern, associated with increased vulnerability to revictimization, as the "sitting duck syndrome" and argued that it embodies a repetition compulsion. He suggested four predictors of patients' sexual involvement with their therapists: (a) severe dissociative and posttraumatic psychopathologies, (b) identifications with their assailants, (c) family dynamics that discourage appropriate self-care, and (d) traumatic deformation of the observing ego.

The Israel TCS Victims Study

The current study was undertaken to enhance our understanding of the process leading to sexual boundary violation in psychother-

ELI SOMER received his PhD in 1984 from the University of Florida. He is a senior lecturer at the University of Haifa Faculty of Social Welfare and Health Studies, and clinical director of Maytal—Israel Institute for Treatment and Study of Stress.

MEIR SAADON received his PhD in 1995 from the University of Haifa. He is an associate faculty member at the University of Haifa Faculty of Social Welfare and Health Studies and director of training at Maytal—Israel Institute for Treatment and Study of Stress.

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Eli Somer, Maytal—Israel Institute for Treatment and Study of Stress, 3 Maayan Street, Haifa 34484, Israel. Electronic mail may be sent to somer@research.haifa.ac.il.

apy from the perspective of former sexually exploited patients solicited as participants from the general population. We also thought it would be helpful to assess how the experience of sexual misadventure changed over time and anticipated that retrospectively reported symptoms of TCS patients would be perceived as worse following the eroticized therapy.

An ad headlined "Research on sexual relationships in psychotherapy and counseling" was published in three leading national newspapers, as well as local papers in Tel Aviv and Haifa, and in several women's feminist and gay magazines. The ad invited women and men who had been involved in such relationships to be anonymously interviewed for the study. Interviews could be face-to-face, with a male or a female interviewer, by telephone, or in writing, without any direct contact with the research team. Each caller who agreed to participate in the study was read or given an informed consent form approved by the university's subcommittee on evaluation of human subject research in the behavioral sciences. Participants were asked not to identify their offending therapists. Our refusal to accept disclosure of the identities of the therapists involved, and hence the preclusion of causing them possible harm, helped, in our view, to curb vindictive fabrication of the information shared with us.

Thirty-five people responded to our ads. Nine respondents asked that we mail them research questionnaires. Four of these declined to participate and did not send data back to us. The responses of our only male respondent (who chose not to have a face-to-face interview, but to reply in writing) were set aside because we questioned their reliability. The data from 3 other interviews were not included because we judged them as relating to therapies with faulty treatment boundaries, nonerotic dual relationships, and erotic transference. None of these interviews contained information on therapist–patient sexual contacts. Our final sample consisted of 27 women. We interviewed 22 women by telephone, while 3 preferred to be interviewed in writing, and 2 held face-to-face interviews.

Control participants were 26 consecutive female patients who followed a standard intake procedure at the Haifa-based office of Maytal—Israel Institute for Treatment and Study of Stress (IITSS). Fourteen controls met *DSM–IV* (*Diagnostic and Statistical Manual of Mental Disorders,* 4th ed., American Psychiatric Association, 1994) criteria for anxiety disorders, 6 received V-code diagnoses relating to relationship difficulties, 4 suffered from personality disorders, and 1 control participant was admitted with the diagnosis of adjustment disorder with depressed mood. Tests of differences between group means and proportions (*t* tests, chi-square) of major demographic variables (age at the time of therapy, educational level, and professional group) found no differences and confirmed the similarity of the two groups.

We used three assessment tools: (a) Sexual Intimacy in Psychotherapy Questionnaire (SIPQ), (b) Traumatic Experiences Questionnaire (TEQ; Nijenhuis, van der Hart, & Van der Linden, 1996) and, (c) Structured Clinical Interview for *DSM–III–R* (SCID; Partial). The SIPQ is a 36-item questionnaire developed by the authors (21 open-ended questions and 15 structured questions), eliciting demographic information and inquiring about the offending therapists' gender, age, mental health profession, duration of therapy, estimated number of sessions, and date of the last professional encounter. Participants were asked to note any special therapeutic techniques used. Other items addressed the physical setting of the treatment, referral source, reasons for that referral, any changes in location or hour of the sessions introduced prior to the sexual intimacy, and any reasons that might have been given to explain such changes. Respondents were asked to describe the process that eventually led to the sexual intimacy; thoughts and feelings during the affair; current reflections on the affair; what became of the therapy once sexual intimacy started; how the relationship ended; if subsequent treatment was sought, then how the therapist was chosen; and positive and negative outcomes of that therapy.

The TEQ is a 30-item instrument by Nijenhuis, van der Hart, and Van der Linden (1996). It was chosen because of its convincing face validity. The TEQ's English language version was translated into Hebrew, and then was translated back by a different person into English. Any discrepancies between the two English language versions were corrected by altering the mistranslated Hebrew item. Respondents were requested to identify whether they had experienced various traumatic situations, the developmental stage of the respondent when victimized, the duration of the trauma and it's impact on the individual.

The SCID (Spitzer, Williams, Gibbon, & First, 1990) follows closely the diagnostic criteria of the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed., rev.; *DSM–III–R;* American Psychiatric Association, 1987), and now the *DSM–IV* (American Psychiatric Association, 1994). SCID modules for assessing major depression, generalized anxiety disorder, posttraumatic stress disorder, somatoform disorders, sexual dysfunctions, sleep disorders, and eating disorders were used. The modules were translated into Hebrew by the same procedure applied for translating of the TEQ. Although many respondents had terminated their treatments long before this study was conducted, we were interested in their current assessments of their mental conditions during the year preceding the treatment and during the time that followed it. Therefore, for each diagnostic item they endorsed, respondents were also asked to provide two 5-point Likert scale scores to reflect the severity of each endorsed symptom, from 1 (*not distressful*) to 5 (*extreme*), in the two corresponding periods (before and after the treatment).

To control for the effect of developing trust in therapy as a facilitating factor in disclosing traumatic memories, we decided to contact the therapists of our comparison group 7 months following the initial collection of data to inquire about delayed disclosures of past trauma.

The offending therapists included the following: 15 clinical psychologists, 4 counselors, 4 social workers, 3 psychiatrists, and 1 art therapist. The former patients' descriptions of the therapeutic techniques included the following: 13 traditional–psychodynamic, 5 expressive, 4 supportive, 3 cognitive–behavioral, and 2 consultative. The elapsed time between the last sexual encounter with the therapist and our research interview was 7.7 years on average (SD = 8.4, range = 0.1–27.0). The average age of the offending therapists was 47.5 (SD = 9.3), and their age span was 30–70. The age range of the patients was 19–46, with a mean age of 32.5 (SD = 8.5).

Sixty-three percent (N = 17) of the offending therapists were chosen because they were recommended by family members or friends, 6 (22%) were referred by other mental health professionals, 3 (11%) were known to the respondents as renowned or reputable professionals, and only 1 (4%) therapist was picked from the *Yellow Pages.* Twenty-one (78%) treatments were conducted

in a private practice setting, and 6 (22%) in a managed are setting (e.g., community mental health center). In all but 5 treatments (81%), no other person was ever present during the therapy hour in the office suite or home in which the therapy took place. Respondents gave multiple reasons for entering therapy. Ten respondents (37%) had been depressed, 9 (33%) wanted to work on their lowered self-esteem, 6 (22%) needed to process issues relating to trauma and loss, 2 (7%) were concerned about their disordered eating behaviors. Twenty former patients (74%) also wanted to solve problems they had encountered in their interpersonal relationships.

To estimate possible *DSM–IV* (American Psychiatric Association, 1994) diagnoses of our respondents prior to their exploitative therapies, we considered only symptoms that were retrospectively salient enough to be ranked 3 or higher on a 5-point severity scale. An examination of retrospective self-descriptions of the conditions that motivated them to seek help revealed that 8 respondents (30%) may have initially met *DSM–IV* (American Psychiatric Association, 1994) criteria for posttraumatic stress disorder, 7 (26%) possibly suffered from major depression, 4 (15%) from eating disorders, 3 (11%) may have met the diagnostic criteria for generalized anxiety disorder, 3 (11%) probably suffered from sexual dysfunction, 3 (11%) from sleep disorder, 3 (11%) suffered significant somatoform disturbances, and 2 (7%) may have suffered from hypochondriasis.

The therapies in question ranged in duration between one session and 60 months. The average therapy lasted 16.8 months (SD = 16.9). Twenty-five cases (93%) involved full sexual relations; in 2 cases (7%) the sexual contact was not fully consummated. The duration of the sexual affairs ranged from a single sexual contact to a 96-month relationship that was still ongoing when the data were collected (long after the therapy had ended). The average duration of the sexual liaisons was 10.2 months (SD = 20.1). Thirteen sexual liaisons (48%) overlapped the psychotherapeutic relationship. That is, psychotherapy continued during the affair and came to an allegedly professional conclusion sometime after the sexual contacts stopped. In 9 cases (33%) the therapeutic relationship was terminated abruptly, only to be immediately followed by a sexual affair. In 5 cases (19%) sexual relations were initiated while the therapy was still in progress, but the introduction of sex into the therapist–patient relationship rapidly resulted in the cessation of both professional and erotic liaisons.

A qualitative analysis of the respondents' accounts of their therapeutic misadventures revealed the following patterns. The process of gradual boundary violation was characterized by therapist disclosure. In 16 cases (59%) we found that prior to the physical violations of boundary the therapists started to reveal feelings, emotions, and information related to their personal lives. Some therapists talked about their preferred foods, films, or poetry; others disclosed to the patients how "special" they were to them, and yet others talked about their emotional, marital, or sexual problems.

Nineteen former patients (70%) experienced some sort of seductive behavior on the part of the therapist prior to their sexual contacts with him. In 11 exploitative therapies (41%) the female patients received hugs from their male therapists prior to the sexual encounter. Six of these women (22%) admitted that they had initiated the embrace. Typical exploitative narratives involved a crisis in therapy in which the therapist offered physical consolation through touching, hugging, or by kissing. This physical intimacy was often the prelude to either immediate or subsequent sex. In three cases (11%) the therapist presented a professional rationale for the sexual contacts, claiming they were therapeutically essential. Five patients (19%) who were exploited during their therapy hours were also billed for these sessions.

In 3 cases (11%) the therapist asked the patient to exchange roles (and sometimes seats) with him. This boundary-violating procedure was eventually utilized by each therapist-turned-patient to share his conflicts concerning his attraction to the patient. The latter always yielded to the confessed attractions. Six respondents (22%) reported that a change of the usual therapy hour preceded the erotic development in the therapeutic relationship. In all 6 of these cases the session was moved to a time slot that precluded any disturbance from patients, office sharers, or family members.

Interestingly, 22 respondents (82%) experienced the sexual liaison at the time as a romantic affair. Asked to describe more specifically all their feelings during their affair with their therapists, a picture of intense, mixed feelings emerged. Seventeen patients (63%) had feelings of pleasure and fulfillment; however, 20 patients (70%) also reported feelings of confusion and disorientation. Fourteen patients (52%) reported feelings of excitement, 9 (33%) felt exploited and humiliated, and 6 respondents (22%) reported they felt numb or dissociated.

In contrast to the 63% (n = 17) report rate on pleasurable feelings experienced during the sexual liaison, only 15% (n = 15) were retrospectively pleased with their erotic involvement with their therapists at the time we collected the data. The proportions of reported negative and positive experiences also changed over time. For example, 33% (n = 9) of the respondents felt exploited at the time of the affair, but 59% (n = 16) retrospectively saw the affair as hurtful and exploitative. We statistically tested this change in perception and found that the described differences were statistically significant, $\chi^2(1, N = 27) = 15.3, p < .001$.

Additionally, 48% (n = 13) of the respondents expressed current anger at their former therapists, 37% (n = 10) still felt guilt and shame over the affairs, and 19% (n = 5) expressed current feelings of disappointment and disillusionment about their unfortunate therapeutic experiences.

We compared the respondents' average rankings of severity for the assessed SCID modules at two points in time: before and after the sexualized therapy. A sign rank aparametric procedure revealed significant perceived worsening of distress for symptoms of posttraumatic stress disorder (S = 68, $p < .005$), generalized anxiety disorder symptoms (S = 56, $p < .01$) and a worsening trend for symptoms of major depression (S = 51, $p = .06$). These findings confirmed our prediction that retrospectively reported symptoms in TCS patients would be perceived as worsened.

We compared computed composite trauma scores for the TCS patients and for the control group to determine whether TCS patients had been more traumatized or abused in their past. To control for the possibility that our comparison group would have been unlikely to reveal traumatic memories during an initial assessment interview, we contacted the assigned therapists 7 months following the collection of our data. We asked them whether the treatment was still ongoing and whether any new traumatic memories had been revealed since the intake procedure. At the 7-month follow-up, 23 of the comparison patients (95%) were no longer in

treatment. Except for 5 (20%) who came for one-session consultations, most continued for a median of 5 months. None of our 26 comparison patients later revealed in their therapies any information concerning past traumata that had not been already retrieved during our initial data collection.

A comparison of the trauma scores presented in Table 1 indicates that patients who had been sexually involved with their therapists were more likely to have been traumatized in the past. TCS patients were more likely to have been parentified as children, were more likely to have been exposed to emotional neglect or abuse, to sexual abuse, and to other traumatizing events. Evaluating whether TCS patients differed from controls in the distribution of the traumata across developmental periods was important for finer identification of high-risk factors. All traumata that occurred in the period 0–11 years were considered childhood traumata, whereas traumatic events that occurred in period 12–19 years were regarded as adolescent traumata. The only trauma category in which the distribution of participants was significantly different from expected was "sexual abuse." TCS patients were more likely to have been sexually abused during their childhoods, $\chi^2(1, N = 17) = 4.4$, $p < .05$. They had also been sexually assaulted throughout their life by significantly more perpetrators than were the controls. Fisher's exact test ($N = 21$) yielded $p = .008$. These results confirmed our second research hypothesis.

Implications and Applications

Licensing boards and ethics committees dismiss some cases of alleged sexual misconduct by therapists (Sell, Gottlieb, & Schoenfeld, 1986), which may suggest that some complaints are not considered valid. However, Schoener and Milgrom (1990) also reported that, during 14 years of experience with more than 1,000 cases of sexual exploitation, few incidents were encountered in which suspected misleading or false information was presented by a complainant.

The emerging tentative profile of a therapist-at-risk for sexual transgressions is one of a reputable, middle-aged, mainstream, male clinical psychologist working alone in his private practice. Given the low base rate for therapist–patient sexual offenses, attempts to identify possible future offenders would probably implicate many mentors in our field and would likely involve a high number of false positives. Suggested preventive training programs specifically aimed at sexual misconduct (e.g., Vasquez, 1988) are limited in that most are offered during graduate training or internship. Regulatory boards must begin to develop strategies for addressing more mature professionals who may be at risk because of a personal crisis, depression, or burnout.

When surveying the literature on the utility of specific preventative education on the subject, we found no evidence that specific training of professional psychologists on sexual boundary violation is effective. Our findings provide empirical evidence of a distinct risk group for sexual exploitation in psychotherapy. We, therefore, suggest the active dissemination of this information to professional and training psychologists, but, more important, public education about proper therapy boundaries. Information on sexual misconduct in psychotherapy and potential legal action could be disseminated through the Internet and through brochures to be given to clients before entering treatment. Such information could also be sent out by professional organizations and regulatory boards on request. Layman and McNamara (1997) suggested that the knowledge that a client is aware of the unethical nature of therapist sexual misconduct as well as the right to file a complaint might act as an external source of control for the therapist's behavior.

We suggest that mental health professionals should include routine screenings for childhood traumata in their psychological assessments. Given the potential for an eroticized transference, the identification of adult survivors of child sexual abuse during the intake procedure might assist the evaluating clinician in deciding about the most appropriate referral. The availability of other peers could act as inhibiting agents, providing opportunity for mutual consultation and physical deterrence inherent in their presence.

Boundary violations appeared to develop gradually. The sexual misconduct was always preceded by lesser transgressions. Dror (1994) found that sexualized boundary violations in psychotherapy were associated with boundary violations of confidentiality, and the reverse. It is conceivable that therapists who are sexually involved with their patients maintain professional boundaries that are generally loose and would thus be inclined to be lenient with regard to other behavior restrictions commonly upheld by most clinicians. An alternative explanation is based on the four-factor-theory proposed by Finkelhor (1984) as a model for understanding incest. The model addresses the fact that there are various paths to

Table 1
Mean Past Trauma Scores by Research Group

Measure	Research ($N = 27$)		Controls ($N = 26$)		Chi-square	p
	M	*SD*	*M*	*SD*		
Parentification	1.74	2.71	0.42	0.74	4.65	.310
Death in the family	0.57	0.74	0.38	0.65	0.57	.449
Life threats (e.g., illness, violence)	0.86	0.96	0.21	0.44	7.44	.006
Traumatizing events (e.g., observed trauma)	1.24	1.09	0.59	0.85	6.83	.009
Emotional neglect and/or abuse	1.95	1.85	1.08	1.45	3.27	.071
Physical abuse	0.95	1.12	0.42	0.76	2.43	.119
Sexual harassment	0.09	1.32	0.17	0.43	5.31	.210
Sexual abuse	1.27	1.42	0.12	0.23	14.02	.001
Total composite trauma score	1.11	0.74	0.47	0.53	12.81	.001

committing incest. Emotional congruence and sexual gratification in exploiting a trusting dependent are the first two factors. Blockage in obtaining gratification from more normatively approved sources is the third, and the fourth factor is associated with disinhibition. This last factor recognizes that not every individual who is tempted to molest actually does so. Sexually exploitative psychotherapists might have desensitized their inhibitory mechanisms by violating less severe restrictions in therapist–patient relations first, thereby disinhibiting their evolving sexual feelings later on. Patient education materials should, thus, include discrete warning signs that could alert the patients to the potential for a slippery slope of boundary violations. Suggestions should be provided in these brochures on how to discuss these issues with the therapist and on available alternative courses of action, should the patient remain displeased with the outcome.

Sexual involvement with therapists followed a script laid down in childhood. It is interesting to note that this Oedipal reenactment included significant age differences between the younger female patients and their middle-aged male therapists. Our findings parallel those of Summit and Kryso (1978), who found that victims of childhood sexual abuse were differentially vulnerable to masochistic behavior. Adults—specifically, adult women—who were sexually abused in childhood are also more prone to involvement in prostitution (Silbert & Pines, 1981), involvement with abusive men (Russel, 1986), and rape (Craine, Henson, & Colliver, 1988). Our findings are congruent with Zelen's (1985) description of the anxious attachment incest victims tend to develop with their therapists. The former were said to be preoccupied with their attachment to significant objects to the point of self-sacrifice aimed at the gratification of their love objects (Carmen & Rieker, 1989). Kluft (1989) remarked how victims of incest learn to distort the perception of the abuse in the interest of optimizing their adaptation and survival.

In her recent book, Jennifer Freyd (1996) offered a new theory to explain how individuals block information that would interfere with their need to trust a caregiver. Some of the predictors of distorting or forgetting abuse by a caregiver she mentioned follow: availability of alternative realities (in the case of our study's participants, ongoing psychotherapy); isolation during the abuse (lack of social validation for the experience, which would allow for cognitively consistent internal denial), alternative reality-defining statements by caregivers ("This is part of the therapy you need," or "This is true love"); absence of any shared explicit discussion of the exploitative events (most of our respondents never worked through the transgression with their offending therapists, nor had most respondents disclosed the sexual affair to others). These factors may explain why most of our respondents reported that at the time the sexual liaison was in progress they perceived it as a romantic affair, and why many respondents retrospectively reported having had pleasurable feelings during the exploitation. Situations where the therapist is the only human bond the survivor–patient maintains should be minimized. The desperate erotic attachments some of these deprived patients formed would challenge at-risk professionals and interact with their own issues of control.

We believe that standards of care for socially isolated adult survivors of child sexual abuse should include some form of support group or group therapy. The reality of their past traumata, of isolation and betrayal by caregivers had to be distorted and decontextualized in the service of their defensive processes. The proclivity to adapt cognitive strategies that disconnect data that can threaten idealized object relations put these patients at risk for revictimization by offending therapists. Isolated from others, as frequently these patients are, they strive to maintain powerful affectionate attachments with persons who resemble the original abuser. A support or a therapy group could provide these patients the opportunity to discuss their experiences with others and to receive feedback or validations about their perceptions, thus, reducing the risk inherent in an unprocessed erotic transference. The knowledge that a client is not isolated and can talk about his or her experiences with others may also act as an additional source of control for the therapist's behavior.

We suggest several specific recommendations on how to avoid the slippery slope of boundary violations: (a) Practitioners are encouraged to carefully consider actions that may lead by small, seemingly insignificant increments toward erotic intimacy, such as offering physical consolation to clients in crisis, personal self-disclosure, and changing the timing of appointments; (b) practitioners should be encouraged to choose an office located in a setting shared by other professionals; (c) special care with regard to the maintenance of clear professional boundaries are always warranted when the client is known to be a survivor of child abuse; and (d) proof of participation in consultation and peer-supervision activities should be considered by regulatory boards as mandatory requirements for license renewal.

References

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Belote, B. (1974). *Sexual intimacy between female clients and male therapists: Masochistic sabotage.* Unpublished doctoral dissertation, California School of Professional Psychology, Berkeley.

Carmen, E. H., & Rieker, P. P. (1989). A psychosocial model of the victim-to-patient process: Implications for treatment. *Psychiatric Clinics of North America, 12,* 431–444.

Carotenuto, A. (1982). *A secret symmetry: Sabrina Spielrein between Jung and Freud* (A. Pomerans, J. Shepley, & K. Winston, Trans.). New York: Pantheon.

Chesler, P. (1972a, June 19). The sensuous psychiatrists. *New Yorker,* 52–61.

Chesler, P. (1972b). *Women and madness.* New York: Avon Books.

Craine, L. S., Henson, C. E., & Colliver, J. A. (1988). Prevalence of a history of sexual abuse among female psychiatric patients in a state hospital system. *Hospital Community Psychiatry, 39,* 300–304.

Dror, O. (1994). *Professional ethics and boundary violation: Clinician–patient sex, confidentiality, and ethical practice among physicians and clinical psychologists* [available only in Hebrew]. Unpublished master's thesis, University of Haifa, Haifa, Israel.

Finkelhor, D. (1984). *Child sexual abuse: New theory and research.* New York: Free Press.

Freyd, J. J. (1996). *Betrayal trauma: The logic of forgetting childhood abuse.* Cambridge, MA: Harvard University Press.

Gartrell, N., Herman, J., Olarte, S., Feldstein, M., & Localio, R. (1986). Psychiatrist–patient sexual contact: results of a national survey, 1: Prevalence. *American Journal of Psychiatry, 143,* 1126–1131.

Grosskurth, P. (1991). *The secret ring: Freud's inner circle and the politics of psychoanalysis.* Reading, MA: Addison-Wesley.

Holroyd, J., & Brodsky, A. M. (1977). Psychologists' attitudes and prac-

tices regarding erotic and nonerotic physical contact with patients. *American Psychologist, 32,* 843–849.

Kluft, R. P. (1989). Treating the patient who has been sexually exploited by a previous therapist. *Psychiatric Clinics of North America, 12,* 483–500.

Kluft, R. P. (1990a). Dissociation and subsequent vulnerability: A preliminary study. *Dissociation, 3,* 167–173.

Kluft, R. P. (1990b). Incest and subsequent revictimization: The case of therapist–patient sexual exploitation, with a description of the sitting duck syndrome. In R. P. Kluft (Ed.), *Incest related syndromes of adult psychopathology.* Washington, DC: American Psychiatric Press.

Layman, M. J., & McNamara, J. R. (1997). Remediation for ethics violations: Focus on psychotherapists' sexual contact with clients. *Professional Psychology: Research and Practice, 28,* 281–292.

Mahler, M. (1988). In P. E. Stepansky (Ed.), *The memoirs of Margaret Mahler.* New York: Free Press.

Marmor, J. (1972). Sexual acting-out in psychotherapy. *American Journal of Psychoanalysis, 32,* 3–8.

Nijenhuis, E. R. S., van der Hart, O., & Van der Linden, J. (1996). *The traumatic experiences questionnaire.* Unpublished manuscript.

Pope, K. S., & Bouhoutsos, J. C. (1986). *Sexual intimacy between therapists and patients.* New York: Praeger.

Pope, K. S., Sonne, J., & Holroyd, J. (1993). *Sexual feelings in psychotherapy: Explorations for therapists and therapists in training.* Washington, DC: American Psychological Association.

Pope, K. S., Tabachnick, B. G., & Keith-Spiegel, P. (1987). Ethics of practice: The beliefs and behaviors of psychologists as therapists. *American Psychologist, 42,* 993–1006.

Robertiello, R. (1975). Iatrogenic psychiatric illness. *Journal of Contemporary Psychotherapy, 7,* 3–8.

Russel, D. E. H. (1986). *The secret trauma: Incest in the lives of girls and women.* New York: Basic Books.

Schoener, G. R., & Milgrom, J. H. (1990). False or misleading complaints. In G. R. Schoener, J. H. Milgrom, J. C. Gonsiorek, E. T. Luepker, & R. M. Conroe (Eds.), *Psychotherapists' sexual involvement with clients: Intervention and prevention.* Minneapolis, MN: Walk-In Counseling Center.

Sell, J. M., Gottlieb, M. C., & Schoenfeld, L. (1986). Ethical considerations of social/romantic relationships with present and former clients. *Professional Psychology: Research and Practice, 17,* 504–508.

Silbert, M., & Pines, A. (1981). Sexual abuse as an antecedent to prostitution. *Child Abuse & Neglect, 5,* 405–411.

Spitzer, R. L., Williams, J. B., Gibbon, M., & First, M. B. (1990). *Structural Clinical Interview for DSM–III–R, Non-patient edition* (SCID–NP, Version 1.0). Washington, DC: American Psychiatric Press.

Summit, R. C., & Kryso, J. A. (1978). Sexual abuse of children: A clinical spectrum. *American Journal of Orthopsychiatry, 48,* 237–251.

Vasquez, M. J. T. (1988). Counselor–client sexual contact: Implications for ethics training. *Journal of Counseling & Development, 67,* 238–241.

Zelen, S. L. (1985). Sexualization of therapeutic relationships: The dual vulnerability of patient and therapist. *Psychotherapy, 22,* 178–185.

Received May 28, 1998
Revision received November 30, 1998
Accepted May 13, 1999 ■