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The Aftermath of Therapist-Client Sex: Exploited Women Struggle with the Consequences

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This study explores the ongoing experience of women who were sexually involved with their psychotherapists (therapist–client sex, TCS). Fourteen women who had been engaged in TCS were interviewed to examine the constructed meanings associated with their experiences. Respondents described themselves as having been problem-saturated, lonely, and victimized by pre-TCS sexual abuse. Many respondents resolved their TCS betrayal in subsequent therapy. For most interviewees, a significant step towards confronting their painful TCS experience was their initiated agreement to partake in this study. Our data suggest that participants went through a significant personal transformation process that encompassed four main themes: self-perception; interpersonal relationships; the dilemma of filing a lawsuit; and their motivation to participate in this study.

INTRODUCTION

This study aimed at enhancing the understanding of the experience of women who had been sexually involved with their psychotherapists or counsellors (Therapist–Client Sex, TCS). It explores the constructed meanings associated with such experiences by women who were willing to be interviewed about this sensitive and potentially embarrassing subject matter.

People who seek help from a psychotherapist are often in emotional distress. They may be traumatized, disappointed with a relationship, unhappy in their work, suffering from acute anxiety or depression, or attempting to alter a destructive behaviour pattern. What many of these clients have in common is the level of trust they have in the therapist they have chosen. Another common characteristic of psychotherapy clients is their emotional vulnerability. The therapeutic alliance in a counselling relationship can precipitate a very intense form of intimacy. It is common for patients or clients to have sexual feelings for their therapists or counsellors, and for therapists to be attracted to their clients (Pope, Keith-Spiegel, & Tabachnick, 1986). Many clinicians acknowledge that sexual feelings are a common ingredient of the therapeutic relationship. For example, Pope et al. (1986) and Bernsen, Tabachnick and Pope (1994) and Rodolfa et al. (1994) stated that 88, 81, and 87% of their respective samples of psychologists or social workers reported having been sexually attracted to at least one client. According to Pope, Sonne and Holroyd (1993; cited in Hedges, Hilton, Hilton, & Caudill, 1997), unless the therapy is brief and focused on a specific, non-sexual issue, it is almost

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inevitable that some aspects of sexuality will emerge in the course of the treatment process. In a large percentage of cases, some degree of sexual attraction will be experienced by one or both members of the therapeutic dyad.

The challenge is not keeping such sexual thoughts away, but maintaining a boundary against harmful sexual contact so that the unique potential of these relationships can be realized. There is no question in the minds of most clinicians that acting on such feelings of sexual attraction, either on the part of the psychotherapist, the client, or both, is a profound problem for the profession (Bernsen et al., 1994; Borys & Pope, 1989; Rodolfa et al., 1994), as well as a harmful experience for the exploited clients (Bates & Brodsky, 1989; Gartrell, Herman, Olarte, Feldstein, & Localio, 1987; Pope, 1988; Sonne, Meyer, Borys, & Marshall, 1985; Sonne & Pope, 1991).

Indeed, from the very beginning, the health care professions have recognized the harm that can result from sexual involvement with patients. The Hippocratic Oath, named after the physician who practiced circa the 5th century B.C., prohibits sex with patients. Freud, the founder of modern psychotherapy, emphasized the prohibition in his writings. The historical consensus among health care professionals that sex with patients is detrimental has continued into the modern age. Many states and countries recognize the unique nature of the therapeutic relationship and require special training for therapists, as well as conformity to codes of ethical conduct, licensing regulations, and specific legislation to protect the privileges of psychotherapy clients.

The American Psychological Association (APA, 1992, code 4.05) standards state that 'psychologists do not engage in sexual intimacies with current patients or clients', and that they 'do not accept as therapy patients or clients persons with whom they have engaged in sexual intimacies' (p. 1605). The codes also prohibit psychologists from engaging in such intimacies with former patients or clients within 2 years of termination (code 4.07). The same code states that even if intimacies occur after 2 years, the therapist must show that no exploitation has occurred. Similar codes of behaviour have been introduced into the ethical guidelines of the Union of Israeli Psychologists (1998). Nevertheless, a relatively small minority of therapists takes advantage of the client's trust and vulnerability and of the power inherent in the therapist's role by sexually exploiting the client. In a national survey of 1320 psychologists, Pope and Vetter (1991) found that half the respondents reported assessing or treating at least one patient who had been sexually intimate with a prior therapist. Most cases involved female patients; most involved intimacies prior to termination and most involved harm to the patient. Harm occurred in at least 80% of the instances in which therapists engaged in sex with a patient after termination.

The scientific knowledge about TCS is primarily derived from studies that surveyed clinicians about the incidence of past TCS among their clients, as well as from investigations on the beliefs and behaviours of psychotherapists (e.g. Bernsen et al., 1994; Gartrell et al., 1987; Pope & Vetter, 1991). Articles on the outcome of TCS have consisted largely of conceptualizations by seasoned clinical theoreticians (e.g. Kluft, 1990). Investigations on the clients' perspectives are sparse (e.g. Ditch & Avery, 2001; Somer & Saadon, 1999), and qualitative studies on developing emotional processes among survivors of TCS may not have been done. In fact, no such research has been identified by the authors of this study.

The present study is based on in-depth interviews with women who were sexually involved with their therapists. The aim of the study was to develop a theoretical perspective within which women's constructed meanings of their TCS experiences can be understood. Inherent to this research method and to the sensitive subject matter of our investigation is the question of respondent motivation to participate in such a study. Disclosing personal and potentially embarrassing information (i.e. involvement in TCS) to a stranger, when no monetary compensation is offered and when trust is already a challenging prospect, is not self-evident. Thus, to enhance our understanding about the motivations that prompted the women to participate in our study, we explored two distinct, though related, notions presented in the professional literature: first, the response behaviour of individuals who are invited to participate in a social science study and second, the motivation to disclose sexual abuse.

Respondent Motivation to Participate in a Research Study

Some of the factors known to influence people's proclivities to comply with appeals for participation in a research study include the net individual benefit, the evoked commitment, the inferred societal outcome of the study, the belief in their needed expertise, and the level of trust in the source of the

appeal (Cavusgil & Elvey-Kirk, 1998; Houston & Nevin, 1977; Rogelberg, Fisher, Maynard, Hakel, & Horvath, 2001).

Net Individual Benefit

This refers to the difference between the perceived 'total gross benefits' and the associated 'costs' of responding to the invitation to partake in any research study. It constitutes the primary motivator (Cavusgil & Elvey-Kirk, 1998). Examples of the 'benefits' may include: enhanced self-image through participation in important studies; gaining a feeling of importance that one's opinions are significant; the possibility of contributing to the development of improved policies or intervention methods. Examples of 'costs' may include the consumption of time, energy and even money if subjects are required to travel to the interview site.

Commitment

A sense of commitment to a potential research subject may cause the respondent to comply with the request to participate (e.g. Childers & Skinner, 1985).

Societal Outcome

When the requested information is intended to be utilized to benefit either society as a whole or an important reference group, compliance is more likely (Houston & Nevin, 1977; Rogelberg et al., 2001).

Expertise

Individuals' belief that they possess expertise or knowledge on the particular topic of the study may increase their motivation to participate in the research (Cavusgil & Elvey-Kirk, 1998).

Source

This variable relates to the credibility of the researchers or the institution with which they are affiliated. An appeal from a very credible source may decrease suspicions regarding the researchers' ulterior motives.

Respondent Motivation to Disclose Sexual Abuse

The Burden of the Secret

When survivors no longer feel dependent on the perpetrator, they may feel a need to break their silence and relieve themselves of the burden of their secret. In a study based on narratives of incest survivors, Mize-King et al. (1995) found that the feelings during or immediately following disclosure included relief and reconnection with others.

Successful and Ego-strengthening Experiences

Mize-King et al. (1995) found that the feelings during or immediately following disclosure also included empowerment. Conversely, such empowering experiences as participation in an academic study can also be antecedents to disclosure by providing a much-needed sense of mastery and competence (Somer & Szwarcberg, 2001).

Concern for the Safety of Others

Many survivors of sexual abuse experience concern for the well-being of other potential victims. Whereas accommodation, guilt and self-blame may initially keep these victims silent, they are more motivated to disclose their secret once the abuse ends out of fear that others may be in jeopardy. An analysis of the annual reports of the Union of Rape Crisis Centers in Israel revealed that 11% of the victims of child sexual abuse who phoned in for help were motivated by concern for the well-being of other at-risk children (Somer, 1995).

Publicity in the Media

With increased media attention, the sexual exploitation of women and children has been steadily moving out of the shadows and into the arenas of research, prevention, intervention, and public awareness (e.g. McDevitt, 1996). A recent study identified media attention given to sexual abuse and exploitation as a promising variable associated with disclosure (Somer & Szwarcberg, 2001).

The present study explores the disclosed experiences of women who were involved in sexual relationships with their therapists. In addition to analysing these women's reports, the study focuses on the constructed meanings they assigned to the reported experiences in relation to their past and current lives. Three overriding questions guided the analysis: How do these women perceive themselves in relation to their TCS experiences? How do the women perceive the connection between their TCS experiences and their systems of relationships? Is there a difference between the ways in which the women view their lives prior to and following the TCS experience?

METHOD

Participants

The sample for this study consisted of 14 women who had been in therapy or counselling and had engaged in TCS. In the case of all interviewees the relationships with their offending therapists had been terminated at least 2 years earlier. Participants were recruited by small unpaid adverstisments inviting readers to participate in a study on therapist–client sex. These notices were placed by consenting journalists at the end of newspaper interviews with the second author about this phenomenon. Twenty-four people responded, of whom 14 women were willing to be interviewed personally.

The age of the participants ranged from 23 to 50 years. Five were single and three were divorced mothers with either one or two children. Of the six married respondents, five had two or three children. Level of education ranged between 12 and 20 years of schooling. Only one of the TCS therapists was a woman, the others were men. Five of the TCS therapists were identified as clinical psychologists, three as social workers, one as a psychiatrist, two as physicians, and two were probably unlicensed helpers. The age of the transgressing therapists at the time of the sexual liaisons ranged from 33 to 57 years.

Procedure and Data Analysis

In-depth interviews with the women were conducted by the second author, who is a trained and experienced clinician, after receiving their informed consent. Interviews lasted from 1.5 to 2 h and were audio-taped and transcribed verbatim, yielding 14 in-depth qualitative interviews. The present study used qualitative methodology in data analysis (Strauss & Corbin, 1990). The interview guide included open-ended questions, such as: 'What happened?' 'What was the experience like?' 'How do you understand this relationship?'

An examination of the responses to these questions constituted the basis for understanding the experience and meaning of a sexual relationship within the context of a therapeutic bond. Two researchers performed the coding separately, while following similar coding instructions. The results of the coding were compared and discussed. Data analysis was conducted by using the following procedure: first, we identified content areas from the interviews dealing with how women accounted for the occurrence of the sexual relationship. We then identified two dimensions that yielded a conceptual scheme: a temporal dimension describing past memories and current experiences, and a relational dimension pertaining to self and others. Thus, a 2×3 matrix had been created: two periods of time, past and present; and three relational constructs: perceptions of self, therapist, and the therapeutic dyad. This study focuses on the first row of the matrix: the women's perceptions of themselves prior to and following TCS. It analyses both past and present experiences with their associated themes in an attempt to answer the question: Have self-perceptions of women who were involved in TCS been transformed?

FINDINGS

Interviewees' accounts of their experiences were dominated by continuous efforts to explain how their therapeutic relationship led to TCS. These attempts seem to have coloured their views of both past and present experiences.

Memories of Past Experiences

The analysis of women's accounts of their past experiences generated two underlying themes or questions. The first question involved an examination of personal character, qualities, and other traits: What is it about me that made the sexual liaison with my therapist possible? The second emerging latent question was embedded in the context of interpersonal relationships: What is it about my relationship with significant others that could have contributed to my involvement in TCS?

What is it About Myself?

Answers to the first question revealed that while most women referred to an inherent and prolonged state of emotional deprivation that preceded their encounter with their therapist, some identified a specific crisis that rendered them desperate for unconditional supportive acceptance. Most women described themselves as deprived of parental (mainly paternal) love or deficient in partner intimacy. They also described themselves as having been problem-saturated, needy, suffering from low self-esteem and lacking in self-confidence. These descriptions were characterized as inherent, fundamental, and descriptive of a chronic state: '*Up to a time three years ago, I weighed twenty kilograms above my current weight. I had all*

kinds of physical problems, low self-esteem and no self-confidence . . . I needed a lot of reassurance . . . I apologized constantly for everything . . . for breathing the air around me . . .' (no. 3).

Often women described themselves as having been harmfully self-centred: '*I was obsessively preoccupied with me, me and only me all the time . . . with all the self-destruction and self-hurting and dramatization . . .*' (no. 2).

Problems at home, loneliness and isolation were also mentioned as life descriptors by some women prior to their involvement with their therapist: '*Life at home was extremely difficult, with violence, abuse and neglect. I couldn't live there and felt like an isolated combatant . . .*' (no. 4).

Other women described a severe crisis characterized by depression and anxiety that had dominated their pre-therapy disposition: '*I was in crisis. All my hopes had crashed, I needed help. I felt that I was losing it, that I was ill. I got lost, I was afraid to talk . . . I feared my own shadow . . .*' (no. 5).

Along with the identification of difficulties, low self-esteem, and personal problems, a few women were also able to identify positive qualities in their pre-therapy selves: '*All my life . . . since I was very young, I have had a huge amount of vitality that helped me keep my head above the water, that made me an excellent student and very socially active . . . I knew what I was worth . . .*' (no. 4).

What is it About my Relationships?

A prevalent theme in interviewees' accounts of past experiences related to their perceptions of their interpersonal relationships prior to the TCS. Participants focused especially on their associations with their parents, mainly with their fathers, and male partners.

Family Relationship History. Many participants described their growing up periods as a difficult and frustrating experiences. Some parents were described as unloving: '*My relationships with my family . . . they are not strong or something, they are not supportive, they ignore me. It has been like that forever; my mother was always very cold and she never cared for me . . . and my father, with him it was even worse . . . for three years I didn't have any connection . . .*' (no. 9).

Unsatisfying relationships with parents were often talked about as the backdrop for the rapidly evolving and rewarding relationship with the therapist: '*I was raised with no sense of parents . . . with no grandparents . . . with no family . . . My father is even more important than my mother. He is a Holocaust survivor, was never given anything. He is unable to give or to offer; he was very cold, never connected emotionally or said anything encouraging or comforting. I never got the feeling from him that "yes, I am here for you" and I always wanted a father . . . I always looked for one. I wanted a shoulder, someone to lean on, someone who would accept me unconditionally and with no criticism*' (no. 3).

Partner Relationship History. Interviewees tend to present their relationship narratives as lacking in love and emotional support, a dissatisfying emotional emptiness, and an ensuing intense craving to fill this emotional void. Comparable words were used to describe their relationships with both fathers and partners. Respondents often drew a connection between the absence of a loving and supportive father figure in their lives and their current involvement in an alienated partnership: '*In my relationships, I did not have a place. I missed being loved . . . He was very rational . . . I needed to be loved . . . I missed being listened to . . . Even though my parents were not a good role model, inside me, I knew what a good relationship is. I knew how it should feel . . . it is about listening . . . opening up, getting close, hugging, touching, feeling, but all of these were not there . . . At the same time, I was a child; I was very dependent and looked for an authoritative father, a male figure. I was willing to pluck down the moon for him had he offered me his love. My father, my husband . . . I couldn't say no to men, I was a "yes woman" . . . they could do whatever they wanted with me . . .*' (no. 6).

A central theme in the interviewees' perceptions of their affiliations was sexuality. Not even one interviewee had reported a past account of a satisfying sexual partnership. Many women described previous victimizations by sexual violence: '*I did not see it as rape; I saw it as being forced to have sexual relations. I was 25 and he was 52, and he demanded that I have sex with him . . . He threatened me and scared me . . . I don't know why I needed him; he was not my age and I had a boyfriend . . .*' (no. 13).

Three women described relationships with sexually abusive male partners: '*Between the ages of one and three, I lived at my uncle's house when my mother was hospitalized . . . I came back traumatized, I couldn't speak, I didn't eat, I was underweight . . . Only after I had been in therapy for a whole year did I discover that I had been sexually abused by my uncle . . . I also had a bad experience during my graduate studies . . . One of the teachers sexually harassed me . . . he would say to me "come sit on my lap . . . just give me a kiss" . . .*' (no. 11).

At least three women mentioned inappropriate contacts with their fathers. They suspected that

they had been abused and only in therapy came to realize that they were victims of incest: '*I thought and I still think that something went wrong in my relationship with my Dad. Looking back, I remember . . . I used to lie down in bed next to my father . . . he hugged me . . . he only had his underwear on . . . He was always lying next to me, his body touching my back side very, very close . . . He loved me more than he loved my mother, no doubt about it . . .*' (no. 6).

Present Experiences

Participants talked extensively about their post-TCS and current self-perceptions. They also shared their current views on relationships in general, and on their partner relationships in particular. In reference to their current experiences, respondents sounded like they have been evaluating their lives in comparison to times prior to as opposed to following their sexual liaison with their therapist. Present memories also focused on self-perceptions and views on their current relationships. When describing themselves at present, two additional themes emerged: the first focused on the motivation to participate in this study, and how this drive was connected to their current views of themselves. The second theme revolved around the dilemma of filing a complaint against their exploitative therapists. Thus, the analysis of present accounts yielded four main themes.

Current Self-perceptions

The women talked openly about the consequences of their TCS experiences and its effects their self-perception. Many seemed to have been left feeling taken advantage of: '*What I really want to emphasize is the feelings I have of being used, exploited. This situation (TCS) caused enormous damage, and it is unforgivable. This is very difficult. But even more difficult is the realization that as a therapist, he should have known that his client sought help because she hurt, but he went ahead and added to her sense of worthlessness and low self-esteem. He tried to show me that I am worth nothing. He did the worse damage that anyone ever could . . .*' (no. 1).

Other women talked about the injustice of the situation: '*I don't think a lot about it, but when I do think about it, I find it extremely unjust. Where would I be today had I been a little weaker? This is like giving birth to a baby and then hitting it with a hammer. That is how unjust it is . . .*' (no. 4).

A large proportion of the women described the worst damage of TCS in terms of their inability to ever trust again: '*There are all kinds of issues with which I don't deal successfully. I am still in therapy, till this day, but I do it for the sake of my children. The worst thing for me is that I am unable to trust people . . . three people contributed to this inability: my Dad, him (the TCS therapist), and the chair of the ethics committee . . .*' (no. 14).

Some of the women were still obviously devastated at the time of data collection. They used phrases like 'the end of the world' to describe the effects of TCS on their lives. Many emphasized a need to rebuild their lives. The most devastated victims seemed to have been those whose engagement with their offending therapists extended beyond the boundaries of the counselling setting to various other aspects of their lives: '*It was the end of the world . . . I now have to start my life all over again . . . I can't stay in the same town, I had to move away . . . I can't stay within the same circle he is in, I cannot visit the same places; I can't afford to be in situations where we could potentially meet . . . I have to change everything . . .*' (no. 2).

If not utterly devastated, the women clearly remained, at the very least, emotionally sensitive. The affair seemed to continue to cast a dark shadow on their everyday lives. Accidental encounters with their former offending therapists brought a myriad of feelings to the surface, reminding them of the unhealed wound: '*I was out with my partner and I saw him with his wife. He didn't see me. It had such an effect on me . . . I froze, I couldn't move, I could hardly breathe. I could not believe that it would still affect me in such a way. That I am crying now shows what an affect it had on me . . . It shows that I am still not over it . . .*' (no. 4).

Sometimes women expressed a conflict between a rational part of their minds, cautioning against the risky TCS relationship, and an emotional part, still longing for that early sense of being loved and cared for: '*Today I have a split. There is that wise part of me which says it was awful, that this was harmful, but there is also that childish part that wants to carry on with it forever, longing to be loved, cared for, and protected forevermore . . .*' (no. 2).

Other women described an emerging sense of empowerment and a recognition of strength and sense of control that followed their emancipation from the therapist's realm of domination: '*I began my struggle for independence when he realized that he had lost me. I told myself that I should break free from him if I ever want to gain any sense of legitimacy, that I am OK. I then became an independent person. I always had my strengths, but they were suppressed for twenty years. I look good now, my self-confidence has increased,*

and I feel that I smile to the world and that the world smiles back at me . . .' (no. 3).

Interpersonal Relationships

Interestingly, in contrast to the respondents' accounts of past memories, in which themes related to their relationships were more prevalent than their descriptions of self-concept, the pattern was reversed when they described present experiences. Accounts of relationships subsided as self-descriptions were elaborated on. The few statements made about current relationships focused mostly on their partners or on their new therapists.

Partner Relationships. A significant number of women had been able, at the time of data collection, to establish relatively healthy relationships in general and with intimate partners in particular: '*My husband, he is very strict, does not express his emotions. He had always complained and whined about* ***me*** *being disappointing . . . he would get angry very easily and I always wanted to please him, wanting to be OK. I was like a little girl who wanted to be loved and approved of . . . He created that vacuum in me . . . Wherever I go now, people want to be around me, they want to get close to me, they are attracted to me, both men and women. I look forward to relationships with men. I seek relationships in which I will be unconditionally accepted . . . I am not taken for granted by my husband anymore . . . He knows that he needs to invest in me and in our relationship . . .*' (no. 3).

Although unable to wholly overcome the TCS, some survivors presented themselves as accomplished, successful and fairly content women who had established healthy, satisfying associations with their partners. Some described a significant change in their lives: '*I am a different person now, inside I am a different person. I detached myself from him completely . . . I feel very, very safe with my partner and that is my best accomplishment. I have other achievements as well: I am smarter, our relationship is very good, we have a dream house, I am active, I am looking forward to the future, I am creative, productive, and I make enjoyable progress in life. I can laugh, I am happy, and I am in love, but it (TCS) is there and it casts a shadow on my life . . . on my ability to trust . . .*' (no. 4).

Therapeutic Relationships. At the time of the interviews most women expressed an interest in re-entering therapy or were already in treatment aimed at mending the damage of the former exploitative treatment. The idea of having a male therapist was unappealing to most. Anxiety symptoms dominated their presenting problems: '*I have many anxieties and fears. Half a year after this therapeutic relationship (TCS) ended, I wanted to go into therapy again because I felt my anxieties took over once more. Today, when I think about being in therapy again, I become very scared. A male therapist is, of course, out of the question, but beyond that, I am fearful that this place that is supposed to provide me with support and a sense of safety . . . that I won't ever be able to feel comfortable . . . Who knows what awaits me there . . . what if I meet another one like him . . .*' (no. 4).

Following the TCS relationships, a significant number of women sought therapy to work out feelings associated with the treatment gone awry: '*For years, he was on my mind . . . I entered another therapy with a woman and stayed with her for five years. I wanted to save some of the good feelings I had had for him, and she helped me sort them through. For two years, I spoke only about him . . .*' (no. 6).

'*I have been in therapy for almost a year since then with M (a female therapist), and I have learned how to prevent boundary crossing. I bake cookies and then I want to give some to her, but she refuses . . . I know that it (her refusal) is therapeutic . . .*' (no. 5).

Despite being keen on re-entering therapy, they were very guarded about the therapeutic encounter: '*With my new therapist, I am detached and reserved . . . It is clear that nothing like that happened to me before will ever happen again . . .*' (no. 9).

Family Relationships. Married interviewees described the ramifications of the TCS on family members. One respondent who often used to meet her transgressing therapist socially with her children remarked: '*My children, they are very angry with him. He was part of their lives, and all of a sudden he disappeared. They feel deserted and abandoned . . . My husband is mad, extremely angry. We won't be able to overcome it . . . it is forever between us . . .*' (no. 2).

Being Interviewed for the Study

A significant number of women associated their current interview experience (with a male psychologist) to their TCS experiences. A few expressed concerns and fears about their exposure and about some dreaded consequences: '*Before I start, I want to make sure that I am well protected; this is one of the things I have learned from this (TCS) story, so I want to make sure that what I tell you is left between you and me and that no names will ever be mentioned or exposed . . .*' (no. 8).

For most interviewees, a significant step towards confronting their painful TCS experience was their

initial response to the investigators' advertised invitation to participate in this study. Women stated they had called in to be interviewed because they felt that they could personally benefit from the process. Some had hoped that this procedure would somehow help penalize the aberrant therapist. In those cases, the interview was perceived as a substitute for filing a lawsuit: *'I think that if his former victims would only unite, we could put him behind bars . . . this is the reason why I called in . . . to look for help. By being interviewed, I can do something helpful, I don't mind the inconvenience of doing this . . . it also gives me some hope that this disclosure could help me . . .'* (no. 14).

For a number of women, the interview assisted in resolving remnant TCS issues: *'I am happy about this conversation; I let go of things . . . I want to feel that I am closing a box, not only closing but sealing it and putting it on a shelf . . . I don't want to touch this subject anymore, and this conversation is very helpful in accomplishing that . . .'* (no. 6). *'This interview is certainly a way for me to close a circle . . .'* (no. 4).

Yet, for others, the research interview provided the first chance ever to discuss this subject with anyone, let alone with a professional: *'For years I suppressed it. This was my way to deal with it . . . This is the first time I have talked about it . . . I never told anyone about it because I was ashamed of myself. I needed to be ashamed of myself . . . I went back to therapy, but I never talked about it even there . . . I called you and was willing to be interviewed because I want to help other women . . .'* (no. 1).

Complaining/Filing a Lawsuit

The question of filing a lawsuit against the offending therapist was brought up quite frequently during the interviews. Women presented different stands towards this issue, ranging from having actually submitted a complaint to an ethics committee, to not considering any legal action against the offending therapist because of their wish to protect him or her. Only two women commenced any legal or disciplinary action. However, both reported encounters with the authorities that only added more hurt to their already accumulated sense of injury and disillusionment with the professional establishment: *'I addressed the chair of the ethics committee; I met with him on several occasions . . . The chair told me that he, personally, knows the therapist and that they jointly serve on several committees. The chair didn't help; in fact, this only made matters more difficult for me because I had to stand there before the full ethics committee hoping they will help, but this turned out to be just another blow . . .'* (no. 14).

'They heard his version of the story and they heard mine, and, of course, they accepted his. He, of course, denied all sexual aspects of the relationship. In their final verdict, the committee stated that they cannot rule out that the 'client truly believes in her subjective account' . . . This (verdict) was another crime. Not only did I have to endure what I had gone through (TCS), they also portrayed me as insane . . .' (no. 8).

Three women decided not to file a complaint, mainly because they felt that it would be futile: *'I did not even consider filing a complaint . . . they won't do anything with it anyway . . . What difference would that make? . . .'* (no. 12).

'I never submitted any complaint, nor did I talk to anyone about it, not even to test people's reactions. During my (psychiatric) hospitalization, when I had said something to that effect, they did nothing about it. I am sure they will protect him; professionals do protect each other. I saw all kinds of things that therapists did in the hospital. They never really listen to their patients. They were never truly interested in my side of the story . . .' (no. 9).

A few interviewees acknowledged that they had neither the courage nor the strength to file a complaint: *'I could not do it . . . I am fearful; who shall I turn to . . . I have no strengths . . .'* (no. 5).

One former patient who was seen in the therapist's home office said: *'I told him that what he did was unethical. He replied that there are no records, that I had no personal file, and that if I complained he would deny I was his patient. He warned me "don't fight" and me, I don't want to fight, I don't even have the strength . . .'* (no. 10).

For two of the interviewees, filing a complaint appeared to be a conflict-ridden issue. One respondent tried very hard to conceal any difficult aspects of her life. Throughout the interview, she presented a very successful, ambitious image of herself. She was concerned that litigation would tarnish her reputation as a successful woman: *'All my life, I was successful in maintaining an image of a successful woman. I hide the hurting blemishes of my life. I will die if this whole thing goes public. I don't want to become a victim . . . On the other hand, I heard that he was appointed to a very prestigious professional p osition, and I told myself that this is bad. He is not qualified for that position. So I am still in conflict . . . maybe the only way to get it out of the way is to file a complaint after all . . .'* (no. 4).

Another reason given by women to explain their reluctance to file a lawsuit was either their lingering romantic feelings for their former therapists or their persistent need to shield them: *'I had these thoughts . . . but I never did anything about it because*

I was in love with him . . . Had I not been in love, I would have probably complained . . .' (no. 7).

'*I feel that I needed to protect him. Had I told about what had happened, it could have ruined his whole life, his personal life. I don't want anything bad to happen to him. I need to take care of him. This is why I never told it to anyone until today . . .*' (no. 9).

DISCUSSION

This study presented personal accounts of women who were sexually involved with their therapists. It sought to examine the meanings constructed in relation to these experiences, with a particular focus on four main themes: changes in self-image prior to and following the TCS experience; changes in their view of interpersonal relationships prior to and following TCS; ambivalence about complaining about or suing the therapist; and motivation to participate in this inquiry.

Based on their own accounts of their evolving self-concepts prior to TCS and following it and their descriptions of pre- and post-TCS interpersonal relationships, we found that our participants went through a significant transformation from victim to survivor. We also discovered that our respondents chose to focus on present issues much more than on issues related to their past, yielding 'thicker' descriptions of the present and 'thinner' descriptions of the past (Geertz, 1973). In the following section we wish to illuminate these and other observations.

A noticeable difference between present and past narratives of our respondents relates to the proportion of descriptions of self compared to interpersonal relationships. In their narratives of the past, little was provided in terms of self-description beyond accounts of low self-esteem and lack of self-confidence. Rather, their past memories were replete with descriptions of interpersonal relationships. Parental (mainly paternal) and couple relationships were characterized as unsatisfying, uncaring, or unloving. When describing present experiences, however, the pattern was reversed: self-descriptions were focal and stories of relationships became marginal.

How can we account for this pattern change in memory descriptions? During their interviews, most participants were preoccupied with how their TCS experiences came about. The women's self-descriptions of past were characterized by a low self-image. At the time of data collection, however, they appeared to be stronger, in better control of their lives, more empowered, and significantly more pleased with who they had become. Their self-image, therefore, emerges as a major theme and as an explanatory factor for their current state of relationships. It appears that this narrative pattern change reflects a transformation in the women's self-perceptions. Rather than using unrewarding interpersonal relationships as an excuse for a weak, needy self, an empowered self explains more satisfying interpersonal patterns.

What led to this transformation? Almost all participants who described such major shifts were involved in a different post-TCS therapeutic relationship aimed at resolving TCS-related pain, fear, and mistrust. The corrective therapeutic endeavour helped in the redefinition of the TCS experience and in reattribution of responsibility, thereby contributing to the transformation of an unfortunate experience into a turning point, marking a qualitative alteration in self-concept.

Nevertheless, not all the women were involved in subsequent corrective psychotherapy, and yet all had obviously contacted us and expressed their wish to be interviewed for this study. This initiative could have very well been these women's turning point from victim to survivor or an indication of a transforming self-concept. Contacting the investigators could be seen as an attempt to be validated. This could be particularly true for respondents who were not or had not been seen in post-TCS therapy and did not have a chance to talk about their TCS experience with anyone. These women reported that partaking in this research interview was a major step towards confronting the painful issues associated with TCS. This finding was in line with Cavusgil and Elvey-Kirk's concept of respondents' '*Net individual benefit*' as a motivator for individuals to comply with appeals for participation in research projects. Our respondents not only identified a sense of commitment to the investigated subject matter (Childers & Skinner, 1985) but also believed this was a unique opportunity to relieve themselves of the burden of the secret (Mize-King et al., 1995) and through this disclosure and processing achieve a sense of mastery and competence (Somer & Szwarcberg, 2001). In sum, our findings seem to suggest that for the oppressed respondents we interviewed, participation in this kind of inquiry was, to some extent, an act of empowerment. For most of our participants, who were reluctant to file a lawsuit, dealing with the ramifications of the TCS experience primarily meant taking measures towards healing from the ill-fated counselling relationship

regardless of the consequences for the offending therapist.

The idea of confronting the TCS therapist legally was too threatening for many respondents to even consider, let alone to implement. Although most women wished that their former therapists would be penalized, many were not willing to risk themselves further by confronting the offender. The two women who did file a complaint with an ethics committee were very disappointed by the invalidating responses they received.

Clinical directors in mental health agencies should be aware of several potential patient risk factors for TCS: new female patients who described themselves as deprived of parental (mainly paternal) love, survivors of sexual abuse, individuals who are acutely deficient in partner intimacy and those low in self-esteem who are seen as extremely needy, should probably be referred to experienced female therapists. When such clients are referred to male therapists, special briefings on the risks for the erotization of the therapy should be provided to the clinician. Ongoing supervision of the therapy could also help identify any budding aberrations in the therapeutic relationship.

Finally, the opportunity to respond to the call for participation in the study would not have materialized without the outreach efforts these investigators had undertaken through the media. Analyses indicate that a promising variable associated with disclosure of sexual abuse was the media attention given to this problem. Our clinical experience and involvement with local Rape Crisis Centres taught us that high-profile media attention to sexual abuse, typically, is followed by a surge of phone calls and by requests for help by people who had never talked about their abuse to anyone before (Somer & Szwarcberg, 2001). Thus, professionals, researchers, TCS survivors and journalists should be encouraged to promote media coverage of this aberrant professional conduct. More media coverage of this hidden problem may not only facilitate the empowering reporting and testimonial processes that are so critical to the recovery of survivors, but would also help curtail this damaging behaviour.

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