articulating courses. Learners now receive a joint certificate from the Urban Native Indian Education Society and Vancouver Community College. The issue of articulation and transfer of credit is becoming increasingly important as bands and tribal councils move towards self-government and control of child welfare services. The provincial and federal governments are expecting trained personnel with a minimum of a Bachelor's degree to run these programs.

[1] The final report from this program is available from the Urban Native Indian Education Society, 285 East 5th Avenue, Vancouver, B.C., V5T 1H2. Ask for information on the *Family Violence Worker Training Kit.*

[2] Denise Nadeau, *Training Family Violence Workers: a resource kit based on the evaluation of the Native Family Violence Training Program* (Vancouver: Native Education Centre, 1991), p.3.

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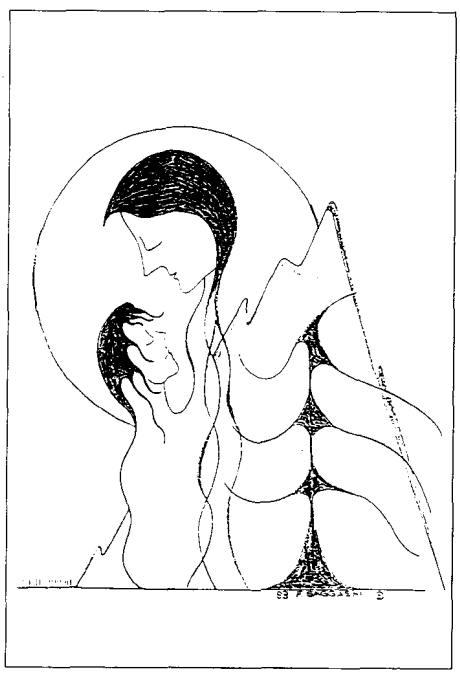

Sex Exploitation of Clients by Therapists

Breaking the Silence and Exploding the Myths

By Temi Firsten and Jeri Wine, in collaboration with Christine Dunbar, Cheryl Rowe and Lynda Davies

The implicit contract at the root of the psychotherapy relationship is that one individual agrees to put aside his or her needs to attend to the unfulfilled needs of another. More than caring and sensitivity, the therapist requires the capacity to delay gratification and keep the other's needs paramount. The client, usually alone and in a very vulnerable state, finds herself with someone who listens and understands and seems to genuinely care. Perhaps it is the first opportunity in the client's life to be heard and understood. And, trustingly, the client divulges everything.

One can appreciate the potential for clients to experience such a relationship as larger-than-life:

I felt totally dependent on him... this was sort of the high point of my existence.

He was the first person I'd ever met that fit into my version of what a normal human being was.... I think I wanted him to be a father figure. He certainly seemed like my lifeline to sanity, to health, to a better way of living, and he was very important to me...

My life was put on hold, my entire life was centred around this hour, four hours a week with him.

That such an intimate encounter might elicit erotic feelings or romantic fantasies for either party is also to be expected:

I thought about him all the time. The first three or four months of therapy my body felt like it was just going to fly right out the window, because I was like an overstimulated child all the time.... I was just barely in control.

I was so infatuated with him, and really wanted to have an affair and would violate any standards to do that....

No matter what thoughts, feelings or behaviour the client brings to the therapy arena, the therapist has the *absolute* responsibility to establish and maintain the therapeutic boundaries. When the contract is broken, the potential to do damage is vast.

As with incest 10 to 15 years ago, the veil of silence around sexual abuse by psychotherapists is just beginning to be lifted. The frequency of this abuse and the leniency of the legal system and professional regulating bodies in prosecuting the offenders is beginning to be brought to light by the media.

Three years ago a group of concerned mental health practitioners came together in Toronto to look at the frequency of sexual exploitation by therapists and counselors of predominantly female patients, and the negative effects that experience has on the patients' lives. We have since organized as *CHASTEN*, the Canadian Health Alliance to Stop Therapist Exploitation Now. We currently have representation from the fields of nursing, psychology, social work and psychiatry. Our members share a clear feminist perspective on this issue, viewing it as a form of sexual exploitation second only to in-

cest in its abuse of trust and power.

The definition of sexual exploitation we use is one provided by the state of Minnesota in a booklet widely distributed to patients throughout the state. Sexual exploitation is "inappropriate sexual conversation, dating or suggestions of sexual involvement by the counselor, and/or any sexual or romantic contact between client and counselor which may include but is not limited to sexual intercourse, kissing and/or touching breasts or genitals."[1]

The three major goals of *CHASTEN* are to give voice through research to clients who have experienced sexual exploitation in therapy; to raise consciousness about this issue among practitioners and consumers; and to lobby for changes that will deter its occurrence as well as make it easier for patients and clients to come forward and seek redress. It is our hope and intention to go about this work without eroding public trust in psychotherapy as a forum for healing.

As members of *CHASTEN*, each of us has worked as a psychotherapist; has been a client in psychotherapy; and brings to our work an acute sensitivity to the vast potential of psychotherapy to either harm or heal.

Activities to date include presentations of briefs to pertinent task forces; facilitating educational workshops for students and practitioners; organizing a public forum on those issues; providing resource material and information to consumers, practitioners and the media; offering a one-day workshop to survivors of therapist abuse; networking with groups in the United States working on this issue; and organizing groups such as ours in other major cities across Canada.

One of our projects over the past two years has been to conduct in-depth interviews with helping professionals who have been sexually abused by therapists in their own therapy. Were we to target all women and men who have had such experiences in therapy, and not just professionals, our sample would exceed 100. We simply do not have the person power to interview all those who have contacted us requesting assistance.

By restricting ourselves to this target group, we have interviewed one male and 27 female mental health practitioners to date. Our goal is to complete 40 interviews. Were it not for the respondents' vulnerable status in their professions, we would be much closer to completing our sample. In two instances, women requested withdrawal of their interview transcripts because they are amid proceedings with regulating bodies and feared harmful repercussions. There were also three women currently training in psychiatry who ultimately decided against being interviewed out of concern that their careers might somehow be jeopardized as a consequence of any form of disclosure, especially in the light of the prominent status of the offending physicians within the psychiatric community.

We wish to share some of the salient themes that have come out of our research so far; themes that dispel some of the myths and distortions surrounding this issue.

Profiles of Abused Clients

The data from our research reminds us, as with the work of some other authors in this field, that there is no particular victim profile and that sexual exploitation in therapy can happen to any of us, especially to women. Five members of our sample are doctoral psychologists, five have post-graduate degrees in psychology and social work, two are psychiatrists, one is a nurse and the remainder have done various forms of specialized psychotherapy training.

Those we interviewed entered therapy with situational crises and problems not uncommon to the majority of women. Almost all respondents were in particularly vulnerable states when they entered therapy, bringing multiple issues into the therapy arena, i.e.: role conflicts between work and mothering, role strains, failing intimate relationships, financial impoverishment, low self-esteem, loneliness, general interpersonal difficulties, depression and anxiety. Some entered therapy only because this was a requirement of their training.

Fifty-nine per cent of the sample were survivors of child sexual abuse. Thirty-six per cent (seven women and one man) were victims of incest, although only half the incest survivors identified incest as an issue that they consciously brought into therapy at the time. It is important to note that such high prevalence of sexual abuse is not uncommon within samples of women seeking professional help and that this is documented in many studies.

Focusing on the client's pathology does not appear to be a viable avenue to the root of this offense. There is an element of victim-blaming here in that responsibility is shifted to the client.

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Therapist Profiles

Just as there is no consistent victim profile, there is no evident profile of the therapist who crosses boundaries. While the tightening of licensing standards is readily considered a remedy for this problem, the vast majority of offenders are licensed professionals. A handful of offenders are, in fact, those who set the standards.

Fifty-four per cent of the offenders in our study are physicians (13 psychiatrists, one general practitioner psychotherapist, one psycho-orthopaedic surgeon). Twenty-seven are men and one is a woman. Of those offenders whose relationship status was known (K=20), 80 per cent were married or living in common-law relationships. While some offenders were amid life crises that may partly account for their behaviour — and there are a few examples of what is described as genuine romantic attachment — this is not evident for the majority.

By questioning our respondents about their perceptions of the physical attractiveness of the therapist, we found that almost half the clients did not find their therapist in any way attractive:

I don't remember ever putting out any

sexual energy in his direction. I was more than not attracted to him. I was repulsed by him.... But I don't know, I mean, I was pretty under water.

I did not find him attractive, personally; physically attractive or even personally attractive.... What I remember is he was big, and he was frightening;.... he always seemed to be looming over me.

Examples like these indicate that many women did not necessarily experience erotic feelings for the therapist, and did not invite sexual involvement.

In our interviews we did not ask respondents to disclose the identities of offending therapists. In the small number of cases where they chose to divulge names, we identified three therapists within our sample as repeat offenders. Forty-two per cent of our respondents, however, knew or had found grounds to believe that they were not the only client or patient to be abused by their particular therapist.

Two major categories of sexually abusive therapists were developed over a number of years by personnel at the Minnesota Walk-In Clinic in Minneapolis. Since the early 1970s, this clinic has worked with over 1,000 sexually exploited clients and many abusive therapists. The first category of abusive therapists consists of those who might be naïve, poorly trained, mildly to severely neurotic, those with limited and isolated lives that meet their needs only through their work, and those who are perhaps experiencing life crises at the time of the sexual involvement. It pertains to those who are not multiple offenders and who have a good prognosis with treatment.

This seems to be the case for less than half of the offenders in our study. Offenders in this category include a psychiatrist recently divorced, another therapist recently widowed, another whose wife had multiple sclerosis and who suffered from impotence, and two instances where real romantic engagement between the participants was apparent.

For more than half the stories we documented, the descriptions are too disturbing to suggest that the therapists involved fit into the first category. The known multiple offenders fall within the second group. This group includes: a gestalt therapist who is reputed to identify one woman for sexual exploits in each of his groups; therapists who clearly draw no boundaries between personal and professional lives, relying on their caseloads for the recruitment of employees, sexual surrogates, roommates, friends and spouses; and those whose treatment of the clients is described in terms that depict outright cruelty, deception, degradation and humiliation:

He wanted me to get to the point where I could urinate in front of him.... He started urinating in the sink in his office, right in front of me. He was trying to get me to do the same thing.

Sometimes it was less than an hour and sometimes he didn't feel like it [sex]. He'd send me home early. He often kicked me out of the sessions. He'd say "Go on. You have to go now! Go on! Go!" And I'd be like a scared little girl, and I'd go. I'd be crying....

Commonly, those in the second category were unethical in other ways as well, such as divulging confidential material about other patients to our respondents, using illicit drugs such as LSD and marijuana and monopolizing sessions with discussion of their own problems. One psychiatrist, for example, talked to an incest survivor respondent about his attraction to his own daughter during sessions.

Members of this second category are the most dangerous to patients, the most difficult to expose and governing bodies need to be especially alert to them.

Nature of Sexual Contact

The sexual contact was restricted to post-termination involvement in only three instances. It began within the therapy setting itself for 92 per cent of our respondents. In six instances, therapy was terminated to pursue the romantic involvement. For two-thirds (65 per cent) of the sample the sexual contact occurred in the first six months of therapy. Within this majority, over one-third of the respondents had experiences during the initial session. This timing factor highlights deliberate action (or perhaps poor impulse control) by the therapist over and above concern about a sexually erotic transference and counter-transference between the two parties.

There were only two instances where the sexualization of therapy was restricted to non-contact experiences such as propositioning and inappropriate preoccupation with sexual material. Contact experiences other than sexual intercourse cited include simulated intercourse, kissing and fondling, lying together, nude massage, fellatio and witnessing masturbation.

Forty-two per cent of our respondents, however, knew or had found grounds to believe that they were not the only client or patient to be abused by their particular therapist.

For the 42 per cent of the sample for which contact culminated in sexual intercourse, several respondents expressed there being no attention whatsoever to their own needs. Two incest survivors describe their experiences:

His whole focus was on his impotence, so he wasn't interested in making love with me, or I don't even think he thought about me; and I didn't want him to, but I resented that he didn't. So my role was just to work on him.

I didn't find it physically very satisfying. I don't think I ever really had an orgasm.... He didn't seem to believe in any kind of foreplay much... it was just kind of "wham, bam, thank you ma'am" sort of experience.

These, as many other examples, dispel the myth that therapist-client sexual involvement is usually romantic in nature. The exploitative nature of so many of these experiences is explicit. Contrary to the nature of the therapeutic contract, they have nothing to do with client needs.

Effects on Clients

We are finding that the apparent sexual misconduct of therapists is not necessarily linked to the intensity of the client's reactions. It seems the violation of appropriate therapeutic boundaries, and of the client's trust, are central to the experience of negative effects. For example, one woman had been in therapy with a male psychiatrist for a year when his wife died. In a subsequent session he announced that she, the patient, was the prime candidate to replace his wife, and invited her for coffee the next week. In some confusion, she did have coffee with him, and immediately afterward terminated her therapy. She states that the experience completely wiped out the considerable gains she had make in her year of therapy, and that her belief in therapy and therapists was so badly damaged that she had no intention of ever trying again.

While two-thirds of the respondents felt equally or primarily responsible at the time of the sexual abuse, that is now true for only one-fifth of the sample. For most, it took subsequent therapy and lots of personal work to let go of the self-blame. This shift of blame appears to be a critical factor in the healing process for sexually exploited patients.

While three-quarters of those we spoke to expressed at least some positive feelings about the transgression of therapeutic boundaries at the time, there are no happy endings. These involvements have been costly to clients in their family lives, their emotional lives and often in their careers. This is true even for those who see their involvement as based on mutual consent. It is true for those whose involvement occurred after rather than during therapy, and it is true for those whose infraction appears minor, such as sexual propositioning only. Words of women depict the tremendous contrast between initial feelings and the aftermath:

THEN: *I believed I didn't need anything else from him and that the sexual aspect was exhilarating, and that if we could just sustain that and have nothing else that would be great.*

AFTER: *I wanted to hang on to the part of it that seemed exhilarating, and forget about the part that has really come out in being in [subsequent] therapy... the humiliation and the hurt. And that is what I feel right now, more than anything else.*

THEN: *It felt enormously comfortable and reassuring;... that he was now willing to be involved with me in this physical sort of way felt very, very reassuring..... Even though it wasn't actually sexual intercourse, it was so riveting for me that it might as well have been, because it was so preoccupying.*

AFTER: *I felt so traumatized by this, and so ashamed. I felt humiliated... that I would have got tangled up in something like this.... It takes a lot of time to recover.... It put me back years.... I was damaged, I did get something out of it initially, but it was very traumatic.*

For survivors of incest, it's a repetition of the original trauma:

He took off his clothes and got into bed with me. He never said anything, but I remember... just the sinking feeling I had, that... "Oh no. Not again." I have a history of abuse, so here was one more. So I felt discouraged, and disgusted and resentful and pissed off.

There had been a pattern of exploitation; of my acceptance that this was what I could expect, of being in this kind of relationship.... there had been earlier abuse, and this was a continuation of exploitation,... a familiar situation. That I knew how to do. I knew how to keep the secret. I knew how to.... I think this balance that women often talk about,.... between trying to get something for yourself, and yet trying to appease the aggressor.

THEN: *I got totally immersed in that, that he loved me. He was going to save me; he was going to marry me and look after me.... That was all going to happen through sex, which is what the incest was about with my uncle. My uncle loved me and was going to look after me.*

AFTER: *The incest for me was like my uncle coming into my body and ripping out my veins.... With Dr. X it was close to my soul, there was a ripping apart; a tearing away of part of you in that process that I'll never get to love. I think that's my metaphor for sexual assault or incest.*

The problems that clients originally bring into therapy do not get addressed, new problems are created, and the injured party is left too scared to re-enter therapy and address them. The possibility that it could, and occasionally does, happen again is too overwhelming.

Conclusion

The issue of sexual exploitation of clients in psychotherapy, as with rape and incest, is not about sex. It is about misuse of power and violation of trust by persons in positions of authority. It is also about gender arrangements in the larger society. Who we are as women and men is experienced in larger-than-life terms in the psychotherapy arena. It is not surprising, then, that the vast majority of offenders are male and victims female.

We have yet to see the evolution of a consumer movement in Canada organized around this issue. This will only happen, as it has in the United States, as more of us come forward to break the silence. We hope that the feminist movement in Canada will play a role in facilitating this end. It is long overdue.

[1] Gary R. Schoener *et al., Psychotherapists' Sexual Involvement with Clients* (Minneapolis Walk-In Counseling Centre, 1989), p.7.

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