

# Sexual Abuse Between Therapist and Woman Patient

by Sue Penfold

Recent articles (1,2,3), and feedback from patients, accents the distressing extent of sexualised interaction between therapists and women patients. This ranges from overt sexual involvement to flirtatiousness or other behavior which reinforces women's status in society as a sex object, and which revolves around both parties' belief that women's mental health problems will be resolved if they become more sexually attractive and pleasing.

While responsibility for the widespread occurrence of this phenomenon has been given to the "sexual liberation" of the seventies (4), in fact the history of psychiatry is replete with accounts of special relationships between famous therapists and their women patients. For instance, during his treatment of a blind woman pianist, Mesmer became permanently estranged from his wife (5). While Breuer treated Anna O, Mrs. Breuer became jealous and morose (6). McCartney, infamous for his paper "Overt Transference," states that Karpman, Boss, Alexander, Hadley and Stack Sullivan all believed that patients should be allowed to act out their transference physically (7).

Most sizable psychiatric communities have tales of therapist-patient marriages, elopements and affairs, and informal blacklists of therapists who are known to sexually abuse patients. These therapists are variously assumed to be misguided, ill-trained, or the bad apples which give the psychiatric community a bad name. Teaching about this problem tends to view the issue as sexual in nature: discussions focus on a reaffirmation of the Hippocratic Oath, and managing one's sexual needs. This paper contends, however, that sexual misconduct with patients is merely the tip of the iceberg; an outgrowth of a much more general and widespread phenomenon. It is argued that sexualisation of the therapist-patient relationship is an expectable outcome of the

medical mystique within which psychiatry functions, of the therapist-patient power differential, and of prevailing stereotypes about expected behavior for women and men. It is facilitated by still prevalent "Blame the victim" (8) sentiments within society and the mental health professions, and by the self-protective stance of these professions. This multidimensional view of sexual issues between therapist and patient is necessary to explain, for instance, why sexual involvement with patients is not related to the psychiatrist's status, position or amount of training (4), and why it occurs between women therapists and women patients as well as (more commonly) between male therapists and women patients.

I will discuss these five areas briefly, illustrating them with complaints and comments from women who have talked to me about their experiences with therapists who were sexually abusive, flirtatious, or whose attitude seemed merely to replicate male-female relationships in society.

## The medical mystique

By presenting, and indeed viewing, itself as a profession grounded in scientific medicine, which has gone from strength to strength on the basis of clinical insights and research discoveries, psychiatry lays claim to an objective body of knowledge with which it purports to cure those ills which are 'mental' in nature (9). Indicators that psychiatry is an art form, or at a pre-paradigm level in many areas, are ignored and lay public and psychiatrists alike may assume that the doctor-patient relationship is unique and bears no similarity to a human interaction between ordinary mortals. This perception is reinforced by all the trappings of the medical system: referral methods, diagnostic practices, billing procedures, report writ-

ing, statistic collection and overall policies.

The women who talked to me believed that therapy entailed some special treatment for the difficulties and that the therapist knew best. This belief was firmly entrenched and held despite clear indications to the contrary that they were being used for the therapist's needs.

"He made me undress and wear a gold slave bracelet on my ankle. I had to kneel in front of him and say 'Master, master'. He told me that it was a special kind of behavior therapy."

"He told me I was frigid and that I needed help to loosen up."

"She told me that I needed to be more comfortable with my body, so we went swimming in the nude. Afterwards we went back to her apartment."

## The therapist-patient power differential

The therapist-patient relationship is superior-subordinate in nature (10). Pain, distress, grief, conflict and so on bring a patient to consult an experienced authority figure. The patient's expectations include support, relief, help with arriving at solutions, safety, protection and caring. The patient role encompasses dependency, trust, disclosure and release of emotion. In a parent-like position vis a vis a vulnerable and needy patient, the therapist's ability to direct and influence the patient may assume gigantic proportions.

"He was everything to me — sun, moon, stars, mother, father, confessor, everything."

"I felt like nothing without him."

"He was just like the father I had never had. Warm, big and cuddly. He told me to sit next to him, he put his arm around me. I snuggled up, feeling so safe, protected and cared for. Then I felt him take my hand and place it on his thigh."

"I felt like a puppet; she pulled the strings."

While most therapists recognize their parent-like status (11), awareness of the enormous power differential, and its potential for exploitation, are minimal.

"He told me that the relationship was equal. But he totally controlled it. He set the time, at his office, at his convenience. He insisted on secrecy, I could not call him at home."

An unethical therapist can readily shape a patient's behavior, or distort the material brought up:

"I felt like a tiny little girl. I had fantasies of bringing his pipe and slippers. I envied his children. Yet he kept insisting that I was having adult sexual fantasies about him."

"He put his hand on my arm. I pulled away. He said 'Don't you like to be touched?'"

### **Culturally determined patterns of behavior**

In our society women are socialised to be compliant, unassertive, nurturing, concerned with meeting other's needs and considering other's feelings, dependent on males and those in authority. In relationships women usually assume a supportive, caring role, putting their partner's needs and wishes first. More expressive and in touch with their feelings, they often do the emotional work of the partnership. A woman in therapy falls easily into a role reversal with her therapist, listening to the therapist's problems and bolstering the therapist's self esteem. Often heard are the comments:

"He told me all his problems. About his wife, kids, job, finances."

"He told me that I was the first person who really understood his feelings."

Women are expected to be sex objects, sexually pleasing, attractive to men. Therapists often assume that their problems lie within their failure to look attractive, and

that their first priority should be to find a sexual partner.

"He told me to get a haircut, that it would make me look sexier."

"She told me to go to a singles bar and pick up a man."

Culturally determined patterns of flirtation, dating and courtship may impinge on or enter the therapist-patient relationship.

"I found myself choosing my prettiest outfit, spending hours on my face and hair, before I went to his office."

"I got nothing out of it. He always flirted with me. He seemed to think that this was the way to make me feel good, to get me out of my depression."

Not too deeply hidden in our culture is the image of women patients as available sex objects for male doctors, as illustrated by some medical advertising.

### **Blaming the victim**

Psychiatry has a long tradition of blaming and scapegoating women. "Schizophrenogenic mothers," mothers of incest victims, battered wives, wives of alcoholics, women who 'abuse' prescription drugs (rather than suffer from over-prescription) — all have been given formal or informal labels which pathologise their behavior, obscure social causes, paper over the responsibility of other parties (12). Women who are programmed to take responsibility for, and feel guilt about, relationships and their vicissitudes, are only too ready to agree that they are indeed at fault. Although women who complain of sexual abuse by their therapist are no longer automatically disbelieved, an undercurrent of blame remains. Women victims see themselves, and are seen to be, somehow responsible.

"It was my fault, I seduced him."

"I felt so bad about it; like I had toppled him off his pedestal."

A therapist who admitted to inappropriate sexual involvement told his victim "You were so compelling, such a strong person." He went on to blame his mother, saying "I had such a powerful mother, when I was a little boy she always controlled me." Then he went back to blaming the victim "So I wasn't able to stand up

to you."

To this day women who have been sexually abused by their therapists are afraid to come forward. Afraid of what their husbands, lovers, children, friends and colleagues will think. Some women will talk to me on the phone, but are unwilling to leave a name or number. Others will fill out questionnaires anonymously. Only a very few, it seems, will make formal complaints or talk openly about their experiences. This misplaced burden of guilt is staggering.

Women who have not suffered actual sexual abuse but have been flirted with, leaned upon, used to hear the therapist's problems and so forth, are likely to view the situation as their responsibility. They cite their failure to be open, to communicate properly, to present their difficulties correctly, to go to the right therapist at the right time and so on. The psychiatric profession ignores or minimizes sexual issues between therapist and patient. For instance, apart from a few comments about the patient's "erotic transference" this is not mentioned in Kaplan and Sadock's 2054 page "Comprehensive Textbook of Psychiatry" (13). Sexual relationships between students and faculty in mental health training institutions are common, but hidden or ignored (14). Despite their knowledge of specific instances of sexual misconduct by psychiatrists with their patients, colleagues rarely report these cases to official bodies (15). The "psychiatric family" turns a blind eye to the abuse in its midst, displaying a "cloud of protectionism" charges the Toronto Metro Action committee on Public Violence toward Women and Children (16).

"I told my GP, he didn't believe me. Then I told another psychiatrist, he didn't believe me either."

"He told me I must have been seductive."

"She told me that I must be imagining it; Dr X would never act that way."

"The board of inquiry was worse than the abuse; no one believed me."

"I told him that Dr C had flirted with me. He laughed and said 'What do you expect, you're so pretty.'"

### **Conclusion**

Sexual issues between therapist and patient are not merely a matter of the iso-

lation and intimacy of the office setting, of poor training, of personality problems, or of male entitlement. They are of multidimensional origin and are rooted in the power differential between therapist and patient, the mystique of therapy, cultural expectations for men and women, society's proclivity for blaming women, and the mental health professions' self protective stance. Training and practice must acknowledge all these aspects in order to ensure that therapy does not become superficial flirtation, game playing, exhortations to fulfill cultural prescriptions, or (at worst) sexual abuse of the woman, whose trust is betrayed, old patterns confirmed and new problems created (17).

### References

1. Gartrell, N., Herman, J., Olarte, S., Feldstein, M., Russell Localio, J.D. "Psychiatrist-patient sexual contact." *Am. J. Psychiatry* 1986; 143: 1126-1131.
2. Holroyd, J. "Erotic contact as an instance of sex-biased therapy." In Murray J. Abramson, (ed.), *Bias in psychotherapy*. New York: Praeger Publishers, 1983.
3. Bouhoutsos, J.C. "Therapist-client

sexual involvement." *Amer J. Orthopsychiat* 1985; 55: 177-182.

4. Stone, A. *Law, psychiatry and morality*. American Psychiatric Press, 1984, pp 191-216.
5. Ellenberger, H. *The discovery of the unconscious*. New York: Basic Books, 1970, pp 891-893.
6. Jones, E. *The life and work of Sigmund Freud*, Vol I. New York: Basic Books, 1953, pp 224-225.
7. McCartney, J.L. "Overt transference." *J. Sex Research* 1966; 2: 227-237.
8. Ryan, W. *Blaming the victim*. New York: Vintage, Random House, 1976.
9. Penfold, P.S., Walker, G.A. *Women and the psychiatric paradox*. Montreal: Eden Press, 1983, pp 3-56.
10. Smith, D.E., David, S.J. (Eds). *Women look at psychiatry*. Vancouver: Press Gang, 1975.
11. Butler, S., Zelen, S.L. "Sexual intimacies between therapists and patients." *Psychotherapy: Theory, Research and*

*Practice* 1974; 11: 139-145.

12. Penfold, P.S., Walker, G.A. *Women and the psychiatric paradox*. Montreal: Eden Press, 1983, pp 114-140.
13. Kaplan, H.I., Sadock, B.J. *Comprehensive textbook of psychiatry/IV*. Baltimore/London: Williams & Wilkins, 1985.
14. Pope, K.S., Levenson, H., Schover, L.R. "Sexual intimacy in psychology training." *Amer Psychol* 1979; 34: 682-689.
15. Gartrell, N., Herman, J., Olarte, S., Feldstein, M., Russell Localio J.D. "Reporting practices of psychiatrists who knew of sexual misconduct by colleagues." *Amer J Orthopsychiat* 1987; 57: 287-295.
16. *Brief to the health disciplines review committee*. Metro Action Committee on Public Violence against Women and Children. Toronto, March 1986.
17. Sonne, J., Meyer, B., Borys, D., Marshall, V. "Clients' reactions to sexual intimacy in therapy." *Amer J Orthopsychiat* 1985; 55: 183-189.

**UNIONS · PEOPLE · IDEAS · ACTION**

# OUR TIMES

is a monthly magazine where working people come together to share victories, exchange new knowledge, and compare fears and insights.

We celebrate the vitality and strength of the union movement in Canada today, and believe our future potential is measured now in our diversity and solidarity.

**PROGRESSIVE JOURNALISM MEANS GIVING PEOPLE A CHANCE TO SPEAK FOR THEMSELVES.**

\$15 for 10 full issues (\$25 institutions).  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Postal Code \_\_\_\_\_

Send to: Our Times 390 Dufferin St. Toronto, Ont. M6K 2A3

**RFR DRF** RESOURCES FOR FEMINIST RESEARCH DOCUMENTATION SUR LA RECHERCHE FEMINISTE

## The Lesbian Issue



• An examination of the lesbian experience in Canada

• Guide to lesbian organizations, periodicals, bibliographies

• Discussion forums on important issues for research and activism

• with Jane Rule, Nicole Brossard, Mary Meigs and many others

## Feminist Practice in Quebec



• A look at issues, research and activism in Quebec

• Research on publishing and pornography, mothers and medicine

• with Micheline de Seve, Louise Vandelac, Yolande Cohen and many others

**RFR DRF** RESOURCES FOR FEMINIST RESEARCH DOCUMENTATION SUR LA RECHERCHE FEMINISTE

**Les pratiques du féminisme au Québec**  
Feminist Practice in Quebec

To order your copy of *The Lesbian Issue*, or *Feminist Practice in Quebec*, send \$6.50 each to: RFR, 252 Bloor Street West, Toronto, Ontario, M5S 1V6, Canada.