

JOURNAL

OF
ADDICTIVE DISORDERS**Professional Ethics: Sexual Relations with Clients / Patients?¹****ARTICLE**

The topic that has been chosen for critical analysis is the ethical and legal fallout when psychotherapists engage their patients in sexual relationships. There are multiple reasons why this particular topic is of paramount importance to the professional field of psychotherapy and other related allied treatment professionals.

First of all, and probably the most obvious, is the ethical considerations that must be examined when sexual relationships are established between psychotherapist and patient. Once this particular relationship is indeed established, how will this affect the therapeutic relationship between the two?

Secondly, this paper will utilize clinical case studies, questionnaires and surveys to examine other psychodynamic aspects such as sexual acting-out in therapy, sexual malpractice claims, characteristics or erotic and non-erotic practitioners, physicians' attitudes and practices regarding erotic and non-erotic contact with patients.

Finally, the focus of the paper will additionally include the analysis of such psychodynamic areas that entail the vulnerability of the patient and psychotherapist due to the sexual relationship, the concept of the psychotherapist as parent surrogate and its relationships to the incest taboo, the need to be loved and the psychotherapist's position of power in reference to his/her patients.

¹ This copyrighted material may be copied in whole or in part, provided that the material used is properly referenced, and that the following citation is used in full: Schuder, J-T.J. (2004). Professional Ethics: Sexual Relations with Clients / Patients? *Journal of Addictive Disorders*. Retrieved from <http://www.breining.edu>.

Sexual abuse of patients has come out of the closet. For too long the helping professions have hidden from the problems that exist when there are sexual intimacies between patients and therapists. Since the major public image of psychologists is that of professionals who deal with problems and behavior disorders, it is very critical to ensure that services rendered to clients, patients and students are ethically responsible and capably performed. A major infraction of this canon occurs when sexual misconduct is actually carried-out devoid of adequate professional response, both for the control of and the undoing of the detrimental results of this behavior (Zelen, 1985).

Sexual intimacy in therapy can be defined as any touching, fondling, kissing, or erotic acts including intercourse which occur between a patient and a therapist. Basically the relationship at this time is sexualized. Nonerotic supportive or friendly hugging, greeting, or kissing are not included as sexual intimacies. Intentionality and awareness of consequences as well as the setting of limits for Nonsexual relations must also be part of the picture. Thus, a friendly pat on the shoulder does not constitute sexual intimacy (p. 179).

The critical factor in discerning sexualization of the patient-therapist relationship must be the context in which they occur. Any contacts that do have a sexualizing context must be deemed sexual intimacy in therapy. A second crucial determinant in the definition of sexual intimacy is the recurrence of the sexualization process. Generally speaking, psychotherapy is an ongoing process, and this type of sexualization (if it transpires) by the therapist will be repeated. Nonetheless, any single clear-cut sexual act or proposition can constitute an act of sexual intimacy. Finally, any failure to deal with this sexualization as a part of the verbal treatment and its separation into acting-out is a concise definition of sexual abuse (Zelen, 1985).

This definition depends to a great extent upon intentionality, context, and repetition. The limitations of such an approach are profound, but fortunately, at the moment, legal niceties need not be met. At some date in the near future many of the aspects of what is sexual abuse of a patient will have to be resolved legally and interpreted in a consistent fashion over time (p. 179).

The American Psychological Association created a task force to address this

particular problematic issue. The results of their national survey, reported by Holroyd and Brodsky in the *American Psychologist* (1977), found on a 70% return of inquires to licensed Ph.D. psychologists that 5.5% of the males and 0.6% of the females performed sexual intercourse with their patients. Additionally, Holroyd and Brodsky discovered that 2.6% of the male therapists and 0.3% of the female therapists participated in intercourse with their patients within three months after therapy terminated, certainly an indication of prior contamination of the therapeutic process (Zelen, 1985).

In a study conducted by Sheldon H. Kardener, M.D., Marielle Fuller and Ivan N. Mensh, Ph.D. entitled "Characteristics of 'Erotic' Practitioners," *American Journal of Psychiatry*, 1976, they reported data derived from a comparison or responses of the 59 Physicians who acknowledged sexual contact. The resulting data, compiled by utilizing a Questionnaire survey regarding sexual contact with patients, was analyzed by comparing the two groups – erotic practitioners (EP) and non-erotic practitioners (NEP) – will be presented in terms of objective numerical responses and subjective "fill-in" statements (Kardener, Fuller and Mensh, 1976).

In the EP group (N=59), the percentages of the total respondents from each specialty were as follows: psychiatrists, 10% (N=12); surgeons, 10% (N=7); obstetrician-gynecologists, 18% (N=15); internists, 12% (N=11); and general practitioners, 13% (N=14). It should be noted that there were no statistically significant differences between the EP and NEP groups regarding specialty, age, years in practice, marital status, years married, number of marriages, or the response to the question, "Do you attempt to treat sexual problems in your medical practice?" (Kardener, Fuller and Mensh, 1976).

There were 246 responses to the question on benefits of nonerotic contact – 37 from the EP and 209 from the NEP group. The polarity of the groups became immediately apparent when their written comments were reviewed, but there was some overlapping. The NEP group responses ranged from "never" to "very conservative," whereas the EP group's responses ranged from "conservative"

to "very liberal." The overlap of course, occurred with the responses characterized as "conservative." Some of the comments from the NEP group included "never beneficial," "I can't think of any reason," "would contaminate the professional relationship," "never kissing or hugging," "if there has been a disaster or catastrophe" (p. 1324).

The EP group's comments were somewhat similar to those of the NEP group's comments with the exception of any injunctions regarding nonerotic contact. Additionally, the EP group made several "liberal" statements: "to provide reassurance [whenever necessary]," "to show support and acceptance," "whenever appropriate," "laying on of hands," "attempt to facilitate [therapy]," "attempt to encourage flowing [sic] with the here and now," "helps feelings of loneliness," "for [greater] rapport," and "when patients leave after long-term treatment" (p. 1325).

There were 221 responses to the second question, "under what circumstances might erotic contact with a patient be beneficial?", 31 from the EP group and 184 from the NEP group. There was absolute unanimity in the comments by the NEP group, all of whom stated at the very least that erotic contact was never beneficial. Many condemned such behavior, e.g., "represents ignorance or exploitation on the part of the doctor" "any doctor who can't control his emotions is unqualified," "appalling to contemplate," "any doctor who does needs therapy," "destroys relationship," "very sick behavior," "doesn't belong in therapy," "unethical," "evidence of psychosis in the doctor" (p. 1325).

In contrast, the EP group provided the following responses: "demonstrates doctor's effectiveness to his patient," "supports and reinforces a patient's sexual appeal," "stimulating the clitoris helps a patient relax," "it's OK since I'm not a doctor, I'm a therapist," "with mature patients," "it was originally for my need, but led to better rapport and more durable relationship," "when the patient is over 21," "with consent but not in the office," "for teaching purposes," and "the intercourse was made part of the therapy" (p. 1325).

Sigmund Freud exchanged letters with Ferenczi in 1931 which discussed the danger of engaging non-erotically with a patient. The gist of the letters essentially stated that while Ferenczi might be able to confine his physical contact with a patient to the non-erotic sphere, the support of such practices would readily lead to both a relaxation and extension of proper limits. The danger of an "anything goes" ethic easily could be the results. The data presented in this particular study tend to support Freud's hypothesis and underscore his concerns (Kardender, Fuller and Mensh, 1976).

The questionnaire afforded respondents a unique and anonymous opportunity for the expression of participation in unusual practices, and the data is consequently more

likely to be representative of such practices. Each specialty represented tended to have its own slightly different orientation regarding engaging in the treatment of sexual problems, beliefs and practices concerning both erotic and non-erotic behavior with patients (Kardener, Fuller and Mensh, 1973).

For example, psychiatrists and obstetrician-gynecologists reported an increased frequency of the treatment of sexual disorders in their practices and were also more wary of non-erotic physical contact than their colleagues, since they primarily believed that such behavior would be misconstrued. Simultaneously, it was the psychiatrists who most often explained why such contact might be beneficial in the treatment of a patient. Internists and general practitioners, on the other side of the coin, indicated a belief in and practice of beneficial, non-erotic physical contact with their patients (Kardener, Fuller and Mensh, 1973).

In another study conducted by Sharon Butler and Seymour L. Zelen entitled *Sexual Intimacies between Therapists and Patients*, Psychotherapy: Theory, Research and Practice, 1977, they discovered that professional psychologists were faced with the potential loss of professional liability insurance sponsored by the American Psychological Association. This particular crisis was due to the copious amount of malpractice suits against psychotherapists regarding sexual intimacies between them and their patients (Butler and Zelen, 1977).

It is estimated that one in five therapists would be intimate with his patients. This scenario illustrates the two faces of the psychotherapeutic Janus. On the one hand are the majority of contacts between therapists and patients that are traditional, professional relationships, and on the other hand there are a small, but significant, number of contacts that led to sexual intimacies (Butler and Zelen, 1977).

As our culture and our society becomes increasingly more open, sexual

expression has also become more open. Consequently, there has been a trend for the psychotherapists to divest himself of his mystical robes and to appear more human. As a result of the aforementioned, those various sexual intimacies that were once shameful secrets of the therapeutic hour are now becoming public information (Butler and Zelen, 1977).

This poses problems in four areas: ethical, moral, professional and theoretical. Theoretically, such intimacies may influence the course of psychotherapy; ethically the professional psychotherapist violates his code of ethics and handicaps himself in the delivery of service; and morally the psychotherapist, in his professional role, introduces additional conflicts for himself and for the patient in an already complicated situation. For the profession as a whole, it limits the psychotherapist's ability to render services to the public image and reputation (p. 139).

According to the traditional psychoanalytic position, Marmor (1972) in an article entitled *The Seductive Psychotherapist* suggested that "the psychoanalyst or psychotherapist is himself beset by deeply rooted, often unconscious, needs that tend to foster or stimulate impulses toward physical closeness towards his patients." He implied that physiological needs, the therapist's need to be a helping figure, and the therapist's counter-transference were involved in this process (Butler and Zelen, 1977).

According to Masters and Johnson, "It's damn hard to be in bed and be objective at the same time. There are few people who can do this, and when therapists are having sex with patients, it is the therapists' needs that are being met." Forer (1974) pointed out that the trend towards adult behavior is oftentimes confused by encouraging one form of contact when the personal desire may be for another form. In many case scenarios where contact is established between the therapist and the client, it may sometimes be difficult to discern whose needs are actually being met, the patient's or the therapist's (Butler and Zelen, 1977).

Attorneys defending therapists accused of sexual contact with patients sometimes have attempted to introduce evidence to the effect that the patients were seductive, that

sexual intimacy during therapy is not below community and ethical standards of practice, and that sexual intimacy with patients may be beneficial rather than harmful. Many expert witnesses have invalidated the first two arguments, but not the third one.

Seductiveness of the patient is irrelevant, as therapist-patient sexuality is analogous to parent-child sexuality. According to this particular analogue, sexual contact/intimacy between the patient and therapist is not viewed as a consensual act between adults (Bouhoutsos, Holroyd, Lerman, Forer and Greenberg, 1983).

A questionnaire was sent to each licensed psychologist in California (N=4385) requesting anonymous responses about patients who reported incidents of sexual intimacy with a previous therapist. For each case reported, respondents were requested to provide information about the previous therapist, the patient, and the relationship. "Sexual intimacy" was left undefined in order to observe what respondents and/or their patients considered sexually intimate behavior (p. 186).

The questionnaires were completed and returned by 704 psychologists. Three hundred eighteen of these (64% male, 35% female and 1% not stated) provided data for 559 patients. Fifty-seven percent of the respondents citing cases gave information for one case, 12% for three cases, and 9% for four or more cases (Bouhoutsos, Holroyd, Lerman, Forer and Greenberg, 1983).

Regarding the impact on patients and the therapeutic process, percentages reported are regarded as conservative estimates, as they are based on the total number of cases, and not all respondents answered the questions. The kinds of evidence that personality was adversely affected included increased depression, loss of motivation, impaired social judgement, significant emotional disturbances, suicidal feelings or behavior, and increased consumption of alcohol and drug use (Bouhoutsos, Holroyd, Lerman, Forer, and Greenberg, 1983).

Additionally, it was discovered that eleven percent of the 559 cases were hospitalized and one percent committed suicide. Among the 26% for whom sexual,

Marital, or intimate relationships worsened, mistrust of the opposite sex increased for 14% of the 559 cases, marriage and/or family were negatively affected for 9%, and sexual relationships were hampered for 7%. It should be noted that some cases were represented in more than one outcome category (Bouhoutsos, Holroyd, Lerman, Forer and Greenberg, 1983).

Forty-eight percent of the 559 cases reported had problems in recommending therapy: Patients were suspicious and mistrustful of therapists, had difficulty establishing a new relationship, were extremely cautious in choosing a new therapist, or did not return to therapy "for a long time." However, 6% were described as seeking therapy from another therapist right away to resolve the conflict that had been engendered. Some patients remained emotionally committed to the previous therapist, some wanted a clear commitment of "no sex" before entering therapy, and some were afraid they would not be believed. The more intense the sexual involvement, the greater the likelihood that patients had difficulty returning to therapy rather than quickly seeking help: 88% of those who had intercourse, 86% of those who had only genital contact, 78% of those who had nongenital physical contact, and 57% of those who only discussed the possibility of sexual relations, $X^2(4) = 13.36, p = .01$. A high percentage of those who only progressed as far as talking about having sexual relations immediately sought help from another therapist (43%) (pp. 190-191).

When taking into consideration all of the responses given to the first four questions, 87% of the patients experienced negative effects in their therapy – either with the previous therapist or with the respondent – or had problems returning to therapy; 64% experienced adverse effects in terms of their personal adjustment; 90% suffered negative effects all told (Bouhoutsos, Holroyd, Lerman, Forer, Greenberg, 1983).

In another study entitled "Sexual Contact between Patient and Therapist," Contemporary Psychoanalysis, 1970, Charles Clay Dahlberg, M.D. analyzed several case studies that proved more than naught that any type of sexual encounter between therapist and patient tend to be destructive to the therapeutic relationship. Case number nine (9) from this study really illuminates just how destructive a sexual relationship can be not only to the therapeutic relationship, but also to the lifestyles of the people who

were involved in such activities (Dahlberg, 1970).

Case 9:

Informant: Patient.

Age: Therapist, about forty-five; Patient, about twenty-two.

Marital Status: Therapist, separated and getting a divorce; Patient, divorced.

The patient had been active in therapy for approximately one year. It was obvious that she was deeply attracted to her therapist, which she freely expressed. The therapist took the lead and proceeded to ask out his client for a drink outside of the office. The patient was initially hesitant but accepted based on his reassurances. The meeting led to further dates and, eventually, to bed. After a few months, the therapist told the patient she no longer needed therapy; he terminated the treatment while he continued to see her socially. Shortly thereafter, they married. When they decided following the marriage that she was in need of treatment again, he made her promise not to tell her new therapist how their relationship had begun. A few years later, as the marriage deteriorated, the patient said that she had reason to believe he was dating one or more of his patients (Dahlberg, 1970).

This case combines all of the worst elements of a situation of this sort, the patient went on to years and years of therapy, several marriages, and untold acting-out, including an almost successful suicide attempt. It is clear that this therapist was out of control; he allowed his own needs to interfere with his therapeutic judgment, and he was willing to sacrifice a former patient, then his wife, to protect his reputation. It should be mentioned that he sent his wife to his own former analyst, who had not been told about this case even though the therapist was in training analysis at the time he treated her. The reason he sent her was that he felt his wife would be afraid to injure his reputation by telling the facts to his former analyst, and also that the training analyst would be deterred from speaking about the situation if he did learn the facts. The therapist was right. The analyst did not learn about these events until several years after the divorce.

Obviously, having to keep this secret interfered with her treatment (p. 117).

In a study completed by Sheldon H. Kardener, M.D. entitled "Sex and the Physician-Patient Relationship," American Journal of Psychiatry, 1974, he identified

and related the topic of incest taboo and how this correlated to the physician as caretaker in regards to the sexual relationship established between the physician and patient (Kardender, 1974).

Woodbury's report on incest estimated that sexual relations between parent and child, extrapolated to the general population, involved at least 5 percent and perhaps as many as 10 to 15 percent of the people in this country. These particular figures are similar to those for erotic behaviors that were noted between physicians and patients in our reported study. Daughters were involved in incest 60 to 75 percent of the time (Kardender, 1974).

Lustig and associates discovered that certain precedent circumstances existed in their study of cases of incest. They discerned that the sexual relationship between the mother and father was often a disturbed one that was lacking gratification for the father. The mother, unconsciously and covertly, encouraged the incestuous relationship by Substantially absenting herself from the family at appropriate times. The daughter oftentimes was used by the mother as a surrogate wife to resolve her own interpersonal and intrapsychic conflicts. The child was therefore left with only one parent. When that parent converted his role to become the lover, the toll the child paid was to become psychologically an orphan (Kardener, 1974).

In an exactly parallel way the physician, as a source of healing, support, and succor, becomes lost to his patient when he transforms his role and becomes a lover. Based on the fact that good lovers are easier to locate as opposed to good effective caretakers, it is psychologically a frighteningly high price the patient must ultimately pay. While the physician, like the good parent, may reassuringly acknowledge the desirability of his patients, it is his ultimate responsibility to help guide his patients' growth and development to eventually achieve meaningful and appropriate gratification

in their lives without sacrificing his availability as caretaker (Kardener, 1974).

This thesis does not mean to imply that adults are children, but rather that, when one seeks professional help for hurt, one is placed emotionally in a childlike posture of dependency characterized by varying degrees of vulnerability, with a concomitant necessity that trust be placed in the wiser, more experienced (“parentoid”) healer. It is this “regression in the service of cure” that may also simultaneously stimulate latent emotional conflicts within the patient. Petulance on the part of the pained or debilitated patient is known to every physician. The patient with a “hot belly” who demands analgesia before a diagnosis is made and the one who insists on an antibiotic treatment for a viral infection are prosaic examples. Most physicians have little difficulty in maintaining a therapeutic posture in the face of such demands (p. 1135).

In terms of sexual acting-out in therapy and the psychodynamics behind it, Judd Marmor made some interesting insights via his research on “Sexual Acting-Out in Psychotherapy,” *American Journal of Psychoanalysis*, 1972. He discovered that therapists who ignore the transference-counter-transference psychodynamics, risk behaviors such as acting-out sexually with their clients and attempt to rationalize it on other grounds, such as the importance of establishing “contact” with their patients, or of removing the sexual inhibitions or fears of “intimacy” of their patients (Marmor, 1972).

Additionally, despite all of the “technical” explanations that these therapists may Attach to their erotic exchanges with their patients, the fact remains that the great majority of patients divest such intimacies with reality connotations, and develop hopes and expectations that are doomed to disappointment. The majority of psychotherapists know that eroticized fantasies of transference – love of tent develop in female patients, but when the therapists lends reality to these fantasies by his overt behavior, he facilitates a serious confusion between reality and fantasy in such patients. The climate consequences are inevitably anti-therapeutic (Marmor, 1972).

McCartney’s discernment that there is a parent-child element to the transference relationship between therapist and patient is indeed correct, but the logic by which he then proceeds to justify an overt sexual relationship between the “parent” and the “child”

is little short of remarkable (Marmor, 1972).

It is precisely because this kind of unconscious relationship exists between patient and therapist that an erotic exchange between them cannot be ethically or psychotherapeutically justified. Since when is it necessary for a parent to have sexual intercourse with his children in order to enable them to achieve sexual and emotional maturity? Such behavior between a therapist and patient has all the elements of incest at an unconscious psychodynamic level, and represents an equivalent dereliction of moral responsibility (p. 6).

In scrutinizing the cases where there has been sexual malpractice, the data from the Insurance Trust indicate that there has been a marked increase in all claims in the last three years, and especially in claims of sexual malpractice. From 1976 through 1984, a total of 726 claims had been filed. Two hundred sixty-six of these claims were filed from 1976 through 1981, a rate of 44 per year for all claims, and 460 claims, for a rate of 153 claims per year, from 1982 to 1984 (Cummings and Sobel, 1985).

Sexual malpractice involves the violation of a trust by the therapist to the patient. The judgments regarding sexual malpractice suits have exceeded all other judgments by at least twofold, since juries find the concept of violation of this trust as very disgusting to them. As a result of this, in 1985, rather than sexual malpractice being an exclusion on the Trust's policy as it has been, the Trust will not pay damages in such cases only to a maximum of \$25,000 for either defense or judgments or a combination of both (Cummings and Sobel, 1985).

Between 1976 and 1981 there were 32 sexual malpractice claims, a rate of 5 per year, all of female patients against male psychotherapists. Between 1982 and 1984, 72 sexual malpractice cases had been filed, a rate of 24 per year – a dramatic increase. Of these, 55 cases consisted of female patients against male therapists (Cummings and Sobel, 1985).

Psychotherapists are vulnerable in the sense that the psychotherapeutic relationship involves an emotional transference. This type of emotional transference

makes it impossible, in the eyes of the courts, for a psychotherapist to go to bed with a patient and simultaneously give this patient proper therapy. It also brings up the question of whether termination of treatment is sufficient in order to initiate a sexual relationship. A number of cases have been filed where treatment has been terminated, a sexual relationship has been started, and a malpractice suit has subsequently been filed. The courts have ruled that the emotional transference is still extant even though the termination has taken place (Cummings and Sobel, 1985).

The behavior of some of our colleagues who have been accused of sexual misconduct is quite appalling to many of us and would be considered unethical. Some carriers have held that confidentiality is primary in all cases and thus will not allow the Insurance Trust to transfer any information to the APA Ethics Committee or to any outside organization. This is in marked contrast to the motion that the APA Council of Representatives passed allowing the APA Professional Services Review Office to transfer recommendations from peer reviewers that based on a peer review report the therapist's behavior may be unethical to the Ethics Committee and revealing that individual's name. However, once a suit is filed the information is public, but the Insurance Trust will not disseminate this information. Some mechanism needs to be developed for the APA Ethics Committee to learn of the malpractice suits that have been filed and settled, but such a mechanism has not been developed to date (pp. 187-188).

In conclusion, a growing and professional need exists in regards to examining the factors related to sexual relationships that are established between therapists and patients. Information about the occurrence of this particular problem, its dynamic bases and how it affects both patients and therapists are vitally needed, so that a more responsible professional perspective can be developed instead of our present taboos. The resistance to readily admit the occurrences of sexual contacts, as well as general suppressive attitudes by the entire profession, have resulted in an absence of data to establish any sort of guidelines (Butler and Zelen, 1977).

It is critically imperative that psychotherapists begin to deal openly with the small but severe problem – that some therapists sexually abuse their patients. With predoctoral education and discussion this problem can be seen by the entering professional as one of

the “risk areas” faced by many of the helping professionals. With education, those psychotherapists who exhibit this problem behavior can first identify themselves for themselves, and then get the help they need. Additionally, with the openness and education, patients who have been victimized may be able to secure assistance more rapidly so that the damage done to them may be more readily and more easily remedied (Zelen, 1985).

At the present time the alternatives for these at-risk, “troubled” therapists is a not-so-simple (or easy) avoidance, a rare “at-risk” treatment program, or else a drastic (and not-so-simple) punishment. Preparation for these kinds of issues must begin early in the professional’s career with adequate training in ethics and recognition given in graduate-professional training and continuing on through to the senior diplomate level (Zelen, 1985).

In a stressful profession, with such a high suicide rate, unmet needs for affection and intimacy, not necessarily sexual, can be devastating if not dealt with. Practitioners must be made aware in the course of their predoctoral as well as in their general professional education that these kinds of periods do occur and that there are institutional resources external to their own professional practice to which they can turn. Many more of these institutions must be developed and they must become openly available. The profession itself must develop and maintain “troubled-therapist centers” where a wide variety of patient-therapist problems, including need for and feelings of sexual intimacy with patients (but not restricted to exclusively), can be explored (Zelen, 1985).

It is intriguing to note that difficulties of these kinds have always beset the ministers, the healers, and the advisors. But the “psychotherapeutic profession” may well be the first to meet the challenge openly, and to utilize the tools of its science to

cope with these problems. Once again a new double-bind develops, the conflict between justified and justifiable professional ethics and legal sanctions on the one hand, and the need of the profession and society to redirect and salvage these individuals on the other (Zelen, 1985).

Aside from the profound legal and ethical dilemmas involved when a troubled therapist has been identified, not only should the profession offer him or her work, discreetly but effectively; it must help the troubled clinician to limit his or her practice to safe sex and age parameters. The therapeutic professions must become aware of their own and their colleagues' vulnerability, so that troubled colleagues may be assisted, not have their unprofessional and unethical conduct denied and covered up. Most important, heightened awareness will enable the helping professions to drop the false model of omniscience and omnipotence (p. 184).

In our efforts to salvage the therapist let us not forget the vulnerable and often neglected patient, the other side of the vulnerable – abused dyad. It would be beneficial 1) if psychotherapists claimed responsibility for the sexualization of the therapeutic process; 2) if the therapeutic profession was aware of the special vicissitudes caused by this sexualization and the special needs these abused patients have, and then instructed about this in their professional training programs; 3) if these patient-related problems could be coped with openly, so that we could procure data at an earlier stage and from a considerably larger sample; 4) if those patients who terminate therapy immediately upon being propositioned were compared with those who lingered, so that there would be evidences of patient strengths and deficiencies; 5) if comparisons could be conducted between those patients who continued the intimate relationship with those who seized sexual intimacy but continued with the professional relationship; and 6) if all this information could give us a “risk factor for a patient,” aside from the “risk factor of the therapist” (Zelen, 1985).

The public likewise must be educated, in a non-alarmist manner, to the consumerism of therapy and the rights of the patients. Better professional education, heightened awareness, and better consumerism will in turn lead to

the establishment of more clear-cut guidelines for both ethical and legal sanctions and viable clinical assistance programs for patients who may have acted in the role of therapist and those who came to be "patients" (p. 185).

REFERENCES AND ADDITIONAL RESOURCES

- Bouhoutsos, J., Holroyd, J., Lerman, H., Forer, B. & Greenberg, M. (1983). Sexual Intimacy between Psychotherapists and Patients. **Professional Psychology: Research and Practice**, 14, 185-196.
- Butler, S., & Zelen, S.L. (1977). Sexual Intimacies between Therapists and Patients. **Psychotherapy: Theory, Research and Practice**, 14, 139-145.
- Cummings, N.A. & Sobel, S.B. (1985). Malpractice Insurance: Update on Sex Claims. **Psychotherapy**, 22(2), 186-188.
- Dahlberg, C. (1970). Sexual Contact between Patient and Therapist. **Contemporary Psychoanalysis**, 6, 107-124.
- Kardener, S.H. (1974). Sex and the Physician-Patient Relationship. **American Journal of Psychiatry**, 131, 1134-1136.
- Kardener, S.H., Fuller, M. & Mensh, I.N. (1973). A Survey of Physicians' Attitudes and Practices regarding Erotic and Non-Erotic Contact with Patients. **American Journal of Psychiatry**, 130, 1077-1081.
- Kardener, S.H., Fuller, M. & Mensh, I.N. (1976). Characteristics of Erotic Practitioners. **American Journal of Psychiatry**, 133, 1324-1325.
- Marmor, J. (1972). Sexual Acting-Out in Psychotherapy. **American Journal of Psychoanalysis**, 22, 3-8.
- Zelen, S.L. (1985). Sexualization of Therapeutic Relationships: The Dual Vulnerability of Patient and Therapist. **Psychotherapy**, 22(2), 178-185.

ACKNOWLEDGEMENTS AND NOTICES

This article was prepared by Dr. Jay-Todd J. Schuder, who earned his Doctor of Addictive Disorders (Dr.AD) degree from Breining Institute.

This article may contain opinions that do not reflect the opinion of Breining Institute, and Breining Institute does not warrant the information and/or opinions contained herein.

This copyrighted material may be copied in whole or in part, provided that the material used is properly referenced, and that the following citation is used in full: Schuder, J-T.J. (2004). Professional Ethics: Sexual Relations with Clients / Patients? **Journal of Addictive Disorders**. Retrieved from <http://www.breining.edu>.