JACQUELINE BOUHOUTSOS, JEAN HOLROYD, HANNAH LERMAN, BERTRAM R. FORER, AND MIMI GREENBERG

Sexual Intimacy Between Psychotherapists and Patients

Information regarding the nature and effects of sexual intimacy between psychotherapist and patient is reported by 318 psychologists who treated 559 patients who had such prior involvement. Characteristics of the previous therapists, their patients, and their relationships are presented. Ninety percent of the patients were reported to have suffered ill effects.

Historically, the health professions have assumed that effects of sexual intimacy between psychotherapist and patient are negative (American Psychological Association [APA], 1975; Boas, 1966; Holroyd & Brodsky, 1977; Kardener, Fuller, & Mensh, 1973; Keith-Spiegel, Note 1), and such intimacy has recently been proscribed in ethics codes (American Psychiatric Association, 1973; APA, 1979; National Association of Social Workers [NASW], 1980. A marked increase in the number of civil cases and ethics committee cases suggests growing public sensitivity to the problem.

Attorneys defending therapists accused of sexual contact with patients sometimes have attempted to introduce evidence that the patients were seductive, that sexual intimacy during therapy is not below community standards of practice, and that sexual intimacy with patients may be beneficial rather than harmful. Expert witnesses have invalidated the first two arguments, but not the third. Seductiveness of the patient is irrelevant, as therapist–patient sexuality is analogous to parent–child sexuality. By that analogue, sexual intimacy between patient and therapist is not viewed as a consensual act between adults.[1] Also, such behavior is not usual and customary by community standards, as only 5.6% of male therapists and .6% of female therapists have been involved in sexual intimacy with patients (Holroyd & Brodsky, 1977; Kardener et al., 1973; Perry, 1976). The third argument has not been refuted by strong evidence showing it to be harmful.

The confidential nature of the therapeutic relationship makes psychotherapy patients unidentifiable and inaccessible to the researcher. Psychotherapists told by patients about instances of sexual intimacy with a former therapist are enjoined by ethical standards (APA, 1973; APA, 1979; NASW, 1980) against reporting such activity to authorities without the patients' approval. Butler (1975; Butler & Zelen, 1977) located eight patients through the therapists with whom they had been sexually intimate, and D'Addario (1977) located 60 patients through public advertisements. The need for more data on the effects of sexual intimacy between patients and psychotherapists is apparent. For this reason, despite possible/probable errors due to memory and secondhand reporting, obviously subjective inferences of causality on the part of the respondents, and a truncated sample that includes only those patients returning to therapy after sexual intimacy, these data are still the best available and will suffice until a better net can be fashioned to collect a better sample.

[1] Memorandum opinion of Judge Vernon G. Foster, Dresser v. Board of Medical Quality Assurance, State of California, C 302489.

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Method

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.[2] 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.

The impact of sexual intimacies on involved patients, their therapy with the previous therapist, and subsequent therapy with the respondents were assessed. The following open-ended questions were designed to elicit all effects, whether positive or negative.

How did sexual intimacies affect the therapeutic process? Did the sexual intimacies with the previous therapist affect the process of your therapy with the patient? If so, how? What effect, if any, did sexual intimacies have on the patient's emotional, social, and sexual adjustment? We are interested in all effects—beneficial, detrimental, or no effects at all. Did the sexual aspect of the therapeutic relationship affect the patient's willingness to recommence therapy with another therapist? How? Did this patient choose you for a therapist for some reason relating to the sexual encounter? Reason: Additional comments on why this happened and effects on the patient.

Brief demographic and attitudinal data were collected on all of the respondents, including

[2] The questionnaire and cover letter are available from the first author on request.

JACQUELINE BOUHOUTSOS *received her PhD from the University of Innsbruck, Austria. She was chair of the California State Psychological Association (CSPA) Task Force on Sexual Intimacy Between Psychotherapists and Patients (1978–1981) and president of CSPA in 1981. She is founder and president of the Association for Media Psychology, and her current research interests include the impact of electronic media on listeners, callers, and the mental health professions. She is in private practice in Santa Monica and clinical professor of psychology, University of California, Los Angeles.*

JEAN HOLROYD *received her degree from the University of Minnesota. She is a professor in the Department of Psychiatry and Biobehavioral Sciences at the University of California, Los Angeles (UCLA) and associate director of clinical psychology training at the Neuropsychiatric Institute, UCLA. Her professional interests are hypnosis, health psychology, psychology of women, and education and training.*

HANNAH LERMAN *received her PhD from Michigan State University and is in the private practice of psychology in West Los Angeles. She is primarily interested in women's issues in psychology and is currently writing a book on Freud and the psychology of women.*

BERTRAM R. FORER *received his PhD from University of California, Los Angeles. He is in part-time private practice in Malibu, California. His current professional interest is in the psychology of travel, with special attention to identity, habitat, and interpersonal patterns.*

MIMI GREENBERG *received her PhD from the California School of Professional Psychology, Los Angeles campus. She is in private practice in Los Angeles and has special interests in posthospitalized adults and abused and neglected adolescents.*

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REQUESTS FOR REPRINTS *should be sent to Jacqueline Bouhoutsos, California State Psychological Association, 2100 Sawtelle Boulevard, Suite 201, Los Angeles, California 90025.*

Table 1: Age Distributions (%)

Age groups	Respondents (N = 318)	Sexually intimate therapists (N = 559)	Patients (N = 559)
<30	2	3	50
30-39	34	29	37
40-49	25	48	11
50-59	26	17	2
60+	13	3	0

whether they had engaged in sexual intimacies with patients and whether they had been consulted by other therapists about the topic.

Narrative responses to questions were coded into categories for frequency tabulation, and nonoverlapping categories were created for chi-square contingency relationships where necessary.

Results

RESPONDENTS

Questionnaires were returned by 704 psychologists. Three hundred eighteen of these (64% male, 35% female, 1% not stated) provided data for 559 patients. Fifty-seven percent of the respondents citing cases gave information for one case, 22% for two cases, 12% for three cases, and 9% for four or more cases. The age distributions of respondents who reported cases can be seen in Table 1. The gender of these respondents was significantly different from that of all licensed California psychologists (28% female, 72% male), $\chi^2(1) = 8.41, p = .005$. Sixty-nine percent of female respondents compared with only 28% of male respondents reported the patient chose them as a therapist for reasons related to the sexual experience, $\chi^2(1) = 79.68, p = .0001$. Twenty-one male respondents (4.8%) and two female respondents (.8%) in the entire sample of 704 reported having engaged in sexual intimacies with patients, a significant gender difference, $\chi^2(1) = 7.78, p = .005$. Seventy-eight percent of these 23 respondents reported that they had had patients who had been sexually intimate with a previous therapist, whereas only 44% of respondents who had not had sexual relationships with patients reported such cases.

Patients and Their Previous Therapists

Ninety-six percent of the previous therapists reported to have engaged in sexual intimacies were male, and 4% were female. The majority (79%) practiced in a private office, 14% practiced in a clinic, and 7% practiced elsewhere. The age distribution of the sexually involved therapists and patients may be found in Table 1. The mean age of the previous therapists (42 years) was significantly greater than the mean age (30 years) of the patients ($t = 26.77, p = .0001$). There was a significant association between therapist age and patient age (older therapists with older patients) where the therapist was male: $\chi^2(3) = 7.76, p = .05$, for 11 male patients; $\chi^2(12) = 33.95, p = .0007$, for 351 female patients. That relationship did not obtain in cases where the previous therapist was a female.

Table 2: Gender of Patients and Previous Therapists

Previous therapist gender	Patient gender: Male (N = 31)	Female (N = 498)	Total (N = 529)
Male	18	489	507
Female	13	9	22
Total	31	498	529

The patients included 509 females, 33 males, and 17 with gender not stated. Genders of patients and their previous therapists are listed in Table 2 for cases in which both are reported. Ninety-two percent of the reported sexual relationships occurred between female patients and male therapists, $\chi^2(1) = 117.90, p = .0001$. The majority of sexual relationships with male patients (58%) also involved male therapists.

THE SEXUAL AND THERAPY RELATIONSHIP

Sexual intimacies began within the first few sessions for 30% of the patients, after 3 months for 25%, after 6 months for 22%, after a year for 19%, and within 3 months after ending therapy for 4%. Therapy ended immediately for 34% of the patients, after 1–3 months of sexual intimacies for 24%, 4–12 months for 26%, and after more than a year for 16%. Both therapy and the sexual relationship ended simultaneously for 55% of the cases. Therapy ended while sex continued for 27%, while sex ended and therapy continued for 18%. The total course of therapy was 6 months or less for 34% of the patients, 7–12 months for 33%, over 1 year for 27%, and more than 3 years for 6%. The sooner sexual intimacies began, the shorter the period of time that therapy could be sustained, $\chi^2(20) = 188.02, p = .001$.[3]

Termination of therapy was usually initiated by the patients. Sixty-seven percent of patients and 15% of therapists terminated therapy, 17% mutually terminated, and 1% had therapy terminated by someone else. There was a significant relationship between who initiated sexual intimacies and who ended therapy, $\chi^2(8) = 20.00, p = .01$. ("Initiated" was not defined but was generally assumed to reflect the attitude of the patient describing the incident to the subsequent therapist.) Almost three fourths of patients ended therapy unilaterally if the previous therapist initiated sex; but only 50% ended therapy unilaterally if the patient was the initiator, and 43% ended therapy if the sexual intimacies were mutually initiated. The therapist was unlikely to end therapy unilaterally no matter who initiated sex (15% if therapist initiated, 14% if patient initiated, and 27% if mutually initiated).

The association between who ended the treatment (therapist, patient, mutual, spouse, other) and whether sex or therapy ended first was also significant, $\chi^2(8) = 21.75, p = .005$. When patients ended therapy, they ended sexual involvement and therapy simultaneously in 63% of the situations, they ended therapy first in 20%, and they ended sexual relations first in 17%. When therapists ended therapy, the comparable figures

[3] The sexual relationship began after 2 years of therapy for three of the five patients who later married their therapists. In most other respects, the relationships of these five pairs appeared similar to other reported relationships.

Table 3: What Constitutes Sexual Intimacy?

Variable	%
Type of activity[a,b]	
Intercourse	58
Oral–genital contact	8
Masturbation	4
Attempted intercourse	2
Touching, fondling, caressing, petting, kissing	17
Discussion of intercourse	3
Exhibition	1
Group sex	1
Other acts	3
Not specified	21
Person who introduced sexual intimacies	
Therapist	42
Patient	6
Disputed or mutual	7
Undetermined	45
Place of activity[b]	
Therapists' office	39
Therapist's home	5
Patient's home	5
Other	11
Unknown	43

[a] Not all respondents answered the question, "What was the nature of the sexual intimacies and how did they begin?" Therefore, percentages do not add to 100%.
[b] In some cases responses were scored for more than one category.

were 44%, 35%, and 44%. When patient and therapist mutually ended therapy, the figures were 45%, 39%, and 16%. In other words, when patients ended therapy, they ended sex and therapy simultaneously more often than when therapist or patient and therapist together ended therapy. Also, fewer patients continued the sexual relationships after they themselves initiated ending therapy, compared with instances in which the patient and therapist mutually ended therapy and instances in which therapists alone ended therapy. In 78% of the cases, payments continued after sexual intimacies began. Furthermore, there was no relationship between who ended treatment and whether payment continued.

WHAT CONSTITUTES SEXUAL INTIMACIES?

Responses were analyzed for type of sexual activities, who did what to whom, and where the activities occurred (Table 3). Who introduced sex into the therapy relationship, how, and rationales given for the behavior were also analyzed. There was much variation in the number of details provided by the respondents. Usually sexual intimacy meant intercourse. Ten percent of the cases were described as beginning casually with "one thing leading to another," whereas 15% involved seduction on the part of the therapist, who in some cases held out promise for a longer relationship. Drugs or alcohol were inducements in 2% of the cases; rewards or bribery in 1%. Reasons for sexual intimacy, when given, included psychotherapeutic purposes (11%), helping a patient with low self-esteem (7%), treatment of sexual dysfunction (4%), and the therapist's need or interest (9%). There were 11 cases (2%) of rape.

Table 4: Effects on Patient and on Therapy Process

Question	%
What effect, if any, did sexual intimacies have on patient's emotional, social and sexual adjustment? We are interested in all effects—beneficial, detrimental, or no effects at all.	
Patient's personality was adversely affected	34
Patient had negative feelings about the experience	29
Patient's sexual, marital, intimate relationships worsened	26
Patient became healthier or improved emotionally and/or in sexual relationships	16
No effect	9
How did sexual intimacies affect the therapeutic process?	
Ended therapy	37
Interfered with therapy	40
Minimal or no effect	5
Positive effect	6
Did the sexual intimacies with the previous therapist affect the process of your therapy with the patient? If so, how?	
Negatively affected patient	25
Negatively affected patient's view of therapists and therapy	14
Negatively affected process of therapy	29
Speeded process of therapy	2
Did the sexual aspect of the therapeutic relationship affect the patient's willingness to recommence therapy with another therapist? How?	
Made it more difficult	48
Patient quickly sought help which was needed to resolve conflict engendered	5
Did this patient choose you for a therapist for some reason relating to the sexual encounter? Reason:	
Gender of therapist	25
Professional reputation for ability, ethics, or gender orientation	13
Patient wanted assistance in dealing with problems engendered by sexual contact	9
Referral by therapist–sexual partner	2
For continued sex	1

Note. Narrative responses to each question were written by differing numbers of respondents. Percentages are based on the total number of cases (559) and therefore are conservative estimates. However, the same case could appear in more than one category due to multiple responses.

EFFECTS ON PATIENTS AND THERAPY PROCESS

Table 4 summarizes the effects on patients and on the therapy process. Percentages reported are regarded as conservative estimates, as they are based on total number of cases, and not all respondents answered the questions. The kinds of evidence that personality was adversely affected (the first category in Table 4) included increased depression, loss of motivation, impaired social adjustment, significant emotional disturbance, suicidal feelings or behavior, and increased drug or alcohol use. Eleven percent of the 559 cases were hospitalized and 1% committed suicide. Among the 26% for whom sexual, marital, or intimate relationships worsened (the third category in Table 4), 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 impaired for 7%. Of course, some cases were represented in more than one outcome category.

Forty-eight percent of the 559 cases reported had problems in recommencing 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, $\chi^2(4) = 13.36, p = .01$. A high percentage of those who only progressed as far as talking about having sexual relations immediately sought help from another therapist (43%).

Considering all responses given to the first four questions in Table 4, 87% of the patients experienced negative effects on 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.

Who initiated the sexual relationship was related to adverse effects on the patient's emotional, social, and sexual adjustment, $\chi^2(12) = 65.97, p = .0001$, and to adverse effects on the previous therapy, $\chi^2(9) = 29.39, p = .0006$. When the therapist initiated sexual intimacies, the patient was adversely affected in 82% of the cases, and the previous therapy ended or suffered interference in 93% of the cases. When the patient initiated sexual intimacies, the patient was adversely affected in 39% of cases, and the previous therapy ended or suffered interferences in 74% of the cases. Positive effects, although rare, were more likely to be found when the patient or the patient and therapist initiated sexual relations.

CHOICE OF RESPONDENT AS THERAPIST

Thirty-eight percent of the respondents responded "yes" to, "Did this patient choose you for a therapist for some reason relating to sexual encounter?" Twenty-five percent of the 559 chose the respondent because of gender: 20% female therapists, 3% male therapists, 2% unspecified. Other reasons for choosing the respondent included professional reputation for ability, ethics, or gender orientation (13%); need for assistance in dealing with problems related to or resulting from sexual contact (9%); and referral by the previous therapist with whom the patient had been sexually intimate (2%). Referral by the previous therapist occurred particularly often (33%) when both therapist and patient initiated the sexual relationship, $\chi^2(15) = 34.82, p = .003$. Respondents also reported that 1% of the patients wanted a sexual relationship with them.

Finally, more respondents who engaged in sexual intimacies regarded the effect of sexual intimacy on their clients' previous treatment to be minimal (11%) or even positive (14%), and fewer reported that the sexual contact had ended the previous therapy, $\chi^2(3) = 13.03, p = .005$. Also, more respondents who admitted to sexual intimacies regarded adjustment of the patient they reported to be improved (32%) or not affected (15%), and a lower percentage regarded the patient as having been affected for the worse, $\chi^2(4) = 17.68, p = .0014$.

LEGAL AND ETHICAL ACTIONS TAKEN

Fifty-two percent of the patients were aware that the therapist's behavior was unethical and illegal. However, only 4% took legal action, 3% notified an ethics committee, and 3% notified the state licensing board. A complaint was lodged by someone else in another 3% of the cases. In the few cases in which a complaint was lodged, one third of the patients took action immediately, and one third took action in the next 6 months; however, 14% waited 3 years or more before taking action. Results of the filed complaints were "nothing happened" in 55% of the cases.

Discussion

The meaningfulness of these data on 559 patients who have discussed the effects of their previous sexual intimacy within the context of subsequent therapy with a psychologist must be evaluated in the light of information about our sample characteristics. Our study is limited to patients who sought out psychologists, regardless of the profession of the therapist with whom they had been sexually intimate. We do not know the effects for patients who did not return to therapy, although the number may be small. Stone (1980) found that 90% of her sample of women who had been sexually intimate with a therapist returned to therapy with a new therapist.

Only 704 psychologists out of more than 4,000 surveyed (16%) returned their questionnaires—not a very representative sample. The most probable reason for low response rate was that our request that everyone return the questionnaire with demographic information (age, sex, etc.), even if they had no cases to report, was buried in the third paragraph of the cover letter. Those psychologists lacking cases to report may have simply thrown out the questionnaire. Nevertheless, there is indirect evidence in the pattern of returns that most psychologists who had cases to report did so. When questionnaires were divided at the median in terms of when they were returned to us, 301 of the 318 psychologists reporting cases were represented in the first 50% of questionnaires returned; this suggested eagerness to reply among those who did have case material to report. Time of questionnaire return as a measure of respondent motivation was suggested by Holroyd and Brodsky (1977), who inferred that nonrespondents had a higher incidence of intercourse with patients than respondents, as respondents who had had intercourse with patients generally waited longer to reply (only 4 responding in the first 400 replies, compared with 17 in the next 303 replies in their study).

How truthful were these respondents? They confessed to sexual contact with their own patients in roughly the same number as established by earlier surveys (4.8% male respondents, .8% female respondents). The similarity of incidence figures when different questions are used with different samples constitutes validation of those earlier findings as well as indirect support for the validity of our data.

How truthful were the patients in reporting the effects of earlier sexual contact with therapists? Most of the respondents believed their patients; in only three instances did respondents question the data. However, the material may be shaped by respondent and patient memory as well as by the usual biases associated with self-report and secondary sources. To assess the effects of those biases, we have to reply on the plausibility of the data reported and ultimately on the confirmation of data from other sources, such as research by other investigators who use different yet complementary methods.

The source of bias most difficult to assess is that incurred by self-selection of patients who returned to therapy after having had sexually intimate experiences with an earlier therapist. Potentially, two different groups of patients are not represented in this sample: those who felt they did not need additional psychotherapy and those who were too traumatized to seek psychotherapy, even though it was needed. There is a clear need for research that locates patients who did not return to therapy with a second therapist.

A criticism that may be leveled at this research on therapist–patient sexuality is that "sexual intimacy" is not defined. In evaluating impact on patients, we chose to include all behaviors our respondents regarded as sexually intimate. One serendipitous result was an empirical definition of sexual intimacy by psychologists in practice. The majority of the cases reported involved sexual intercourse. Some cases, however, were reported in which only a therapist's verbal suggestion of sexual contact was sufficiently upsetting to cause the patient to seek another therapist. Between intercourse and the discussion of intercourse were all gradations of behavior considered sexual intimacy by psychologists and their patients, including a number of cases involving touching, fondling, caressing, petting, or kissing.[4] The respondents, as well as the previous therapists, were considerably older than their patients, but it was not necessarily a Lolita type of relationship implied in the earlier literature.

Bearing on the question of what constitutes sexual intimacy in the therapeutic relationship is the definition of that therapy relationship. As far as we know, distinctions have not been made between brief-treatment patients (e.g., hypnosis for smoking) and long-term-treatment patients, between people in growth-oriented and psychopathology oriented therapy, between those in group and individual treatment, or between patients and their relatives seen in collateral consultation (e.g., parents of child patients).

Another area for future discussion is the time variable. Although some psychologists[5] feel a therapist is obligated to end therapy if a sexual relationship is developing and there is mutual desire to change the relationship structure, others feel that this would result in expedient and premature endings to therapy. Many of our respondents included cases in which the sexual contact was made after therapy ended but within a period of 3 months—an arbitrary cutting point adopted in previous research (Holroyd & Brodsky, 1977) and continued here. Ethics codes are not specific on this matter of the duration of the therapeutic relationship. Some authors (Davidson, 1977; Finney, 1975) have suggested that a therapist should not ever have sex with a person once seen in the therapeutic context.

[4] The courts have ruled that sexual misconduct can take place without actual intercourse. *Cardamon v. State Board of Optometric Exam* [165 Col. 520, 441 p. 2d 25 (1968)] involved an examination of a 14-year-old's breasts with her clothing removed. *Clark v. Michigan State Board of Registration Medicine* [367 Mch. 343, 116 N.W. 2d, 797 (1962)] involved indecent advances toward a woman. *Jacobi v. Texas State Board of Medical Examiners* [308 S.W. 2d 261 (Civ. App., 1957)] dealt with manipulation of genitals of eight women. *Texas v. State Board of Medical Examiners* [159 Tx. 479, 322 S.W. 2d 609 (1959)] involved genital contact short of intercourse with seven women. Licenses were revoked in all of these cases cited.

[5] Rules of Conduct (11th draft, October 31, 1980) of the Minnesota Board of Psychology, 717 Delaware Street, SE, #343, Minneapolis, Minnesota, 55414: "Psychologists shall not engage in any non-professional relationship (sexual, social, economic, etc.) with a client. If the psychologist has an interest in developing any such non-professional relationship with a client, the psychologist shall terminate the professional relationship and inform, in writing, the client and the Board of Psychology. The psychologist shall, also, consult with at least two other licensed psychologists for the purposes of providing any necessary referral of the client and providing any other assistance needed. The names of the psychologists who are consulted shall be provided to the Board in writing" (p. 7).

The primary aim of this research, to discover the effects of sexual intimacy on patients and their therapy, seems to have been achieved. Even though ample opportunity was provided for reporting positive outcomes, the results of this study clearly demonstrate that sexual intimacy within the therapeutic context is harmful to patients. In our study those who purportedly engaged in sex for therapeutic purposes (11% for general therapeutic purposes, 4% for sex therapy) certainly could not have been relying on clinical or scientific evidence that it is a helpful therapy procedure, for there are few reports of positive effects in the literature (but see McCartney, 1966; Shepard, 1971; Taylor & Wagner, 1976). In this study there were some positive effects in 16% of the cases (improved patient self-concept, improved sexual adjustment, etc.). It is necessary, however, to keep in mind that many of these patients also experienced negative effects. Only 10% of the patients were reported to have come through the experience unscathed.

Two findings new to the literature on sexual contact in therapy deserve mention. They have bearing on hypothesized reasons for the occurrence of sexual contact. Kardener (1974) has suggested that the social isolation of a private practice might contribute to engaging in erotic behavior. In fact, although most sexual contacts in our study occurred in the course of private practice, in 14% of the cases, the sexual activity took place in a clinic setting. Second, Holroyd (in press) suggested that sex role stereotypes of males in the ascendant, more powerful position and females in the weaker social position permit the acting out of erotic feelings in therapy for male-therapist–female-patient pairings. However, sex role stereotypes do not account for our finding that more than half of the sexual contacts with male patients involved male therapists.

Reasons why sexual intimacies lead to problems in therapy are suggested by this research. It may be said, "When sexual intercourse begins, therapy ends." Data on the typical time frame for sexual relationships within the context of therapy provide some support for this maxim. In our study, once sexual activity began, therapy ended immediately for one third of the patients. Furthermore, for one third of the cases, the onset of sexual intimacies was within the first few sessions, and for three fourths it occurred within the first year. Hence a sizable number of patients did not have the benefits of psychotherapy for their original problems, and added to those problems were the complications of a sexual relationship.

When the therapist was the sole motivator for sexual contact, almost three fourths of the patients walked out on therapy. In fact, the involved therapists almost never terminated therapy, although that has been a recommended option (as mentioned above). When sexual intimacy did become a part of the therapy process, continuation of that sexual relationship seemed necessary if therapy were to continue. Therapy was able to be continued in only 18% of the cases in which sexual intimacy ceased. Thus, control of the course of therapy appears to pass out of the hands of the therapist once sexual intimacy occurs. At the very least, the therapist is limited in his or her ability to help the patient. Sexual intimacy is extremely disruptive of therapy.

A few therapy relationships (16%) continued for over a year after sexuality began. These continuing relationships have been the subject of much discussion about the therapist's responsibility when the patient "chooses" to return weekly for sessions with the therapist and in three fourths of the instances continues to pay for the sessions. Individual comments by respondents suggested that freedom of choice may be illusory, given the strength of transference and the neediness of patients.

Conclusion

This research has provided data in an area that has been extremely difficult to study: the effects of sexual contact on patients. It is important to stress the truncated nature of the sample, which included only those patients returning to therapy after having become involved in sexually intimate behavior with a former therapist. Of the 559 patients described, 90% were reported to have suffered some ill effects from sexually intimate involvement with their previous therapists. The ill effects, which ranged from difficulty trusting a new therapist to committing suicide, could be traced to therapist behaviors that extended from intercourse to merely proposing sexual relations. Sexual contact was especially disruptive if it began early in the relationship (the majority of cases) and if it had been initiated by the therapist (also the majority of cases). We conclude that sexual intimacy in therapy is harmful, for 9 out of 10 patients in this sample were adversely affected. The harmfulness of sexual contact in therapy validates ethics codes of the mental health professions prohibiting such conduct and provides a rationale for enacting legislation proscribing sexual contact between psychotherapists and patients.

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