Sexual Boundary Violations by Health Professionals – an overview of the published empirical literature

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EXECUTIVE SUMMARY

INTRODUCTION

Clinical and therapeutic interventions inevitably render individual patients and clients vulnerable, and trust relies on providing a safe and boundaried space in which these can be carried out without compromising the person's dignity and bodily integrity. Sexual boundary violations occur wherever a clinical or therapeutic relationship is turned into a sexual or sexualised encounter. It is always the responsibility of the practitioner to manage and maintain these boundaries.

A scoping of the existing literature was commissioned as one component of the Council for Healthcare Regulatory Excellence's (CHRE) national project on Clear Sexual Boundaries between health care professionals and patients. The objective was to scan and review current research on sexualised behaviour by health and social care workers towards patients. The review focuses on:

- Clarifying the **nature of sexual boundary violations**
- The **prevalence** of such violations
- The **impact** on patients and clients
- **Predictors** of sexual boundary crossing or violation by professionals with patients or clients.

METHOD

Three electronic databases were searched – Medline, PsycLit and Social Care Online, for all dates from 1970 to May 2006. Papers were only read in full and included in this report if they reported empirical data.

Limitations include difficulties around definitions of 'sexual boundary violation' and of 'professionals'. Also, the evidence base is also inherently problematic as sexual boundary violations are essentially covert.

KEY FINDINGS

Boundaries

Discomfort, attitudes and lack of clarity regarding boundary crossing

- The majority of responding health professionals view sexual contact with patients/clients as inappropriate and harmful
- Health professionals education and/or training on sexual ethics is widely perceived as inadequate
- There is a lack of consensus amongst health professionals regarding the definition of an '*ex* client/patient'
- Health professionals being able to openly discuss sexual attraction to patients/clients with a supervisor was supportive and increased professionals understanding
- Health professionals expressed confusion about whose responsibility it was to maintain sexual boundaries
- Professionals had scant knowledge about how to handle situations involving sexual boundary violations and many would not report colleagues.

Ways in which to decrease sexual boundary violations

- Professionals who have received education/training on sexual boundaries are less likely to 'offend'
- Factors to consider in training include communication skills, manner, explanations, sensitivity to patient's perceptions, use of chaperones, and avoidance of sexual humour
- Positive training environments promote healthier coping responses by professionals

Reported prevalence and incidence

- The majority of reported sexual boundary violations involve male health practitioners and female patients/clients
- Between 38 and 52% of health professionals report knowing of colleagues who have been sexually involved with patients, although several professionals may be citing the same case. Self-reporting rates are considerably lower
- Self-reporting by health professionals acknowledges high levels of patient attraction
- Greater awareness of professional guidelines and sanctions reduces prevalence.
- For therapists: Between 22 and 26% of patients report having been sexually involved with a previous therapist to another practitioner

Impact of boundary violations

- The impact on survivors of professional sexual boundary violations/abuse shows considerable and enduring harm
- Symptoms include post traumatic stress disorder, anger, a sense of betrayal and exploitation, guilt and self-blame
- High levels of dependency on the offending health professional, confusion and dissociation are found
- The negative impact of sexual abuse by professionals can be exacerbated by a patient/clients youth and a previous history of sexual abuse

Factors associated with boundary violation

- Difficulties in researching the subject, together with an understanding of systemic and organizational factors, leads to reluctance to rely on a predictive profile of offenders
- Rather than a simple 'bad apple' model, an alternative view is that *all* health professionals should be aware of their 'trouble spots' around sexual boundary issues
- A higher proportion of offenders are male, older than 'average' sex offenders, and suffer from a variety of psychopathologies
- Professionals who themselves had been severely sexually abused are more likely to have engaged sexually with patients/clients
- Women are the main victims of abuse
- A significant proportion of abused clients are previous victims of abuse.

SUMMARY and FURTHER RESEARCH

This report highlights the large empirical literature on sexual misconduct by health professionals. The studies show similar findings across different professional and semi-professional groups. Findings are similar across different countries.

Despite the methodological limitations of this review, it is possible to draw out a number of themes from the studies:

- Clear sexual boundaries are crucial to client safety of the patient/clients
- Specific education changes attitudes toward sexual contact with patients/clients but must be delivered in a conducive environment
- Sexual boundary violations commonly result in significant and enduring harm to patients/clients

- Reported incidence of abuse is low, but concentrated in general practice and psychological therapies
- Client vulnerability is associated with higher prevalence.

Further research is recommended as follows:

- UK based studies, within general practice, psychiatry and obstetrics and gynecology
- Research in other regulated professions
- Research in non-regulated professions, particularly psychotherapy, complementary medicine, and within social and long term care
- Research as to the effectiveness of different educational interventions.

1. INTRODUCTION

1.1 SEXUAL BOUNDARY VIOLATIONS

What are "sexual boundary violations"? The term is used to describe a range of situations in which professional boundaries are crossed and sexual actions and feelings are allowed to enter into a relationship which is supposed to operate in the interests of the patient/ client, and which, by virtue of the patient/client's vulnerability, is inherently unequal. The patient is, at least temporarily, dependent on the clinician and relatively needy in relation to him or her. Clinical interventions necessarily involve crossing ordinary social boundaries in order, for example, to do physical examinations or to explore difficult feelings and emotions. This can only be done if the patient/client can be sure that this is a safe and non-sexual space. Patients are not in a position to give valid consent to sexual involvement with health professionals as they are bound into the unequal relationship in which they have real need and which is either a fiduciary relationship (that is it is being paid for by them as individuals), or provided as part of a service level agreement or contract with a voluntary body or public service.

Sexualized behaviour was defined in the Independent Investigation into how the NHS handled allegations about the conduct of Clifford Ayling as behaviour that was:

"Over familiar to sensitive and intimate examinations which bordered on the unprofessional and was distressing to both the recipient and observer." (Para 2.26)

(Pauffley, 2004)

For the purposes of this literature review we have defined sexual boundary violations in the following terms:

Clinical and therapeutic interventions inevitably render individual patients and clients vulnerable, and trust relies on providing a safe and boundaried space in which these can be carried out without compromising the person's dignity and bodily integrity. Sexual boundary violations occur wherever a clinical or therapeutic relationship is turned into a sexual or sexualised encounter. It is always the responsibility of the practitioner to manage and maintain these boundaries.

As the literature demonstrates, the term is used to describe a number of situations and circumstances, for example:

- Clinical interventions of an intimate nature which are not warranted by the person's condition and/or are carried out inappropriately
- Clinical interventions such as intimate examinations which are wrongly framed in sexual terms or accompanied by sexual comments
- Clinical or therapeutic relationships in which the sexual gratification of the clinician takes precedence over the therapeutic goals and needs of the patient/ client
- Clinical or therapeutic relationships in which sexual attraction or emotional closeness is acted upon by the practitioner whose role it is to maintain boundaries in the interest of the clinical or therapeutic needs of the patient/ client
- The practitioner responding to sexual approaches made by a patient or client especially as these may be indicative of previous boundary violation or confusion
- Mutual attraction that is acted upon while a clinical or therapeutic relationship is still in operation or recently terminated.

Dual relationships, in which a social relationship occurs alongside a clinical responsibility, for example where a GP meets patients in other community settings, or in which a pastor/ counsellor becomes a friend in the context of other community activities, are not in themselves boundary violations. However, they may compromise the clinician's impartiality and/or make the

patient uncomfortable in the face of particular medical or therapeutic interventions and consideration should be given to re-assigning the patient to an alternative practitioner where this is feasible. A practitioner who deliberately fosters a dual relationship *in order to* initiate a sexual relationship would be considered to have violated a proper sexual boundary.

1.2 LITERATURE SCOPING FOR THE CHRE SEXUAL BOUNDARIES PROJECT

A scoping of the existing literature was commissioned as one component of the Council for Healthcare Regulatory Excellence's (CHRE) national project on Clear Sexual Boundaries between healthcare professionals and patients. The objective was to scan and review current research on sexual and sexualised behaviour by health and social care workers towards patients. The review is intended to inform the development and implementation of the other products of this project, including guidance for healthcare professionals, information for patients, guidance for health employers and future educational materials.

Sexual abuse of patients within professional relationships is not an easy subject to face up to. Many of us would prefer to turn away, to downplay the risks, to preserve the right of professionals to practise without scrutiny or safeguards, and to minimise the evidence that this behaviour causes lasting damage to some, already vulnerable, individuals. This review sets out the evidence for considered reflection, whether as individuals, as clinicians, as managers or as regulators; about our role in preventing such boundary violations and in ensuring that when they occur they are dealt with promptly, fairly and proportionately.

The review could not be strictly systematic, but aimed rather to balance a broad focus on four key areas:

- Clarifying the **nature of sexual boundary violations**
- The **prevalence** of such violations
- The **impact** on patients and clients
- **Predictors** of sexual boundary crossing or violation by health professionals with patients or clients.

These key areas are referred to in short throughout the report as boundaries, prevalence, impact and predictors. The review seeks to provide an overview of findings, to consider the limitations of published research in this area, and to suggest potential future research in this area.

1.3 KEY FINDINGS

The studies reveal a number of key themes, which will be examined in detail in the forthcoming chapters.

- The literature highlights issues of definition and difficulties acknowledging sexual boundary violations, which are usually covert
- Boundaries are crucial to client safety. A slippery slope of sexual violations can occur following other seemingly innocuous boundary crossings.
- Specific education changes professionals attitudes toward sexual contact with patients/clients, but must be delivered in a conducive environment. Professionals can continue to feel unprepared even after educational sessions.
- Sexual boundary violations commonly result in significant and enduring harm to abused patient/client's emotional wellbeing and functioning
- Reported incidence of abuse is low, but concentrated in general practice and psychological therapies
- Client vulnerability is associated with higher prevalence.

2. METHOD

2.1 SEARCH STRATEGY

Three electronic databases were searched – Medline, PsycLit and Social Care Online, for all dates from 1970 to May 2006.

The search strategy used the following MeSH terms and keywords, with the number of records located for each line in brackets:

Medline

1 Sexual Harassment/ (870)
2 Professional-Patient Relations/ (14046)
3 Trust/ (2150)
4 Ethics, Professional/ (5652)
5 Professional Misconduct/ (1812)
6 Boundar….. (With any word ending) (26798)
7 1 or 2 or 3 or 4 or 5 or 6 (50236)
8 Sex$ (462830)
9 7 and 8 (2803)

PsycInfo

1 Professional Client Sexual Relations (414)
2 Dual Relationships/(135)
3 Patient Abuse/(128)
4 4 1 or 2 or 3 (639)

Social Care Online

1 Sexual abuse and ethics
2 Vulnerable adults and sexual abuse

2.2 SELECTION AND CATEGORISATION OF PAPERS

As a first stage, all available abstracts were skimmed to gain an overview of the literature in the four areas of boundaries, prevalence, impact and predictors.

Papers were excluded in the further work if they referred only to sexual harassment of students or colleagues; sexual harassment/abuse of staff by patients; non-sexual boundary crossing and dual relationships; or professional misconduct, with no detail. All of these areas may be relevant in that they appear to provide 'evidence' of the following:

- That sexual boundaries are not infrequently crossed by regulated health professionals
- That patients sometimes initiate unwelcome sexual advances
- That boundaries in general are grey areas, with extensive debate as to their maintenance and management when they are crossed.

However, reviewing these papers in depth was outside the scope of this piece of work.

Some additional papers have been included to reflect work carried out about all abuse of vulnerable adults, within which abuse by health professionals is one subset. This enables reference to be made to the literature on sexual offending and models for understanding covert and abusive sexual encounters from other arenas including child sexual abuse and abuse by priests and clergy. Additional reference is made to Inquiry reports as a source of evidence and informed comment (see Matthews 2004; Pauffley 2004; Pleming 2005).

Papers selected were categorised as belonging mainly to one of the four headings of boundaries, prevalence, impact, or predictors, recognising that some papers provided evidence on all of these. Papers were also

categorised as predominantly an empirical study; literature review; or discursive review, commentary or opinion piece. Papers have only been read in full and included in this report if they reported empirical data.

2.3 ISSUES OF DEFINITION

All aspects of this topic create definitional problems. What, for example, is meant by "sexual"? How are we to distinguish appropriate, though intrusive, interventions, such as an intimate vaginal examination in pregnancy, from acts that are unrelated to clinical concerns or from sexually exploitative relationships that take advantage of the patient's vulnerability in relation to the practitioner? Terminology in itself sets, and limits, the tone of the discussion. It is important therefore to note at the outset that those boundary violations, especially sexual acts that involve individuals who are not able to give proper consent, and/or situations in which the perpetrator exploits a position of trust in relation to the patient/ client, which are against the law should be dealt with through the criminal justice system. This should pre-empt action taken under disciplinary or regulatory mechanisms. The literature referred to in this report has grown up in isolation from the growing evidence base on sexual offending amongst the general population, or of the dynamics of child sexual abuse with its processes of targeting and grooming of potential victims. This generic literature sheds light on the dynamics at work when powerful professionals use their position to sexually exploit their patients or clients.

The use of sanitized terminology, such as "boundary violation" should not obscure the fact that some of these encounters have more in common with other sexual offences than with ordinary clinical practice and are no less serious or culpable simply because they are couched in these terms.

What is meant by "professional" in this context is also open to debate. If the abuse of power is a key element of boundary violations, should non- or less

well regulated professions such as healthcare or social care assistants be included alongside higher status professions such as psychiatrists and gynecologists whose power base is more incontrovertible? Professions outside the health and social care fields, who also wield considerable personal as well as institutional power, are also prone to crossing sexual boundaries in ways that have been well documented. The literature relating to priests and teachers may therefore hold lessons for the health professions (see, for example Goode et al 2003). The literature included in this review tends to focus on those professions that engage in one-to-one encounters and treatment modes, whereas there is also considerable evidence that patients/clients are prone to sexual exploitation within congregate settings such as long stay wards, residential homes and in day care settings, even though the dynamics that pertain in institutional settings may be somewhat different.

The evidence base is also inherently problematic because sexual boundary violations are essentially covert and there are many reasons why individuals would not want to report them and/or might feel powerless to act in the face of them. **Abuses tend to come to light after the event, in spite of protestations from the perpetrator and often in the face of denial or barriers thrown up by institutional processes and defenses. Colleagues may not want to believe their eyes or ears when they see or hear of a fellow professional acting inappropriately. Critically, they may not feel confident enough to challenge or refer the matter to management or to their professional body**. An emerging literature focuses on the systems that exist to promote more systematic reporting and referral, including important interfaces with the systems coordinated by Social Services for safeguarding information about abuse of all vulnerable adults, and this is outlined towards the end of the review.

2.4 LITERATURE REPORT STRUCTURE

This report contains a chapter each on boundaries, prevalence, impact and predictors. Each chapter follows the same format. A brief introduction is followed by a summary of the key findings emerging within the topic area and an overview of findings and their limitations before listing in detail the results presented in each of the studies reviewed.

The report does not claim to be a comprehensive record of all the empirical work on this topic, and the discussion of all four sub-topics reflects this in its summary of emerging themes.

3. BOUNDARIES

3.1 INTRODUCTION

"Boundaries are key to establishing therapeutic relationships. They recognize the separateness of clients and therapists, validate their uniqueness, and foster the safety necessary for client disclosure. Since clients assume a position of vulnerability in therapy by disclosing intimate information and see therapists as expert… boundaries determine the context for power, authority, trust, and dependence. Ideally, the boundaries make it possible for the client to express anything, including feelings toward the therapist, knowing the therapist will not act on these.
Boundaries are derived from social, cultural, political, philosophical, clinical, ethical, legal and theoretical considerations, as well as the therapist's personal limitations and choices. They vary depending on the therapist, client, relationship, setting and time. The purpose of boundaries is to contain the therapy and do no harm. Nonetheless, there is disagreement about what constitutes appropriate boundaries."
(Harper & Steadman 2003)

Boundaries are widely discussed in the literature, much of which is discursive. These discussions are not reported on in depth, but the quote above seeks to place the empirical studies described below in a context – recognising that boundaries are problematic and complex. Definitions of appropriate sexual boundaries vary, for example some of the literature seeks to distinguish sexual boundary crossings from boundary violations. We can also see that definitions have changed over time, both in guidance from professional bodies and in classification of misdemeanors.

That said, the following quote from Norris, Gutheil, & Strasburger 2003 illustrates the consensus that sexualised relations between healthcare professionals and patients constitute a boundary violation, and are harmful and exploitative:

"A boundary is the edge of appropriate professional behaviour, a structure influenced by therapeutic ideology, contract, consent, and, most of all, context….

Boundary violations differ from boundary crossings, which are harmless deviations from traditional clinical practice, behaviour, or demeanour. Neither harm nor exploitation is involved. Boundary violations, in contrast, are typically harmful and are usually exploitative of patients' needs – erotic, affiliative, financial, dependency, or authority. Examples include having sex or sexualised relations with patients…"

The empirical studies in this area focus on a broad range of issues relating to sexual boundaries, both boundary crossings and violations. The following areas are covered:

- Discomfort, and a lack of clarity regarding sexual issues in general
- Variation in the way boundaries are viewed and the "exceptions" which are put forward to the "rule" of no sexual contact between health professional and patient
- Ways in which to decrease the likelihood of sexual boundary violation.

3.2 KEY FINDINGS

- The majority of health professional respondents view sexual contact with patients/clients as inappropriate and harmful, but there is significant variation in attitudes and beliefs about behaviour within the relationship, and about sexual contact after the professional relationship has come to a close
- Students who experienced a sexual attraction to patients/clients and discussed it with their supervisor were more likely to show an understanding that such attraction was potentially harmful to clients
- The majority of health professional respondents felt that they had not received adequate education or training on sexual ethics
- A lack of consensus amongst health professionals exists regarding the definition of an '*ex* client'

- Confusion was expressed by health professionals about who was responsible for maintaining boundaries
- Many health professionals reported that they would not know how to handle a situation involving sexual boundary violations and would not report colleagues
- Respondents rated their educational preparation for sexual boundary issues as inadequate
- Health professionals who have received education on the topic are less likely to 'offend'
- Factors to consider in training include communication, manner and dress, explanations about intimate inquiries/examinations, sensitivity to patient's perceptions, use of chaperones, 'special patients' and avoidance of sexual jokes/humour
- A correlation exists between positive training environments (tackling acceptance, safety, encouragement, openness, sensitivity, frankness, adequate understanding, respect, privacy, support) and healthy coping responses by health professionals regarding attraction to patients/clients.

3.3 DISCOMFORT, ATTITUDES AND LACK OF CLARITY REGARDING BOUNDARY CROSSING

3.3.1 Introduction

As stated above, much discursive material exists on this topic. What we also see in empirical studies on attitudes to sexual contact is an illustration that the boundaries espoused in professional guidelines do not necessarily fit with the stated attitudes and beliefs of those in the professions. Nor is there consensus across professions and settings about what constitutes an appropriate boundary, or what warrants an exception to this rule.

3.3.2 The studies in detail

3.3.2.1 Discomfort with sexual issues

Discussions of sexual boundaries are often confounded by reference to abuse of professionals *by* clients as well as of patients by professionals, as if these were equivalent risks that cancel each other out. Moreover there is **evidence that workers find all sexual issues difficult to talk about or face up to, even in areas of medicine where this is necessary and an everyday occurrence**. For example, Walfish 1983 surveyed 105 volunteer telephone counsellors at a life crisis centre, with 58 (55%) returns. The survey asked about how often 100 different situations arose and the participant's level of comfort with them. Of 32 areas rated as generally uncomfortable, these were grouped into seven problems areas, one of which was sexual. Under this heading respondents had included obscene calls and client positive affect toward the counsellor, as well as client reports of sexual abuse. Women were found to be significantly less comfortable with obscene calls, and these were reported as occurring more frequently to them. Older counsellors were significantly more comfortable with a client asking 'do you love me?' The authors suggest that these interactions are infrequent but suggest that the findings can be used to design specific training experiences.

Closely related to discomfort with this issue, is the concern raised in a study by Haas, Malouf, & Mayerson 1986 about **action a professional would take regarding ethical concerns**, although it is clear that sexual boundary issues were considered seriously. In their study they surveyed 500 randomly selected members of the American Psychological Association with 294 (59%) response, using 10 vignettes of ethical dilemmas to elicit views on action the therapist would take. One vignette pertained to professional sexual misconduct – learning of a colleague's sexual advances toward a

patient. 57% said they would encourage the patient to report the issue him or herself, and **only 17% stated they would contact the licensing board.** In this same study, however, respondents rated colleague's sexual conduct as 4.12 /5 for seriousness, higher than a number of other ethical areas of concern, including their own sexual impulses or conduct (3.21/5).

3.3.2.2 Attitudes to boundary violation

There is no one consensus about what constitutes an appropriate boundary and there are considerable areas of ambiguity and disagreement. Many of the studies of reported incidence and prevalence (to be discussed in the following chapter) asked respondents about the appropriateness of sexual contact with clients. **Although it is clear from these studies that the majority of respondents viewed sexual contact with a current client as inappropriate and harmful, there is considerable variation in attitudes and beliefs regarding sexual contact following termination of the professional relationship.**

Nor is this debate always neutral but may serve the interests of those who exploit such ambiguity, for example Herman, Gartrell, Olarte, Feldstein, & Localio 1987 found that **psychologists who have engaged in sexual contact with patients have a greater tolerance for this conduct, tend to under-rate its potential harm, and are more likely to oppose the idea of imposing sanctions.**

Goodyear & Shumate 1996 studied the perceptions of practising therapists with regard to a therapist disclosing attraction to a client, assuming the attraction would lead to sexual activity, with a particular focus on gender differences. Sixty male and sixty female therapists (psychiatrists, counsellors, social workers) listened to one of twelve versions of a simulated therapy session, using different gender and disclosure or non-disclosure of mutual attraction combinations. No differences were found in

the perception of the therapist's trustworthiness, but disclosing therapists were perceived as more attractive, and non-disclosing therapists were perceived as more expert, with women also seen as more expert regardless of the disclosure status. **Erotic disclosure was rated as less therapeutic than non-disclosure**.

Salisbury & Kinnier 1996 surveyed 200 counselors about attitudes and behaviors with a 48% response rate (n=80). Of these, **33% believed that a post-termination sexual relationship could be acceptable**, with 62 months being the mean amount of time before such a relationship could be considered. This was contrasted with 25 months for a friendship. When considering post-termination relationships, counselors were most concerned about potential harm to the client, the mental health of the client, the ethical and legal repercussions, the possibility that counseling may be reactivated and counter transference issues.

Coverdale, Bayer, Chiang, & Moore 1996 surveyed 172 1st and 154 4th year students in a US medical school about sexual contact with patients. Of 141 (82%) and 98 (63.6%) responses for 1st and 4th years respectively, they found that **less than 20% thought that arranging a date or dating away from the clinical setting was appropriate and less than 14% thought that genital sexual contact actually during a treatment session was appropriate**. It was thought to be even less appropriate for psychiatrists than for internists or obstetricians and gynaecologists. **The majority of respondents thought that sexual contact could be appropriate after termination of treatment, with male respondents more likely to hold this view**. The majority also thought that hugging might be appropriate.

Herman, Gartrell, & Olarte, et al. 1987 surveyed 5574 psychiatrists from the American Medical Association file, probing attitudes toward sexual contact with patients in a range of contact and settings. 1423 (26%) responded,

with 98% believing sexual contact was always inappropriate during or concurrent with sessions and 97.4% believing it was usually or always harmful to the patient. 68% thought that hugging could be appropriate, 11% kissing and less than 5% genital contact. However, some **exceptions were given for 'romantic love'** where 4.1% felt it could be appropriate and another 4% reserved judgment. **29.6% thought that relationships after the professional relationship had come to a close could be appropriate.** The authors report a wide range of views, including respondents who distinguished between casual sex and serious relationships. **Amongst their sample were 84 respondents who acknowledged that they had had sexual contact with their patients, and these were found to differ in their attitudes, although the majority still conceded that such contact was inappropriate. 19% said that sexual contact could sometimes be beneficial to patients in the guise of therapy** versus 1% of non-offenders highlighting their capacity to provide post hoc rationalizations for their breach of boundaries. They also allowed more exceptions to the 'no contact' rule, particularly if the contact was post-termination of the therapeutic relationship (74.1% versus 27.4% non offenders). **In addition a distinct sub group of those who had offended with more than one client emerged, with 10/16 of these putting forward beliefs in the therapeutic value of sexual relations, and being more likely to describe the negative impact as being on them rather than on the patient, thereby confusing the issue of responsibility still further.** This type of projection has also been noted in relation to pastoral care where warnings were initially couched in terms of "predatory" women rather than exploitation of vulnerable parishioners.

Housman & Stake 1999 carried out a survey of directors of clinical psychology doctoral programmes assessing the amount of training on sexual ethics delivered, and sampled four of each respondent's 4th year students on their knowledge of sexual feelings for clients, relations with

current clients and relations with former clients. 84 (48%) of 176 programmes participated, with a total of 451 student participants. 88% of directors reported formal sexual ethics training in courses, and 94% of students reported some form of sexual ethics training. Students were significantly ($p<.0001$) less likely than directors to suggest comfort with discussing the issues (mean 3.58/7 versus 4.32, $p<.0001$), with their faculty being a safe environment (3.87 versus 5.23) and faculty providing adequate role models (4.97versus 5.84). 50% of those students who reported being attracted to a client discussed it with their supervisor, and men were statistically more likely to report an attraction. In regression analyses, **students who experienced a sexual attraction and discussed it with their supervisor were more likely to show knowledge of the (un) acceptability of acting upon attraction to clients**. No significant predictors were found for knowledge scores for relations with current clients, but programme atmosphere ratings and supervisor consultation were related to knowledge regarding the rules about relations with former clients. The authors suggest their findings highlight the **importance of addressing sexual issues in therapy early in training**.

Berkman, Turner, Cooper, Polnerow, & Swartz 2000 assessed master's level social workers' attitudes and educational preparation regarding sexual contact with clients using a survey of all 380 students on a field placement, with 349 (91.8%) responses. The majority of the students were women (84.5%) with a mean of 4.4 years of experience. The survey presented 11 circumstances in which hypothetical sexual contact might take place and asked the respondent to state their degree of approval, as well as addressing adequacy of education on the topic and willingness to report a colleague. Between 30 and 35% of respondents approved of sexual contact in circumstances in which professional relationships were terminated more than five years ago, were less than two sessions, or had involved only limited or concrete services, such as provision of advice or mobility aids.

Disapproval increased with each year of experience and those who thought class content on sexual ethics was inadequate were more likely to approve of sexual contact between social worker and client, although these variables only explained a small amount of variance in the model. Although 85% of students reported some education on this topic, **the majority felt that they had not received adequate education or training on sexual ethics**, and 35.2% reported not being trained to recognise their own sexual feelings toward a client, 45.6% to cope with the issue of sexual contact with clients and 61.7% to cope with sexual contact initiated by a client. 88% stated they would speak to a colleague who was considered to be having inappropriate sexual contact with a client, and 56% would report to the authorities.

Harris 2001 surveyed students on 27 of 43 Commission on Accreditation for Marriage and Family Therapy Education-accredited master's programmes, on their feeling regarding sexual attraction toward or from clients. The majority of the 259 respondents reported that they would feel cautious (85%) and uncomfortable (69%), and also nervous (53%), flattered (48%), respectful (44%), anxious (44%), embarrassed (22%), vulnerable (18%) or scared (15%) if a client expressed attraction to them. Students also reported discomfort with being with a client to whom they were attracted, but showed a willingness to discuss this with colleagues, although a minority feared being seen as unethical if they did so, and the **majority felt that the attraction would not affect the therapy**. The author suggests this is indication of the importance of addressing the issue of sexual attraction in therapy.

Mattison, Jayaratne, & Croxton 2002 identified a current **lack of consensus in the social work profession regarding the definition of an 'ex client'** and investigated whether the lack of a consistent definition had an effect on perceptions of appropriate behaviour, mailing a survey to 1200 randomly selected social workers in practice on the US register. 654 (57.2%)

responses were received, with 46.8% agreeing that a client is always a client, 40.9% that the client becomes an ex-client at the point of termination, and the remaining 12.1% giving their own specific time period ranging from six months to ten years. **Those working in private practice were more likely to suggest that once a client, always a client**. The majority of respondents considered that going out on a date with an ex-client (95.2%) and having sex with an ex-client (95.8%) was inappropriate, although this was significantly more so for those who saw a client as always a client. **The authors suggest a need exists to define the 'ex-client' in order to improve consistency of ethical standards.**

White 2003 surveyed medical students in an Australian university, using a questionnaire focused on boundaries, designed to collect both quantitative and qualitative data from medical students in all 6 years of the medical curriculum. Of the 293 students who participated (94.5% response rate), the overall majority (60%) thought it unacceptable to have sexual feelings for patients, though 57% of the year 6 students thought it acceptable. 79% reported that sexual contact with a patient was never appropriate. **Some confusion was expressed about who was responsible for maintaining boundaries. The response to case scenarios of boundary crossings suggests that many would not know how to handle the situation and would not report colleagues, particularly if they were senior. 87.4% respondents reported feeling unprepared by their education (mostly lacking) in this area.**

Shavit & Bucky 2004 interviewed six psychoanalytic psychologists who had been in practice for over 5 years and indicated, when asked by the researcher, that they had not engaged in sexual contact with a current or former therapy patient, and were heterosexual males. The participants showed almost universal agreement that termination of treatment did not resolve transference and counter transference issues and therefore

opposed the concept of terminating the therapeutic relationship in order to enter into a sexual relationship. They were also opposed to the concept of a minimum two years break prior to sexual contact – they **did not feel that an arbitrary time limit would resolve issues or avert potential harm**, that they perceived as possible (though they did not wish to make blanket statements about this) or know whether the rules should be varied if the sexual relationship resulted in a long term relationship / marriage, as the power differentials were perceived never to disappear.

3.4 ATTITUDES TOWARDS PREVENTION AND WAYS TO DECREASE SEXUAL BOUNDARY VIOLATIONS

3.4.1 Introduction

A number of studies are reported here, the vast majority of which focus on education of the professional, and a small number on empowering the client. **In many studies, respondents rated their educational preparation for sexual boundary issues as deficient, although the perception of its inadequacy has decreased over time.** A number of studies report on the impact of such educational interventions, usually localised, and with small groups of participants. The majority of studies report increased awareness of the issues following such interventions:

In addition, studies on reported prevalence and incidence suggest that **those who have received education on the topic are less likely to 'offend'** or report that boundary crossings might be appropriate.

These studies have been carried out, variously, with psychologists and medical students. **What none of these studies can do is discuss the longer-term impact of the training interventions** on trainee practitioners,

as they all evaluate attitudes after the intervention, rather than subsequent action in practice.

Two studies are found, one focused on learning groups with clients with learning disabilities, and the other using a consumer brochure in psychotherapy, which aims to empower the client. Both report positively on the **potential for patient education and advocacy to contribute to avoidance of abusive situations**. Focusing on patient education as opposed to professional awareness raising is an alternative strategy. This strategy carries risks especially if it implies that patients/clients have equivalent responsibility for avoiding sexualized encounters or assumes that they will be able to successfully challenge the behaviour through formal or informal channels. Such interventions should not minimize the power differentials involved especially if they are directed at client groups that are particularly vulnerable. Nevertheless, the evidence suggests that making explicit the non-sexual nature of the professional relationship both arms the patient and informs the practitioner, and lays the groundwork for clear expectations between them.

3.4.2 The studies in detail

3.4.2.1 Education provision

It appears from Samuel & Gorton's 1998 study that **sessions on sexual issues have only been relatively recently added to core curricula for psychologists in the USA**. They surveyed all directors of psychology internships accredited by the American Psychological Association (n=410) about the status of internship education related to prevention of psychologist-patient sexual exploitation, with a 56.9% (n=230) response rate. Virtually all responding directors (98.7%) reported that their programme provided at least one session on this topic and rated the topic as having high importance, and 96.9% indicated that such education should be part of the mandatory internship curriculum. Ninety-four percent of responding programs had instituted the reported training within the prior 10 years, with 60% within the previous 4 years and 29% within the previous two years only.

3.4.2.2 Impact of education

In medicine, three studies were found.

Robinson & Stewart 1996 describe a course developed to deliver to medical students, residents, fellows, faculty members and physicians in practice, and adapted for allied health professionals in Canada, focusing on sexual misconduct by physicians. The **course aimed for participants to be able to interact sensitively and warmly with patients and learners without sexualizing the relationship**. Of 392 attendees on the courses, 345 evaluated them. The course overall was rated highly and, of particular interest here, 130 (38%) stated they already practiced in a manner congruent with that presented**. A further 133 (39%) stated they would change their teaching or practice as a result of the course. The largest**

groupings of proposed change were to introduce more teaching on the topic (n=26), more formal manner and dress (n=15), more care with patients and students (n=14), improved explanations about intimate inquiries or examination (n=14), more sensitivity to patient's perceptions (n=12), more care in use of chaperones (n=10), more caution with 'special patients' (n=10) and a reluctance to tell sexual jokes to patients or students (n=10). While the majority of changes were constructive, some caused concern for the authors, and they also noted that follow up is required to see if actual behaviour change results.

Coverdale & Turbott 1997 assessed the impact of an educational intervention on medical students' attitudes toward social and sexual contact with patients by 211 (all) fifth year medical students in New Zealand, with four groups of students randomly allocated to control and five to intervention. Controls completed a questionnaire on appropriateness of hugging, dating and sexual contact with current and former clients for general practitioners, obstetrician/gynecologists and psychiatrists prior to the educational intervention and interventions one month after the session including discussion, literature summary and a video on harm. 141 questionnaires were completed (76 control, 65 intervention). As many as 14.5% of control group students thought it was (sometimes or usually) appropriate for general practitioners to date their own patients and at least 3% thought it appropriate for members of any of these 3 medical specialties to engage in sexual contact with their own patients. However, there were no significant differences in attitudes toward hugging, dating or sexual contact with current patients between those who had attended the seminar and the control groups. However, the intervention group was significantly less likely to endorse obstetrician/gynecologists and psychiatrists (when the groups were combined) hugging and having sexual contact with former patients. Despite this change, the relatively **high levels of endorsement,**

particularly with former patients, were discordant with professional ethical standards.

White 2004 used an action research method to design, implement and evaluate a programme focused on assisting medical students in setting and maintaining social and sexual boundaries, within their training and in future medical practice. Pre-education questionnaires were given to all six years of medical students at an Australian medical school and the programme delivered to 46 year 6 students who also had clinical experience and who then completed a post education questionnaire. The programme used individual reading, brainstorming, discussion, group work and role-play, video clips, and information on prevalence. **The material on sexual misconduct was reported to have made an impact, particularly by highlighting similarities between psychiatry and general practice. Pre- and post- programme surveys showed an increase in beliefs that boundaries are essential and of awareness that violations can amount to sexual misconduct. Participants in the programme articulated a continuing belief that sexual contact with current patients is never acceptable but expressed more ambiguity about former patients; and said that the programme had influenced their knowledge and attitudes. However, 7 of the students reported still feeling inadequately prepared for doctor-patient sexual relationships.**

In psychiatry, two studies were considered.

Gorton, Samuel, & Zebrowski 1996 evaluated the impact of a 6-session pilot course (background, ethical issues, video material, case material, and therapist predisposing factors) on sexual feelings and boundary maintenance in the treatment setting with nine 4th year psychiatry residents, using a pre and post questionnaire and comparing this with similar residents from another institution who did not receive the course. **Residents showed**

significantly increased knowledge (79% vs. 63%) **regarding boundary and counter-transference issues after the course as compared to controls.** Comfort with counter-transference situations in which strong feelings of sexual attraction were expressed toward different groups of patients increased, particularly for men. The authors suggest that such training should be mandatory in the residency programs.

Meek, McMinn, Burnett, Mazzarella, & Voytenko 2004 evaluated the perceived effectiveness of Christian and secular graduate training programs in preparing Christian psychologists to deal with experiences of sexual attraction by surveying 200 graduates from secular programmes and 192 from Christian programmes, about the training environment and coping styles. A response rate of 68% was achieved (n= 258). **A positive correlation was found between a reported positive training environment (acceptance, safety, encouragement, openness, sensitivity, frankness, adequate understanding, respect, privacy, support) and healthy coping responses when faced with feelings of sexual attraction.** Graduates of Christian programmes reported higher satisfaction with training programmes regarding handling sexual intimacies than those of secular programmes. The authors suggest that the training environment relates to willingness to discuss sexual attraction to clients, and that there was no reservation regarding this in these Christian programmes.

3.4.2.3 Empowering the client

Singer 1996 evaluated a self-protection group for seven people with learning disabilities living in a residential group home. Although not exclusively targeted toward sexual behaviour, the course covered 'good and bad touches' and included role-play regarding verbal, physical and sexual abuse. The home manager made assessments of the participants before and after the course, and course trainers interviewed the clients before the

course about how they would respond to different situations and this was compared to their behaviour in role-play. Overall most **participants showed an increase in social interaction and assertiveness scores with friends, staff and strangers but not with authority figures**. The author recognizes the study's small scale but suggests that the programme was successful in that participants learned to respond more assertively in role plays of situations involving verbal, physical, and sexual abuse.

Thorn, Shealy, & Briggs 1993 gathered feedback from 54 psychotherapy clients and 52 therapists in response to a brochure on sexual misconduct in psychotherapy using questionnaires. Mean scores of between 5.02 and 5.90 (on a scale of 1 to 7) were found on various items associated with the brochure's ability to enable clients' trust, understanding of appropriate behaviour, assertiveness, and confidence to face sexual misconduct. **The majority of both clients (67%) and therapists (69%) felt the brochure should be made available before or during the first session.** The authors also surveyed 139 college students considered to be potential psychotherapy clients, before and after reading a brochure on client-therapist intimacy or a 'control' brochure. For all items – trust, understanding, assertiveness, therapist discussion of sexual life, sexual contact, touch and self-disclosure, subjects who read the intimacy brochure had higher post test scores (increased negative attitudes to sexual misconduct) than the group reading the control brochure, indicating **that openly stated values do cut across the propensity for sexual boundary violations and remove the potential space for self-serving rationalizations.**

4. REPORTED PREVALENCE AND INCIDENCE

4.1 INTRODUCTION

"The term *prevalence* refers to the proportion of persons affected with a particular condition in a specified population at a designated point in time (Gordis 2000). This proportion is typically presented as a percentage." (Horner Johnson & Drum 2006). He continues: "Prevalence is often confused with incidence, which refers to the number of new cases of a condition or experience occurring during a particular time period within a population at risk (Gordis 2000). **Thus, *incidence* refers to the rate at which something occurs."**

Empirical studies in this chapter cover both reported incidence and prevalence. The studies vary vastly in the time period covered, and also in the source of the incidence or prevalence data. They have been grouped as follows:

- Analysis of complaints or disciplinary via administrative data
- Reports from professionals of sexual violations by other professionals
- Self reports of sexual contact with clients by professionals
- Sexual contact with professional reported by clients
- Literature reviews.

The majority of the studies are from psychiatry or psychology, and from the US, although many professional groups are represented, as are other countries in a small number of studies. Prevalence studies have been numerous since the 1970s with the majority concerning psychotherapy and psychiatry, and with later studies usually citing a number of landmark studies that brought the issue of sexual boundary violations to light quantitatively.

This literature needs to be read cautiously and critically because sexual boundary crossing is, by and large, a covert activity and there are many disincentives to disclosure, reporting and record-keeping. Most cases, even the minority that were challenged at the time, are not collated and tend to disappear from view and from the organization's history within a short period of time (Brown 1994). Many organizations, including the NHS, do not have the mechanisms to support those making this type of complaint (see for example the three recent Inquiries undertaken by the Department of Health - Matthews 2004; Pauffley 2004; Pleming 2005) and there are many organizational barriers and defenses that impede investigations and disciplinary action. It is therefore important to read between the lines and make an educated guess about which professional groups and which patients/ clients are likely to be under-represented in reported figures. For a patient to persist in their complaint, especially if met with initial denial or prevarication, they need to bring considerable personal resources in terms of their awareness, credibility, status and perseverance; patients who do not have these characteristics are both more likely to have been abused and less likely to have reported it.

Not all reports have the same status, as will be seen in the ensuing discussion. Some studies are based on unproven allegations about colleagues, others are reports by patients, which have not necessarily been corroborated, or subject to due process, and others are "admissions" by the professionals involved. Some reports will refer to single incidents, which may vary from sexualized comments through to coercive sexual acts, while others may refer to relationships occurring over a considerable period of time.

Moreover, some professional groups have been more focused upon than others. 'Semi-professions', such as care workers and nursing assistants,

tend to have been the focus of fewer studies and/or did not show up in our searches. **The literature on abuse of vulnerable groups, especially people with intellectual disabilities, suggests that such violations are relatively common in residential settings (see for example reports of abuse in homes in Sutton reported in The Guardian 17/1/07). The settings, which are the focus of the following studies, tend to be those characterized by one-to-one personal encounters masking the endemic nature of boundary violations in these even more under-resourced and less scrutinized areas of health and social care.**

Probably, the most realistic way of reading these reports is therefore to regard them as studies of reporting behaviour, more than studies of actual incidence or prevalence of boundary violations. This in no sense weakens the picture that can be gleaned from the studies below, but merely acknowledges that it these represent a partial view and probably a considerable under-estimate of the actual occurrence of these behaviors.

4.2 KEY FINDINGS

- Between 38 and 52% of professionals report knowing of colleagues who have been sexually involved with patients.
- Self-reporting rates by health professionals are considerably lower, but high levels of patient attraction are acknowledged
- A proportion of professionals violate boundaries with multiple patients
- Between 22 and 26% of patients report to another practitioner that they have been sexually involved with a previous therapist
- Greater awareness of guidelines and sanctions reduces prevalence.

4.3 PREVALENCE REPORTS FROM PROFESSIONALS OF KNOWN SEXUAL CONTACT WITH CLIENTS

4.3.1 Overview and limitations

Partly to overcome the methodological limitations several studies have approached the issue by asking professionals if they have treated clients who have reported sexual contact with previous 'therapists', covering the **US, UK, Switzerland and Australia**. These **studies show a reported prevalence of between 22 and 26% of clinicians treating patients who reported having been sexually involved with a previous therapist. Between 38 and 52% of these professionals also reported that they knew of colleagues who had been sexually involved with their patients**. These are all reasonably sized surveys, with variable response rates, and have similar reported rates. It is difficult to judge if the surveys were comparable, or to quantify the results in terms of prevalence. It is difficult to know if many professionals are reporting acquaintance with the same case, or to ascertain details such as the length of time that has elapsed since the sexual boundary violation took place.

4.3.2 The studies in detail

Gartrell, Herman, Olarte, Feldstein, & Localio 1987 surveyed 5574 randomly selected (every fifth member) US psychiatrists on the American Medical Association's register on their attitudes and practices regarding sexual misconduct. Of the 1423 **(26%) respondents,** 65% (n=290) **reported treating patients who had been sexually involved with previous therapists.** This sexual involvement was reported with 3031 patients, 2760 of whom were women.

Garrett 1998 carried out a national, anonymous survey of 1000 randomly selected members of the Division of Clinical Psychology of the British Psychological Society in relation to their experiences of sexual contact with patients, both personal (see below) and at second hand, with a response rate of 58.1%. Of respondents, **22.7% reported having treated patients who had been sexually involved with other therapists, most commonly psychiatrists, private sector psychotherapists, nurses and social workers.** Additionally, 38% of the respondents reported knowing of clinical psychologists who had been sexually involved with their patients, through sources other than their own patients.

Leggett 1994 surveyed 500 Fellows of the Australia and New Zealand Royal College of Psychiatrists, being every third member on the list. In addition to questions about their own sexual contact with patients (see section below), **68.7% (of 344) respondents reported that a patient had given a history of sexual contact with a previous therapist, and 50.3% had at least two patients who had given such a history**.

Parsons & Wincze 1995 surveyed all 678 licensed therapists in Rhode Island and about client-therapist sexual involvement in terms of having treated a client who reported previous sexual involvement with a therapist between 1989 and 1991, with a 49% (n=331) response rate. **26%** (n=86) **of the respondents reported having treated clients previously involved with a therapist**. A wide range of sexual behaviour was reported. In addition, the treating therapists reported 120 incidents of other boundary violations. **The majority (85%) of perpetrators reported were male and the majority of victims were female (87%).**

Wincze, Richards, Parsons, & Bailey 1996 compared this study with a comparable survey of therapist sexual misconduct in an Australian state. In addition to the survey of the licensed psychologists in the state of Rhode

Island (n=678) they also surveyed all psychologists, psychiatrists, social workers, therapists and counselors (n=1057) in the state of Western Australia, using the same method as the (Parsons & Wincze 1995) paper cited above. Their Western Australia response rate was **48%** (n=479) with 81 (22%) respondents **reporting treating previously abused clients**. The majority of therapists who had been reported by clients as sexually involved were male (81%) and functioning as psychiatrists or psychologists, and the majority of victims were women (90%). The authors therefore report that **despite some very distinct cultural and training differences between the two professional psychology populations, there was remarkable similarity in the percentage of respondents who reported having treated victims of therapist sexual abuse. This study is stated to be the first to provide survey data on this phenomenon in Australia and the first cross-cultural comparison.**

Kullgren, Jacobsson, Lynoe, Kohn, & Levav 1996 surveyed a random sample of 328 members of the Swedish Psychiatric Association using three clinical vignettes covering sexual relationships with a patient. Of the 214 (65%) respondents, **41% stated they believed there were abuses of psychiatry in Sweden, with 38% of these respondents reporting abuse of a sexual nature.** Twenty-six respondents provided detail of sexual abuse cases, 10 involving psychiatrists, five other staff, two psychotherapists and nine not specified.

Bachmann, Bossi, Moggi, Stirnemann-Lewis, Sommer, & Brenner 2000 surveyed all nurses at two Swiss psychiatric hospitals (n=714) with a 39% (n=279) response rate, about sexual contact between therapists and patients, noting the lack of prior data on nurses. As well as reporting their own sexual contact with patients (see below), **52% of respondents reported knowing of at least one colleague who had had sexual contact with patients**.

4.4 PREVALENCE REPORTS FROM PROFESSIONALS CONCERNING THEIR OWN SEXUAL CONTACT WITH CLIENTS

4.4.1 Overview and limitations

The majority of the studies concerning prevalence have been conducted using professional self-reporting in postal surveys. Two early studies – Kardener, Fuller, & Mensh 1973 and Holroyd & Brodsky 1977 - are referred to by the vast majority of subsequent authors, and have clearly been instrumental in bringing these issues out into the open.

Numerous studies are found under this heading, and several use similar survey tools, methods and populations, allowing some indication of change over time and some comparability. Several key limitations are also noted, and often acknowledged by the authors themselves, detailed below. In the studies, definitions of sexual contact vary, response rates are variable and representativeness of the eventual sample is not always examined. **The studies rely upon self-reporting with prevalence rates decreasing over time coterminous with increasing guidelines and awareness of the penalties associated with discovery of such relationships.** The issue of contact during or after termination of the relationship can be muddled as the time for 'after termination' varies by study. Williams 1990, commenting on Pope's 1990a review of the literature in this area, claims that research on this topic cannot meet minimal standards for survey research and may have insurmountable validity problems, an issue not disputed by Pope 1990b in his reply.

Nevertheless, the advantage of these prevalence papers is that they highlight the extent to which sexual boundary violations *do* occur, and

that, although the majority of practitioners do not breach professional codes of conduct, cases are not limited to a few extreme individual cases (a finding supported by CHRE's examination of all UK regulators' fitness to practice cases as part of its statutory function). The studies also reveal that amongst practitioners who breach boundaries, a proportion do so serially or with multiple patients.

Broadly, Carr, Robinson, Stewart, & Kussin 1991, in their review of existing literature, concluded that **7.1% to 10.9% of male therapists and 1.9% to 3.5% of female therapists admitted to engaging in intimate contact with patients.** Seto 1995, when reviewing the literature, suggested that the true base rate of prevalence was unknown - **although estimates from self-reporting were consistent, these were probably an underestimate.**

This is likely to be an under-report rather than an over-estimate as there are many reasons why a professional would not admit such breaches and no reason for owning behaviour that had not occurred. As the papers below indicate, these figures have decreased more recently, with papers now citing rates as low as 2% (Lamb, Catanzaro, & Moorman 2003) but it is difficult to infer whether this reflects an actual decrease in the incidence of boundary violations, or an increased awareness of the need to be secretive about it for fear of censure or sanctions. This confirms the view of these studies as studies of reporting behaviour rather than actual incidence and prevalence.