

Women Sexually Victimized in Psychotherapy Speak Out: The Dynamics and Outcome of Therapist-Client Sex

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ABSTRACT. The present study was a result of an extraordinary opportunity to interview 23 women patients who had sexual relations with their therapists. The paper presents the phenomenological viewpoint of therapist-client sex (TCS) from the victims' perspectives. Patients were asked to describe their emotional experiences during the misguided therapy period. They depicted a sense of ambivalence towards TCS that included feelings of dependency, helplessness, and powerlessness, along with feelings of being chosen and achieving control over the therapist. The former victims' accounts revealed both short- and long-term emotional harm. doi:10.1300/J015v30n01_01 [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2007 by The Haworth Press, Inc. All rights reserved.]

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Although ethical codes of psychotherapy professionals specifically prohibit sexual contact between therapist and client, 3%-10% of surveyed therapists reported erotic behavior with their patients (Bouhoutsos, Holroyd, Lerman, Forer, & Greenberg, 1983; Gartrell, Herman, Olarte, Feldstein, & Localio, 1986; Gechtman, 1989; Herman, Gartrell, Olarte, Feldstein, & Localio, 1987; Lamb et al., 1994; Lamb & Catanzaro, 1998; Pope, Keith-Spiegel, & Tabachnick, 1986; Stake & Oliver, 1991). In contrast to most research articles on therapist-client sex (Therapist-client Sex; TCS) that is based on data gathered solely from therapists, the purpose of this study was to investigate TCS from the clients' perspective. To shed additional light on these issues, we chose a strictly qualitative methodology for this study. The interviews with the patients exposed intense emotions associated with TCS and unveiled the far reaching consequences of this immoral behavior.

Freud, who was the first to recognize that a client's warm feelings can often turn into erotic yearning, devoted an article to the subject, "Observations on Transference Love," with the primary intention of drawing the analyst's attention to the dangers of transference love (Freud, 1915). Scholars have regarded therapist exploitation as equivalent to incest (Kardener, 1974; Pope & Bouhoutsos, 1986). The power differences inherent in the therapist-client relationship make it difficult for the client to undermine the therapist's authority, often yielding to the short-term secondary gains associated with the attained "special status." Like victims of incest, some of the patients who have had sexual relations with therapists report mixed feelings towards the lapsed therapist, ranging from positive feelings of respect and fondness to feelings of betrayal, mistrust, and rage (Luepker, 1990; Somer, 1999).

The scant amount of research into TCS seems to stem partially from the difficulties faced by both transgressing therapists and exploited patients in coming forward and reporting their experiences. Most of the research into TCS has focused on attempts to characterize the offending therapists. The few studies that have examined the effect of TCS on patients have relied almost exclusively on the reports of subsequent therapists (Bouhoutsos et al., 1983; Pope & Vetter, 1991). The minority of studies dealing with TCS clients have focused on their condition at the time the data were collected, often many years subsequent to the TCS.

Three studies on TCS (Ditch & Avery, 2001; Somer & Nachmani, 2005; Somer and Saadon, 1999) have attempted to evaluate the emotional processes experienced by patients during TCS events and thereafter retroactively. Somer and Saadon (1999) found that the proportion of reported negative and positive experiences seem to change over time. For example, although 63% of the clients reported feelings of pleasure during the sexual liaison, only 15% expressed satisfaction, in retrospect, with their erotic involvement with their former therapists. While 33% felt exploited when the event actually occurred, in retrospect 59% perceived the event as painful and exploitive (Somer & Saadon, 1999). Somer and Nachmani (2005) later showed that former patients'

accounts of their experience during a sexual liaison with their psychotherapist could be classified as either romantic (TCS-Romance) or abusive (TCS-Abuse). During TCS, individuals in the TCS-Romance group reported having experienced overall better emotional states and more favorable perceptions of both the perpetrating therapists and the treatments they provided, but their reported experiences with their offending therapists deteriorated and showed marked negative effects in the long run.

Reporting on their study of the TCS client population, Ditch and Avery (2001) used both quantitative and qualitative methods to examine the emotional experiences of study participants. Participants described a mixture of positive and negative feelings: At various points throughout the TCS relations, patients had felt special (75%), taken care of (55.7%), emotionally moved (53%), loved (47%), and in love (46.3%). Simultaneously, 81% also felt confused, 41% concurrently felt bad about themselves, and 80% of the participants blamed themselves for what had happened.

These three studies uncovered an ongoing process of ambivalence among TCS clients, with the proportion of positive and negative experiences changing over time, painting a more somber picture of TCS. Yet the process through which patients' feelings and perceptions of their therapists and the TCS change remains unclear.

We hoped that providing former patients of sexually offending psychotherapists an opportunity to talk freely about their experiences would shed more light on the ambivalence inherent in TCS. We felt that it would be improper to study these individuals using quantitative research indices. The selection of a qualitative research method, therefore, seemed to us the most appropriate means for studying this usually voiceless group of exploited women. The questions that directed our research were: What were the common themes in the evolution of clients' feelings in relation to their TCS? How was the transgressing therapist perceived during, shortly after, and long after the TCS experience? How did their understanding of the impact of TCS develop over time?

METHOD

Participants

The sample for this study included 23 women interviewees. Eleven telephone interviews and 12 face-to-face meetings were conducted. The research interviews took place, on average, 8 years after the last sexual encounter (range 2-25, $SD = 5.6$). The age of the participants ranged from 23 to 57 and averaged 43 years ($SD = 7.6$).

All respondents were Caucasian Jewish Israeli citizens residing in Israel. Average number of school years was 16 (range = 12-20, $SD = 2.3$). Their occupations included psychotherapy, education, interior design, and hairdressing. Seven women (30%) were single, 10 (44%) were married, and 6 (26%) were divorced.

Procedure and Data Analysis

Public and media interest in TCS, following media coverage of a legal suit filed against an offending therapist, resulted in several stories published in the Israeli media. Journalists agreed to include in their reports an invitation to people who had been involved in sexual relations with their psychotherapists and were willing to be interviewed for a research study on this subject to call the researchers.

Thirty-two women and one man volunteered, initially, to participate in this study. In a preliminary telephone conversation, information concerning the nature of the study and the format of the interview was provided to the applicants. They were told that the information provided would be integrated anonymously into a larger data set and that all identifying information would be deleted or carefully concealed. During this initial telephone interview, 9 applicants were found to be inappropriate to participate in the study. These were former patients who had erotic feelings for their therapists but never acted upon them and patients who had a sexual encounter with a professional who was not a therapist (for instance, physicians who were not psychiatrists). Participants who had been in counseling with alternative medicine therapists (e.g., healers, mind-body therapists) were included only if the treatment consisted of verbal treatment, consultation, and psychological guidance intended to cater to the emotional needs of the distressed client. Similar inclusion criteria were applied by Ditch and Avery (2001).

Although we had interviewed the sole male respondent, the uniqueness of this interview prohibited its inclusion in the women's data set. Despite our exclusion of the man's experience from our analysis we believe future study of male victims of TCS is warranted.

We felt that the sensitive subject matter of this study warranted allowing participants to opt for a telephone rather than a face-to-face interview. Prior to each interview, the participant was asked to articulate their informed consent to participate in the study (if conducted via a telephone) or sign an informed consent document if interviewed in-person. All interviews were carried out by the first author, a practicing clinical social worker. When necessary, minimal emotional support was offered by the researcher. The study was approved by the Ethics Board for Human Research at the University of Haifa's Research Authority.

Participants were asked to reply to open-ended questions relating to their perceptions and feelings as experienced during the eroticized treatment relationship and following it. For example, What did you feel about your sexual contact with your therapist? How did you explain this development to yourself? How did you think that becoming involved sexually with your therapist could help you as a patient? Did you perceive your therapist as your "partner" (Please explain)? The full interview format appears in the appendix.

The interview focused on 4 phases during or following the therapy: before the sexual liaison, during the sexual liaison, at the end of the sexual liaison, and at the time of data collection. When relevant, participants were requested to answer each question in relation to these time frameworks. The interviews were audio-recorded and transcribed verbatim.

The two researchers performed the coding of the audiotapes separately, using similar coding instructions. The results of the coding were compared and discussed. Content analysis of the resulting text indicated several central themes. This paper will identify them and report how many of the participants addressed these subjects. The premise of content analysis is that many of the words or ideas expressed can be classified into categories bearing a similar, common meaning (Weber, 1990), that is, any identified theme can represent a group of concepts with a similar content word. For instance, descriptors like God, guru, angel, or savior, when used to describe the therapist, were grouped in a theme category representing “an idealistic perception of the therapist.” A similar method of integrating data was used in TCS studies conducted by Butler and Zelen (1977) and by Ditch and Avery (2001).

Participants were also asked to provide demographic data and other details pertaining to the eroticized counseling and the straying therapist.

RESULTS

Boundary Violation

The findings suggest that prior to TCS the therapeutic relationship was characterized by a slowly progressing process of boundary violation. This process unfolded on three spheres: changes in the therapeutic setting (duration of sessions and seating arrangements), self-disclosure by therapist (e.g., details about emotional and marital problems), and the therapist’s attitude towards the client (e.g., compliments on personality and appearance).

TCS Characteristics

The TCS dyad. The most common gender dyad was male therapist–female client (83% of cases). In 3 cases (13%) both therapist and client were female. Over half of the therapists were psychologists. The rest were social workers (3), psychiatrists (2), alternative therapists (4), and 1 family therapist. Our analysis of the therapy descriptions indicates that the therapeutic strategy used in most cases was probably a psychodynamic approach.

At the time of the TCS, the average age of the therapists was 44 (range = 30-57, SD = 6.7), and the average age of the participants in the TCS was 31.5 (range = 19-48, SD = 8.5 years). During the period of treatment, 12 participants (52%) were single, 10 (43%) were married, and one (4%) divorced. The average level of education among participants was 15 years (range 12-20, SD = 2.2).

Treatment duration. On average, therapy lasted for 27 months, ranging from 3 weeks to 10 years. The sexual contact spanned an average of 41 sessions (range = 1-288, SD = 70). In 83% there was partial or full chronological overlap between the sexual contacts and the therapy.

Sexual aspects. The findings also indicate that in 13 cases (56%) the TCS included full intercourse. In 18 dyads (78%) the initiator of sexual contact was the therapist, and in 14 cases (61%) the patient initiated termination of the sexual relations. Six participants (26%) reported that they were aware of the fact that their therapists had sexual contacts with other patients as well. Three participants (13%) noticed that their therapist suffered from erectile problems.

Stated rationale for TCS. Seven participants (30%) reported that their therapists had provided a professional rationale for the TCS (e.g., "You need to learn to relax," "You are sexually inhibited," or "This will help you to work through your sexual abuse experiences").

Payment. Of the 19 patients seen in private practice, ten (53%) continued to pay for their therapy sessions even after the start of the sexual involvement with their therapists.

Re-Victimization

Sexual assault re-victimization is most often conceptualized as "the phenomenon in which individuals who have experienced child sexual abuse are at greater risk than others for adolescent or adult sexual victimization (Muehlenhard, Highby, Lee, Bryan, & Dodrill, 1998).

Many interviewees told us that the script for their re-victimization seemed to have been somewhat predetermined by their painful past. In total, 11 participants (48%) experienced either physical or sexual childhood trauma. Two (9%) reported they had been raped. Four (17%) were subjected to other abusive acts. Eight women (35%) reported other intrusive or violent sexual assaults. Only two former TCS victims reported no history of prior sexual victimization.

One of the patients interviewed, who was a victim of incest by her father, described her TCS experience as follows:

He claimed that he had to teach me to relax and let go. I felt that it was his perversion, but I was so totally dependent on him. I came to him [the therapist] as a result of something similar that had happened at home. For me, it was a natural continuation of life . . .

Another patient said:

I was also raped in the army. It hurts me that it happened again, but I know that it couldn't have been otherwise, I was in no condition to choose . . .

Perception of TCS and the Offending Therapist

Ambivalence. Eighteen participants (78%) reported experiencing immense confusion at some point during the TCS timeline (before the sexual contact, during that period, and following it). This confusion reflected mixed feelings both about the therapist and the sexual liaison.

For instance, one participant, who had sexual relations with her psychiatrist over a period of two months, said:

Somehow, I knew it was wrong. The things he said and what I felt just didn't add up. I felt ambivalent feelings both of being used and of being helped, and often, as a patient, I came to therapy in order to make him feel better—I both paid him and relieved his loneliness.

This individual appeared to derive some satisfaction from the role-reversal in the caring relationship. She was motivated to be a monetary and a relationship resource for her therapist, but the imbalance in this transaction left her feeling exploited (“used”).

Therapist idealization. When asked to report how they had perceived the therapist during the therapy and TCS, half of the participants described their therapists in idealized terms: God, guru, prophet, savior, angel, superior figure, and goddess were only some of the adjectives used. Our impression was that many TCS patients were in utter awe of their therapists.

In the words of one patient, who had sexual relations with her psychologist for 4 months:

I attributed magical powers to him. He was a good fairy, the personification of beauty. I was beautiful because he reflected beauty on me. I felt like a dwarf standing next to a giant. I could not believe it, it was grace, it was a miracle, a messenger from God . . .

This woman can see, in retrospect, that her perceptions of her offending therapist were largely the product of projective processes (“I attributed . . . to him”). However, she also poignantly portrayed the compromised reality testing that had characterized the perceptions of some of these victims. For the duration of the TCS, the woman quoted above actually thought of her therapist as “the personification of beauty” and “a messenger from God.”

Control. Ten participants (43%) felt that during the sexual liaison they were controlled by the transgressing therapists and could not express any resistance to them or question their authority. Eight of the participants interviewed related that they were fully compliant and did whatever their therapists asked them to do. Some of the perpetrators were so intrusive as to dictate to their victims what color their nail polish should be, selecting which earrings they

should wear, changing their cell phone model, or what entertainment they should seek outside therapy.

Following is an excerpt from the account of one sexually exploited participant.

I don't feel good about it [TCS], but I didn't feel I had any control over it. That's the price I have to pay. He forced me to do it. I'm not saying I resisted, I didn't have the nerve to resist. I didn't feel I could let myself resist . . .

Another respondent said:

When I was speaking to him I used to tremble. I was deathly afraid. He had a kind of control over me. I now realize that it was a sick relationship. The fact that my expressions of admiration towards him empowered his sense of authority is sick, that a relationship of power over me was established is sick . . .

These women describe their oppression and meek compliance as related to an incapacitating dread of their therapists despite their veneration. They both demonstrate a sober retrospective appreciation of the true untherapeutic nature of the therapist-client relationship by admitting their hesitance to resist the deviant aspects of the relationship.

Nine other participants (39%) acknowledged having had some sense of control over their sexual liaisons. This realization, arrived at after the offending therapists, reportedly, became "needy," may have had some positive effects on the exploited patients. Here is an illustration:

He became dependent on me. This gave me a sense of power. I enjoyed giving, I enjoyed being thanked. I liked his needing me . . .

Twelve participants (52%) felt privileged that the therapist had specifically chosen them as a preferred partner. For example, one participant, who moved in with her sexually exploitive psychologist for a period of one year, related the following:

He adored me and thought I was God. I thought he was in love with me. It was very flattering. I later realized that the central issue was power and not sex. He built me up as a superwoman, and he needed to win [this match] to defeat superwoman.

This woman describes an intoxicating empowerment experienced during the misguided relationship. However, the benefits of the perceived power changes, in retrospect, into a bitter realization about the exploitive nature of the association.

Dependence. Eleven participants (48%) described intense feelings of dependency on the therapist. One woman used the metaphor of a disabled person trying to walk without crutches to describe her attempt to sever her relationship with the transgressing therapist. Another interviewee used the term “lifesaver” to depict the critical role her therapist played in her life. Two participants used the word “addiction” to portray their yearning for their therapists during the therapy.

One participant, who at the age of 19 had a sexual liaison for several months with her 40-year-old psychologist, said:

I was so weak. I couldn't go on without him. I felt I was not on his level. “Why should he want me as a partner?” I felt that I had nothing except for him. I was helpless. [I thought] No one will ever care for me the way he does.

This woman regarded her therapist as providing her with essential life energy. Without him she experienced herself as paralyzed, destitute, and worthless. Her dependency on the deviant therapist could only be understood as a corollary of her utter contempt for herself and her deep conviction that she stood no chance of being cared for by anybody.

Guilt. Twelve participants (52%) were blamed by their therapist for the sexual affair and its outcome. Several therapists told their patients that they (the patients) had tempted them, that they had actually wanted the sexual involvement, and that any distress associated with the TCS was explained by the patient's unique pre-therapy history and not by the TCS itself.

One interviewee was sexually involved with her therapist during her military service when she was 19 years old. She said:

He claimed that it was a trap I had laid for him. During the sexual relationship, I felt that it was entirely my fault, not his. I felt I was so bad that I could trap anyone and that he was innocent and naïve and couldn't put up his defense mechanisms against me. When I ended the relationship, I hated myself, I felt I had done something terrible. I began to believe that I was a black widow capable of trapping even a man as strong as he is . . .

Another participant said:

I felt a lot of guilt. He made me feel guilt. He said to me: “The woman is the source of the problem.” That sentence stayed with me. He waited for the sexual initiative to come from me. He said I left him frustrated . . .

These victims were persuaded by their offenders to believe that they were responsible for the crimes perpetrated against them. The first woman tried hard to preserve an innocent image of her deviant therapist. Since she sensed

that something bad had transpired between them, however, to maintain an untainted representation of her caretaker, she had to attribute the evil to herself.

In some cases, a sense of guilt appeared to arise only after the relationship was terminated. For example, one former patient said the following about her relationship with her female therapist of 6 years:

I felt that she left because of me. Had I behaved better, she would still be with me now. I was responsible for her distancing herself, for not having had enough patience with me. I blamed myself for not being able to bear the ambiguity in the relationship.

In an attempt to make sense of her painful abandonment by her therapist-turned-lover, this victim saw her insistent attempts to clarify the confusing dual relationship with her transgressing therapist as responsible for her agonizing abandonment.

Short-Term Outcome of TCS

In this part of our interview the women were asked to comment on the various impacts TCS had had on their lives. The methodology and nature of this study precluded adequate measurement of pre-TCS symptoms. Still, interviewees were explicitly requested to relate to symptoms that in their subjective experience were related to the sexual relationship in question and its termination.

Depression. TCS seemed to have contributed to the development of a myriad of emotional and somatic symptoms of depression. When asked about feelings after the TCS relationship had ended, 9 participants (39%) retrospectively reported suffering from depression, 8 respondents (35%) reported having had suicidal thoughts, 5 women (22%) reported a loss of appetite, 7 (30%) described frequent bouts of crying, 4 (17%) reported feeling a drastic drop in their self-esteem, 4 participants (17%) found it hard to function at work or had to quit their jobs altogether, 3 (13%) said they suffered from newly developed migraines and sleeplessness. One participant described a subsequent psychotic breakdown. Another was admitted into a psychiatric hospital because of a grave depressive crisis that could not be controlled in an out-patient treatment facility. One married mother who had been sexually exploited by her female therapist developed an upsetting confusion about her sexual identity that precipitated a severe marital crisis.

Other feelings. Six women (26%) described a sense of relief subsequent to the termination of the sexual liaison. Two used the word "survivor" to describe their current post-TCS state. Here is a representative statement:

The strongest feeling when I left was one of relief, even more extreme than relief. I felt I'd been rescued from something, I felt I had woken up from a nightmare . . .

Fifteen participants (65%) also experienced anger towards the offending therapist. Six (26%) felt humiliated; 6 (26%) felt a deep sense of disappointment. However, 8 women (35%) retrospectively reported feelings of compassion and pity towards the misguided therapist. Three (13%) admitted they still longed for him.

Long-Term Outcome of TCS

Lingering damage. Thirteen TCS survivors (57%) expressed profound changes in their outlook on life following their abuse. They talked about a loss of trust in themselves, in therapists and in men in general. One participant described her crisis of trust as follows:

[I experience] . . . a sense of having lost trust in humanity, if one cannot trust her therapist then who can one trust . . . a difficulty in re-building trust in life . . .

The shattering of core understandings about the world seems to be portrayed. The betrayal by the trusted therapist was so profound that this victim lost her ability to have faith in anything (“*lost trust in humanity . . . in life*”).

Ten participants (43%) still felt guilty, when they were interviewed, for not having terminated the sexual liaison. One participant said:

This (the research interview) is the first time I have told anyone about it. I’m not very proud of it. I felt a lot of guilt. I blamed myself, how could I have let it happen?! . . .

This quote also describes how she had been silenced by the shame associated with her sense of responsibility for the TCS. This shame had also protected the perpetrator from exposure.

Six participants (26%) said that they had difficulty establishing intimate relationships with men following the TCS. One of them intimated:

Today I see that I have been seeking relationships that cannot be accomplished: two relationships with married men and one with a man much younger than me. I see that I am simply looking for love relationships that cannot materialize. I am afraid of getting hurt. I can’t open up emotionally . . .

Disillusioned and hurt, many of these women cautiously enter relationships that are destined to be temporary, thus, defensively relating in ways that decrease their vulnerability but leave them, ultimately, lonely.

Positive outcome and favorable regard towards the former therapist. Two participants (9%) reported they had more confidence in themselves and in

their sexuality since the TCS. Commenting about their perception of the therapy at the time of the interview, these two claimed that they had wanted the sexual contact and felt no need to blame the therapist for it. Three participants (13%) still perceived the therapist as capable and reported favorable results from their therapy.

DISCUSSION

This study attempted to address the scarcity of research literature dealing with sexual relations between patients and therapists in psychotherapy, and to introduce a phenomenological viewpoint representing the victims' perspectives. Our analysis of the statements offered by our interviewees shed more light on the complexity of the therapeutic relationship associated with TCS and the ensuing damage.

Most of the respondents related that in the investigated relationship they had felt controlled, passive, and submissive. In their experience, the offending therapists, using their power and dominance, had ignored the true needs and the emotions of their patients and used them as objects. Their reported tendency to shift responsibility for the therapeutic relationship that went astray onto the victimized patients, combined with an emphasis placed on their patients' pathological attributes and an encouragement of their idealization, have all placed formidable obstacles in the path of their patients' emotional growth. We believe that these patterns of therapist-patient relations caused long-term harm to our respondents' ability to trust their own choices.

The selection of a qualitative research method reflected the value we placed on understanding the subjective viewpoint of these exploited persons. By listening attentively to their accounts, we achieved the closest approximation to a faithfully reflected account of the investigated experiences. In addition, by allowing us into their worlds, these women, hopefully, regained recognition of their personal reality, their hurt, and the injustice done to them.

The results reported in this paper support previous suggestions that TCS can also be seen positively by some clients (e.g., Ben Ari & Somer, 2004; Luepker, 1990; Somer, 1999). The accounts related by some of the patients we interviewed in this study also included stories that add complexity to the multifaceted picture of patient reactions to TCS. For instance, some of the participants reported certain benefits as a result of the aberrant sexual liaison with the therapist. They related how the sexual ties enabled them to attain control of the therapist and their relationship. That they were chosen by the therapist to become sexual partners and that the therapists became dependent on the respondents for their favors were significant for many of those we spoke with. Other interviewees reported that even many years after finishing the investigated therapies they could still identify positive outcomes of that bond and feel positive emotions towards their former therapists. Because sexual relations be-

tween therapists and clients are potentially very harmful to patients, this outcome cannot justify TCS.

The “victim” is oftentimes seen in the social-legal, clinical, and feminist discourse as a powerless object that is typically passive and helpless. Although important advances in public, academic and legal awareness for the phenomena of violence against women are to be commended, it can be argued that this is selective recognition given only to those women that meet the criteria of what is termed “the convincing victim” (Lamb, 1999). Thus, descriptors that do not comply with the sanctioned nomenclature for the experiences of assault and its repercussions are marginalized and are not allotted a proper place in the political analysis of the problem. We fear that similar attitudes could run the risk of mimicking traditional patriarchal stances that have described women in a labeled and reductive manner (e.g., as dependent, masochistic, or hysterical). We feel it is a sad irony that some among us so rightfully upset by this kind of attitude inadvertently contribute to the re-creation of a similar climate. In our opinion, special care must be given to prevent the risk for the feminist discussion to stumble by adopting the much criticized male-influenced language used to portray women in the past. We believe that women who dare to describe a complex TCS experience, which may include positive elements, need not be ignored or silenced because their words might damage the “cause.” We maintain that no other person has the right to define the essence, importance and the meaning of their experiences, but the victims themselves. Although we do not intend to obscure the fact that the central experience arising from the accounts of the interviewed survivors of TCS is a sense of helplessness and disempowerment, we also feel that it is of supreme importance to provide an integrative and multi-dimensional representation of their accounts.

The current research indicates that in 3 out of the 23 cases, the abuse was committed by a female therapist. These results are similar to those found in previous studies indicating that, much like the statistics regarding other forms of sexual assault–incest, rape, and sexual harassment, sexual abuse in psychotherapy occurs mostly between a male therapist and a female patient (Bouhoutsos et al., 1983; Gartell et al., 1986; Herman et al., 1987; Lamb & Catanzaro, 1998; Pope et al., 1986; Stake & Oliver, 1991). The feminist literature of the past decades has emphasized the role of gender in sexual assault and defined the phenomenon in terms of a powerless group that is being hurt by a group with power. Nevertheless, one should not ignore the fact that 1 of every 7 cases of sexual abuse in psychotherapy we documented was committed by a woman. It seems that some of the women who achieve the status of having such power may find it hard to resist the temptation of abusing it. Only in recent years have we started witnessing the exposure of sexual abuse by women (Faller, 1987; Finkelhor & Russell, 1984). Social and political barriers may impede an honest investigation of this phenomenon (e.g., women’s embarrassment about exposing their involvement in lesbian sex, conventions dictated by the need to be politically correct, or a tendency to view certain

behaviors in women as an affectionate expression of caring rather than as an inappropriate behavior). We identified no unique emotional processes in women who have been hurt by female therapists. We posit that the yearning for the therapist's love, the betrayal of trust, and exploitation are universal experiences transcending the genders of the participants in the TCS drama. These initial impressions should be investigated with larger samples. We hope that future studies will provide some answers to the following questions: Are same sex TCS relationships characterized by unique emotional processes? Is TCS between two women interpreted differently by female patients? Are the implications of the sexual relations different in these cases?

The current study suffers from a number of methodological drawbacks. First, participants were recruited through an advertisement posted in the printed media. This makes it hard to ascertain how representative our sample was of patients who had sexual relations with therapists. Patients who did not respond might have been fondly protective of their offending therapists or too angry, remorseful, or ashamed to share their stories. We suspect that our non-random sample might under-represent those who had not been harmed, or possibly even benefited from the relationship (Williams, 1992). That said, this limitation has hopefully been partially balanced by our choice to use a qualitative methodology during data collection. This is, arguably, evident in the complexity of the shared TCS stories, which also included positive reports on the experience. We are aware that our sample could have been enlarged had we employed a snowball sampling methodology. However, we were concerned that this approach would have resulted in a sample that would have been too homogenous. Furthermore, we were very careful not to risk any breaching of our respondents' privacy.

An additional limitation in this kind of research has to do with its retrospective nature. We inquired about memories of events, some of which had occurred many years ago. That the experiences described were of a developing nature (e.g., positive experiences that with time become negative) and not unified (some positive and some negative) testify to the participants' efforts to provide authentic, intricate, and distinctive pictures of their sexual experience in psychotherapy.

In a study conducted at the beginning of the previous decade, Sonne and Pope (1999) reported on reactions of professionals treating patients who had experienced TCS. They described reactions such as disbelief and denial, minimization of the damage, and a sense of helplessness. Since then, social and professional attitudes related to sexual exploitation by therapists have developed considerably. We believe that current therapeutic Feminist discussions have ripened to a point where a diverse range of abuse narratives can be tolerated. The current zeitgeist seems mature enough to discard defensive outlooks in favor of more intricate, uncensored depictions of the relationship between the sexes.

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APPENDIX

Interview Guide

The following questions relate to the changes that occurred in the therapeutic relationship before the sexual relationship had developed. We would like to learn of how you experienced these changes. We ask you to share with us your experiences during that stage of the therapy. You can use the following questions as aids when you describe your experience:

What did you think about these changes? How did you feel in reaction to them? Did you have any conflict regarding these changes? What was this conflict about? Did you have any fantasies concerning your therapist or about the therapy process? If so, what were they? Did you talk to the therapist about these changes? If you did, what did you say? What was it like talking to him about it? How did the therapist react? What was your reaction to his response? If you had not talked to him about this, why did you choose not to?

Similar questions were presented with regard to the period associated with the beginning of the sexual relationship and a separate set of similar questions addressed the period beginning right after the termination of the sexual relationship up until the current time. Sample questions addressing the later periods included:

What did you feel about the developing sexual nature of the relationship? How did you explain to yourself the sexual nature of your relationship with your therapist? Did you think of yourself as the therapist's partner? To what extent did you believe the relationship could serve your needs as a patient? Did you tell others about your sexual relationship with your therapist? How did you feel when the relationship ended? At the time, how did the termination of the sexual relationship affect your emotional condition, your work, and your relationships? Were there any attempts to restore the relationship to its previous status? If so, who initiated them? Was there any change in your perception of this sexual relationship over the years? How do you regard the therapist today? Does this sexual relationship still have any lingering effects on your current life (e.g., self image, intimate relationships, world view, etc.)?