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Therapist-Patient Sexual Relations: Results of a National Survey in Israel

Alex Aviv, MD, Joseph Levine, MD, Assaf Shelef, MD, Nili Speiser, MA, and Avner Elizur, MD

The Program of Psychotherapy, School of Continuing Medical Education and Abarbanel Mental Health Center, Sackler Faculty of Medicine, Tel Aviv University, Ramat Aviv, Israel

Abstract: Background: Studies focusing on Patient-Therapist sexual relations have been carried out mainly in the U.S. This study comes to broadly explore this phenomenon in Israel. *Method:* An indirect questionnaire was sent to all 1,817 psychiatrists, psychologists and social workers who are members of the Israeli Psychiatric Association, Psychologists Association and Psychotherapy Association, respectively. *Results:* 29% of the responding therapists reported that at least one of their patients had experienced sexual relations with the most recent, former therapist. *Limitation:* The design of our survey made it impossible for us to conduct a follow-up after termination of therapy and to differentiate intercourse from nonintercourse sexual exploitation. *Conclusions:* Similar numbers of the gender of the exploiting therapist and exploited patients were obtained for both the indirect current Israeli study and previous U.S. studies. This may suggest that such parameters are influenced by common norms regarding the relationships between men and women of both societies, and from the psychotherapeutic dyadic situation.

Introduction

Over the past two decades the public, as well as mental health professional organizations, have become increasingly aware of the issue of patient-psychotherapist sexual relations. A consensus in the professional psychotherapist community indicates that while sexual fantasies expressed within the realm of transference are part of the therapeutic process, the actual acting out of such fantasies is deleterious and prohibited.

Gabbard and Lester (1) maintain that although discussion of sexual boundary violations generally implies that interpersonal boundaries are being crossed, earlier in the process inner boundaries between self and object representation is eroded. Long before the first physical contact between the therapist and the patient, the therapist generally begins to feel a special kinship with the patient. There is a common tendency among mental health professionals to claim that therapists who violate sexual boundaries are a small handful of "impaired professionals." The fact is that every therapist is potentially vulnerable to various kinds of boundary violations, including sexual ones. The above distinction between "us" and "them" implies that there is no problem of poor training or bad techniques that are relevant to sexual misconduct in psychotherapy, resulting in ignoring the origins of this very problematic phenomenon (2).

Psychiatric training about boundary issues has continued to be ineffective despite today's wider awareness of this serious problem. Norris et al. (3) believe that the denial — "this couldn't happen to me" — plays a significant role in the persistence of the problem. They also count a number of risk factors which could lead a therapist to violate boundaries, among them: life crises, illnesses, loneliness and impulse to confide, idealization of the patient and so forth. Although some risk factors may also be found in the patient, it is always the therapist's responsibility to set the limits and to maintain the boundaries of the therapeutic situation.

Comparison of patient-therapist sexual relationship and incest within the family has been reviewed in the literature (4, 5). Witztum et al. detail what Pope named "therapist-patient sex syndrome" to emphasize the serious damage that such relationships might bring about for the patients (6, 7). The extent of such behavior among mental health professionals was found to be from 5% to 12% for male psychotherapists, and from 0.6% to 3% for female

Address for Correspondence: Dr. Alex Aviv, MD, Abarbanel Mental Health Center, 15 Keren Kayemet St., Bat Yam 59100, Israel. E-mail: alexaviv@gmail.com

psychotherapists (8–13). The overall percentage for exploitation by psychotherapists seems to be 5% to 7% of all therapeutic situations (8, 14–16).

The numbers mentioned above, and the potential deleterious effects of such phenomena stress the importance of studying therapists' sexual exploitation of patients for future prevention. Most of the studies surveying the extent and characteristics of the phenomena have been conducted in the U.S., and a few in the U.K. and Australia (17, 18). Patient-therapist sexual interaction, as in any other sexual behavior, is assumed to be affected by social and cultural circumstances. Therefore, firstly it seems that one cannot simply extrapolate various characteristics of such phenomena studied in one social and cultural environment to other social and cultural environments. Secondly, it appears that to fully understand the influence of such social and cultural factors on patient/therapist sexual relationships, one should examine the expression of such phenomena in different environments.

Wincze et al. (19) conducted a comparative survey of therapist sexual misconduct between an American state (Rhode Island) and an Australian state (Western Australia). They found that in spite of differences in therapist training and in spite of cultural differences, there were noteworthy similarities in the following: the incidence of patient reports to subsequent therapists of sexual contact with a prior therapist; the types of sexual behaviors reported to have occurred; the predominance of male therapist offenders and female patient victims; and the degree to which this sexual contact was judged by the subsequent treating therapist to have had a negative impact on the client. Their data suggest that therapist sexual misconduct problems that have been identified in American surveys also exist at about the same rate and manner in Australia.

This study investigated some characteristics of such phenomena in Israeli society, a relatively-young, democratic, immigrant community, establishing its identity through internal and external conflicts. This society is still in a process of establishing new social and legal orders with, as yet, no law of psychotherapy. Only recently an amendment was made to the Israeli law of punishment, determining that a sexual relationship between a therapist and a patient is an illegal offense that could result in serious criminal punishments (including serving time in jail). This kind of behavior was already forbidden before the amendment, in the professional code of ethics of the Israeli Psychologist Association, but could only result in disqualification (20). Sexual relations are also mentioned as a forbidden behavior in other professions' ethical codes; in a position paper of the Israeli Psychiatry Association it is stated to be a serious breaking of the ethical code which might be the cause of a lawsuit (21). It is also stated to be an unethical and forbidden behavior in a position paper of the Israeli Medical Association and in the ethics code of the Israeli Social Workers union (22, 23).

There are some data regarding patient-therapist sexual relations in Israel. Rubin and Dror investigated attitudes and practices regarding sexuality and confidentiality's boundary violations among psychologists versus physicians (other then psychiatrists): 3.4% of the psychologists reported to have violated sexual boundaries with their patients. The authors point out that their sample is not representative of the whole population of therapists; only 96 psychologists took part in that study, out of which some were still students and some were interns. Also, they used a direct questionnaire, which could lead to underestimated results (24).

Methods

Sample selection

In order to obtain the most accurate result of this survey, we decided to use the entire population of therapists in Israel, instead of a sample. We used the current membership directories of the major mental health professional organizations: Israeli Psychiatric Association (647 members), Israeli Psychology Association (1,057 members), and the social workers of the Israeli Psychotherapy Association (113 social workers).

Instruments

It was decided that because this was the first survey of this kind conducted in Israel, the entire range of sexual relationships, and not just intercourse behavior, should be estimated.

A 25-item questionnaire was constructed that comprised five items on the demographic character-

istics of the recipient (gender, age, professional discipline, years of practice, client population) and 20 "yes or no" questions, or questions requesting the recipient to state a number. The first six items were a request to the participants (reporting therapists) to indicate whether they had treated a patient who had had sexual relations with their most recent previous therapist (in order to eliminate multiple reporting on the same patient by more than one therapist). If the answer was positive, the participants were requested to answer questions concerning the gender of patient and exploiting therapist, followed by questions on the consequences of the sexual relations (Appendix A).

The questions, taken from Pope and Vetter (25) with a few modifications, were reviewed by several psychotherapists and survey experts before being distributed. The reviewers were asked to evaluate the language and wording used, the unequivocality of the questions, and the relevance of the items to the goals of the survey. Only questions rated by all the reviewers as "good" and above (in a scale of very poor, poor, average, good, very good) were included.

Procedure

The one-page questionnaire, a one-page cover letter, and a stamped addressed return envelope were mailed out to 1,817 psychotherapists, in 1998.

The cover letter explained the purpose of the study. The anonymous responses were key punched and tabulated. Twelve weeks after mailing, approximately 50% of the forms had been returned, additional forms arrived at a very slow rate, and data collection was halted.

Results

Characteristics of the responders

Survey forms were returned by 929 of the 1,817 potential respondents: 19 envelopes were undeliverable; of the returned forms, 11 were incomplete and/or contained hostile comments. The results we report are based on replies from 918 (50.5%) respondents. There was no significant difference between the percentages of returned forms among the three professional groups (Table 1).

Table 1. *Characteristics of responding psychotherapists*

Subgroup	No. of respondents	Percent of the potential recipients
Profession		
Psychologists	521	49.43
Psychiatrists	329	50.9
Social workers	68	60.2
	No. of respondents	**Percent of respondents**
Gender		
Female	542	59
Male	371	40.4
Failure to indicate	5	0.6
No. of exploited patients treated by a single current responding therapist*	**No. of respondents**	**Percent of respondents**
1	191	72
2	57	21
3	10	4
4	4	1.5
5	3	1.1
6	1	0.1

* Patients exploited by most recent previous therapist

Of the total number of respondents, 57% were psychologists, 36% psychiatrists and 7% social workers. Most responders (88%; N=810) reported treating adult clients. The mean age of responders was 48.5 years with a range of 30 to 88 years. The average therapeutic experience was 17.6 years, with a range of 1 to 51 years.

The mean age and experience of therapists who reported treatment of exploited patients was higher than therapists who reported no treatment of such patients (mean difference SD; $p<0.05$). There was no significant difference between the proportions of male or female therapists (32.6%, 26.8%, respectively) who reported treating at least one such exploited patient, or between the percentage of such positive answers among psychologists, psychiatrists and social workers (27.6%, 31.6%, 26.5%, respectively).

Table 2. *Characteristics of 372 patients who had sexual relationships with their most recent previous therapist (as reported by the responding therapist)*

Characteristics	No. of patients	%
Sexual relations with the most recent previous therapist started during therapy	327	88
Sexual relations with the most recent previous therapist started after termination	45	12
Patients who were minors at the time of sexual relations with the therapist	13	4
Patients who experienced incest or other child abuse	45	12
Patients who experienced rape prior to intimacies	10	2.7
Patients who had beneficial results	16	4.3
Patients who suffered harm	277	75
Patients who stopped treatment as a result of sexual relations with the most recent previous therapist	134	36
Patients who required hospitalization	13	4
Patients who attempted suicide	23	6
Patient who committed suicide	1	0.3
Patients who had had overt social relations with the exploiting therapist	34	9
Patients who filed formal complaints to ethics committees	24	6
Patients who filed formal complaints to the police	7	2

As a whole, this survey shows that more than a quarter (29%; N=266) of the 918 therapists who returned the forms reported treating at least one patient who had had sexual relations with their most recent previous therapist.

Characteristics of the Client Population

The respondents reported treating 372 patients who had had sexual relations with their most recent previous therapist. Most of these patients (338 [91%]) were women, and only 34 patients (9%) were men.

The characteristics of 372 patients, who had sexual relationships with their previous therapists, are presented in Table 2.

Discussion

The above results and interpretations should be considered with great caution. It was Pope and Vetter who, concerning these surveys, stated "it is impossible to overemphasize the need for care and caution in interpreting data" (25). It seems that until standardized research methodologies will be established, comparison will be possible only between studies of similar methodologies. Since direct surveys of such phenomena might influence the reliability of the results obtained, we decided that for the first national survey, the indirect method would be preferable, followed by future direct surveys. The ensuing paragraph compares the results obtained in this study with only indirect studies of the relatively-older, democratic, immigrant society of the U.S.

Several characteristics of the phenomena seem to be of similar magnitude in both Israeli and U.S. societies. These characteristics may be divided into three groups:

Firstly, gender of exploited patient and exploiting therapist, and minor versus adult exploited patients. These characteristics included: the percentage of exploited women (our study, 90.6%; Bouhoutsos et al., 94% [14]; Gartrell et al., 91% [26]); the percentage of male therapists exploiting women patients (our study, 98%; Bouhoutsos et al., 98% [14]); the percentage of patients reported to be minor at the time

of the exploitation (our study, 3.5%; Pope & Vetter, 5% [25]).

Secondly, discontinuation of patient-therapist relationships or, conversely, open relationships with the exploiting therapist. Such characteristics are: percentage of patients who stopped treatment (our study, 36%; Bouhoutsos et al., 37% [14]) or engaged in a publicly open relationships with the therapist (our study, 9.1%; Gartrell et al., 13% [26]); patients who reported marriage to the therapist, or were in a committed relationship (Pope & Vetter, 3% [25]).

Thirdly, deleterious characteristics of the exploiting relationships. Such characteristics were obtained for hospitalization after such exploitation (our study 3.1%, Bouhoutsos et al., 1.8% [14]), for trying to commit suicide (our study, 6.2%; Bouhoutsos et al., 1% [14]; Pope & Vetter, 14% [25]), and for actually committing suicide (our study, 0.3%; Pope & Vetter, 1% [25]).

These similarities might be understood as indicating that factors depending on the diadic psychotherapeutic situation and the process of therapy (i.e., the handling of psychosexual conflicts), along with norms common to both with regard to relationships between men and women, and between minors and adults, are similar to both Israeli and American societies. Future studies may demonstrate whether these similarities might be extrapolated to other western societies.

Various characteristics show lower numbers in our study, compared to indirect U.S. studies. These lower numbers were reported for relatively "soft" data (data which is remote in time [i.e., history of exploitation in childhood], or data concealed or denied by the patient, thus requiring active enquiry and evaluation on the part of the responding psychotherapist). Such lower numbers may indicate lesser awareness of Israeli psychotherapists of such phenomena. Lower numbers were obtained for history of incest, rape or sexual exploitation in childhood (our study, 12.1%, Pope & Vetter, 32% [25]); for history of rape before exploitation by the most recent therapist (our study, 2.7%; Pope & Vetter, 10% [25]); for patients reported not to have deteriorated following the exploitation (our study 25%; Pope & Vetter, 10%; [25] Bouhoutsos et al., 9% [14]).

A striking result is the low percentage of respondents treating these patients in Israel, compared to U.S. indirect studies (our study, 29% [266 of 918]; Pope & Vetter, 50% [25], Bouhoutsos et al., 44% [14]). Assuming the magnitude of the phenomena in the Israeli society is at least similar to that of the U.S. community, it seems that these differences may be attributed to the lesser awareness of the Israeli psychotherapists. However, one should stress that lower numbers (obtained in our study) may also be interpreted as a less frequent occurrence, effort to hide or conceal information on the part of the responding therapist, fewer reports of exploited patients to the responding therapists, or the different methodology used in our study. Until more information from future direct and indirect studies is obtained, our conclusions should be considered as preliminary assumptions only.

The above survey has at least four possible advantages over previous indirect surveys: 1) It is solely an indirect questionnaire, and does not question the behavior and ethical standards of the respondents themselves. Previous studies collecting indirect data included direct questions as to whether the therapist who reported sexual involvement of his patients with a previous therapist was himself involved in such an activity (14, 27), or whether the respondents themselves attended educational programs that provided adequate training for treatment of such abused patients, or whether they accepted these patients for a reduced, or no fee (25). It seems that, until proven otherwise, one cannot rule out that such direct questions may influence the rate of response or its reliability. 2) We asked the respondents to report only those cases for whom they were the first therapist after the exploiting one. This question enabled us to try and estimate the number of exploited patients, avoiding reporting the same patient by more than one therapist. The question may also enable estimation of the number of exploiting therapists, when data from future direct studies concerning the percentage of therapists who exploit more than one patient will be obtained. The number can be compared to that obtained solely from the direct study, thus enabling cross-examination of the number of exploiting therapists obtained by indirect and direct methods. 3) The survey covered almost all registered psychotherapists in Israel of the three main profes-

sions engaged in psychotherapy. Previous main indirect studies surveyed psychologists in California only (14, 27) or as a sample on a national U.S. level (25). 4) There was a fairly good return rate of 50%, similar to other studies, such as Pope and Vetter (25), that collected indirect data and whose rate of return was about 50% (654 of 1,320), and is greater than Bouhoutsos et al. (14) who had a rate of 16% (704 of 4,385 returns). We found an approximately equal rate of return for psychologists and psychiatrists (49% and 50.8%, respectively) and a somewhat higher rate for social workers (60.2%). This last population was about 1/5 to 1/7 the size of the two other populations.

However, due to the design of our survey we could not adhere to the length required for follow-up (at least 1 year) of the exploited patients after termination of therapy with exploiting therapists. We also decided not to differentiate intercourse from nonintercourse sexual exploitation, questioning the reliability of such distinction reported by a third person. These shortcomings need to be measured in future studies.

Finally, we call for future research using standardized methodology of different socio-cultural populations, thus providing a broader understanding of the phenomena, which will enable development of efficient ways to prevent its occurrence.

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APPENDIX A

Questions addressed to the recipient therapists concerning exploited patients

A. Gender of the patient:

B. How many, if any:

1. male patients had had sexual relations with a male/female therapist
2. female patients had had sexual relations with a male/female therapist
3. patients had started sexual relations with a therapist after termination of therapy
4. patients were minors at the time they had had sexual relations with a therapist
5. patients who had had sexual relations with a therapist, had experienced incest or other child abuse
6. patients who had had sexual relations with a therapist, had experienced rape prior to these relations
7. patients had benefitted from sexual relations with a therapist
8. patients had suffered harm as a result of sexual relations with a therapist
9. stopped treatment as a result of sexual relations with a therapist
10. required hospitalization which, in the opinion of the survey respondent, was at least partially a result of sexual relations with a therapist
11. attempted/committed suicide as a result of sexual relations with a therapist
12. had overt social relations with a therapist as well as sexual relations
13. filed formal complaints to ethics committees/police