

Sexual contact between patients and psychologists



*Sexual relations between applied psychologists and service users, and between psychologists and students/trainees was the subject of a study by **Tanya Garrett**. Here she presents her findings and calls on the Society to give urgent attention to the issue*

IN 1992 I conducted a national, anonymous survey of members of the Division of Clinical Psychology (DCP) of The British Psychological Society in relation to their experiences of sexual contact with patients, both personal and at second hand, for example through their patients who had engaged in sexual contact with previous therapists. While I surveyed 1,000 members, I had not expected the level of response which I eventually received (58.1 per cent).

The survey generated both quantitative and qualitative data about the experiences and views of clinical psychologists in this sensitive and difficult area, an area which until recently was much under-researched in the UK. It also raised many issues of concern which I felt were the legitimate concern of the Society, in terms of policy, training and disciplinary matters.

This paper is an attempt to provide some feedback to the Society and its members, in the area of sexual ethics and professional practice. It is also an attempt to generate a debate in the area, which may influence the policy and practice of the Society. I believe that this study, while restricted to clinical psychologists in terms of respondents, has far-reaching implications for Society members in general, both those who are applied psychologists and those working in education.

Summary of the results of the study

The results of the study have been summarized elsewhere (Garrett & Davis, 1994, in preparation *a, b*). Briefly, under four per cent of the sample reported that they had engaged in sexual contact with their own patients who were at the time either in therapy or discharged. A sub-

stantial minority (22.7 per cent) had treated patients who had been sexually involved with previous therapists, of which the most commonly cited professional groups were psychiatrists, private sector psychotherapists, nurses and social workers. This figure is not dissimilar to that reported by Kuchan (1989) who found that 19.9 per cent of therapists surveyed in Wisconsin reported such knowledge.

Over 38 per cent of respondents knew — through sources other than their own patients — of clinical psychologists who had been sexually involved with patients. Most of these respondents knew only of one such clinical psychologist. Just over half (54.6 per cent) of these clinical psychologists had, to respondents' knowledge, been reported to an appropriate body.

Logistic regression analysis showed that homosexuality, sexual involvement with educators during postgraduate training, and longer postqualification professional experience predicted sexual involvement with patients. However, the statistical model used had poor predictive capacity and therefore considerable caution must be applied in interpreting the relationship between these variables and sexual contact with patients.

Responses to a small number of open-ended questions suggested that while the majority of respondents did not view sexual attraction to patients as inappropriate, a minority actively avoided it for ethical reasons. The majority of respondents who had not engaged in sexual contact with patients refrained from such behaviour for ethical reasons, but the responses of a minority suggested that were the opportunity to arise, or were negative consequences removed, they might engage in such behaviour. A minority of respondents were unaware of their duty to report colleagues engaging in such behaviour.

Professional implications

The Society has published two very relevant documents: the Society's Code of Conduct (1997) and *Professional Practice Guidelines* (BPS/DCP, 1995). Publicity for these documents (as well as those relating to other branches of applied psychology) is required, because some respondents in the study were unaware of their reporting duties in relation to colleagues who practise unethically (e.g. who have sexual contact with patients). It may be that clearer guidelines are needed in relation to the circumstances under which members are required to report colleagues for unethical behaviours. Indeed, some respondents in the study mentioned that they viewed the existing guidelines as unclear in respect of sexual impropriety. Although the recent BPS/DCP guidelines (1995) contain more specific guidance for psychologists in respect of potential concerns about colleagues' conduct, only brief reference is made to specific concerns which may arise, and which may necessitate action.

In respect of sexual matters, the guidelines refer to 'the nature of the relationship between a colleague and his or her client' (e.g. potential abuses of power) (p.16). Clearly, this fails to specify that psychologists are required to take action in relation to sexual contact between colleagues and patients. Additionally, publicity appears necessary for recent changes in the BPS/DCP *Professional Practice Guidelines* (see 1995 edition). For example, these contain new rules on sexual contact with discharged patients. It would appear that simply to send a copy of the guidelines to members, as has been the procedure in the past, has been unsatisfactory, perhaps particularly as time passes and memories fade. Specifically, I would suggest that the guidelines be promulgated within the profession both at pre- and post-qualification levels via mandatory training courses.

Training issues

One possible means of increasing awareness of the Society's Code of Conduct/guidelines on professional practice would be to introduce a training approach, for example by requiring professional training courses to address ethical issues and issues of professional responsibility as an accreditation criterion, and to introduce ongoing continuing professional development (including ethics training and refresher courses in professional issues) as a requirement for Chartered status, as well as to supervise trainees. Arguably, it is postqualification training such as this which is most urgently needed, since the

present research suggested that those clinical psychologists who had been qualified the longest were among the group most likely to engage in sexual contact with patients. While this proposal may appear somewhat bureaucratic, and perhaps impractical, it would considerably increase professional standards in applied psychology, and perhaps go some way towards preventing ethical violations.

According to Pope *et al.* (1986), the therapist's sexual attraction towards patients is a common and entirely normal process in therapy, and insufficient consideration of this issue in training programmes can result in clinicians believing that sexual attraction towards their patients is unethical and most appropriately avoided.

In this way, substantial numbers of therapists may be losing valuable therapeutic information which could be gained through a recognition and consideration of their sexual feelings towards patients. This suggests that the issue of sexual attraction towards patients could usefully be included in professional psychology training programmes, and the distinction between private feelings and overt behaviour clarified.

Most therapists in a recent study had received little or no training about sexual attraction to patients (Pope *et al.*, 1986), and in the present study, there is a suggestion that many respondents viewed sexual attraction to patients as potentially problematic or taboo. Thus, the issues of attraction to patients and sexual contact with them could be addressed in professional training courses (cf. Thoreson *et al.*, 1993). Other matters which might usefully be raised in professional training include concepts of transference, countertransference and boundaries (Folman, 1991). In particular, Guthel (1989) argues that training should equip therapists with a knowledge of transference and its power to produce flattering attitudes in the patient, and of countertransference, with its potential to trigger the feeling that the therapist and only the therapist can 'save' the patient. Such issues could also be raised by supervisors with trainees in supervision. This may be particularly important for psychologists with behavioural or cognitive-behavioural orientations, where relatively little attention is traditionally paid to process issues.

A presentation of the research-based literature in the area of dual relationships, as well as discussion of ethical implications of sexual contact with patients (Borys & Pope, 1989), could serve to raise awareness in training. Educational programmes for psychologists could aim to provide a supportive environment within which students and educators can consider their own

impulses which might tempt them into unethical dual relationships (Borys & Pope, 1989).

Trainer-trainee sexual contact

The results of the present study suggest that those trainees who had sexual contact during postgraduate training with supervisors were more likely to go on to become sexually involved with their patients. This conclusion is supported by research conducted in North America (Folman, 1991; Pope, 1989; Pope *et al.*, 1986). One means of addressing this link would be for the Society to adopt for all its Divisions the guidelines developed by its Division of Criminological and Legal Psychology (Thomas-Peter, 1991) in relation to sexual contact between teachers and trainees — which courses accredited by the DCLP are required to follow — so that all professional psychology training courses accredited by the Society are required to prohibit such sexual contact and to take specified action against those who contravene the guidelines. Again, this would increase professional and quality standards.

Fear of retaliation

Some respondents to the survey did not take action in respect of colleagues who were sexually involved with their patients, for fear of retaliation or retribution, for example in situations where the person was managed by the psychologist who had practised unethically. However, the current BPS/DCP *Professional Practice Guidelines* (1995) say only that it is 'advisable' for a psychologist to speak to the colleague about whom they have concerns before approaching the Society — it is not required. The Society's current Code of Conduct, indeed, does not require this to be done (see Clause 5.10).

Treatment and rehabilitation

At present the Society has developed no public guidelines or procedures to address the treatment of such psychologists, or their rehabilitation. One can imagine that employers might seek advice from the Society as to alternative means of deploying such psychologists (or indeed other professionals), or whether they are able to change their behaviour and undertake clinical duties in the future. It would therefore be appropriate to consider the initiation of guidelines and advice services, as well as a register of psychologist consultants with expertise and experience in this field, who could act as advisors and assessors in this area.

Summary and conclusions

Sexual contact between professional psychologists and the users of their services is a serious issue which requires the Society's urgent attention, both for clinical psychologists and other applied psychologists. There is now a substantial body of research which shows that it is a real problem and that it is damaging for patients (Pope & Vetter, 1991). My research highlights a number of areas which could be addressed by the Society to prevent and address sexual contact between psychologists and the users of their services. These include publicizing the existing professional guidelines, enhancing existing training arrangements (including addressing the link between trainer-trainee sexual contact and therapist-patient sexual contact), enhancing disciplinary procedures and making provision for the assessment and treatment of psychologists who do transgress the sexual boundary in their professional work. The latter should include professional advice to the employers of psychologists.

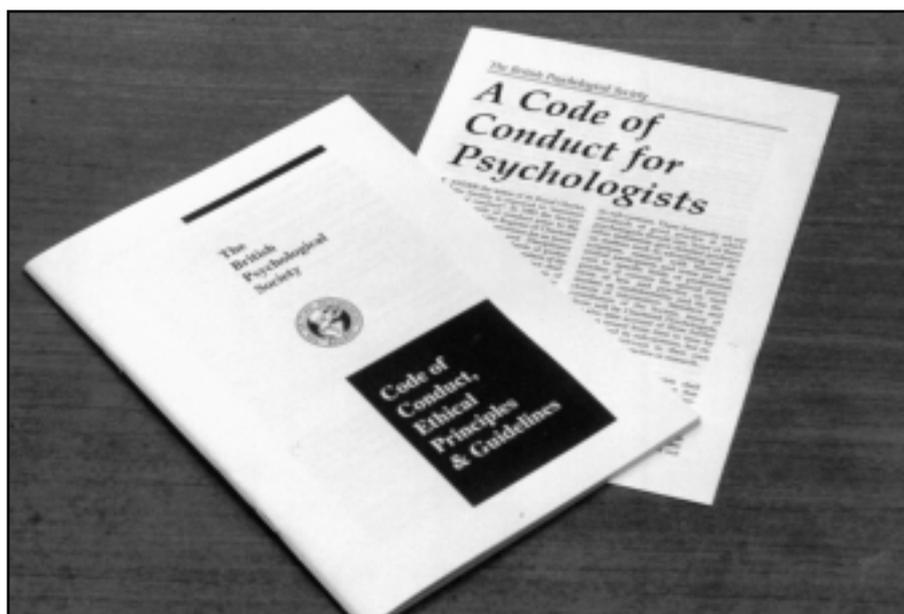
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