McNulty, N., Ogden, J., Warren, F. (in press) Neutralising the patient': therapists' accounts of sexual boundary violations. Clinical Psychology and Psychotherapy.

'Neutralising the patient':

therapists' accounts of sexual boundary violations.

Dr Nick McNulty¹, Professor Jane Ogden², Dr Fiona Warren².

¹South London and Maudsley NHS Foundation Trust

² Department of Psychology, University of Surrey

ABSTRACT

Sexual contact between psychological therapists and their clients is regarded as highly damaging, both to the clients and to the professions, and regulatory bodies impose increasingly severe sanctions upon those practitioners who are disciplined. The present study sought to capture therapists' accounts of sexual boundary violations through Interpretative Phenomenological Analysis of interviews with three disciplined practitioners about their relationships with clients and former clients. The results highlighted two key themes relating to i) therapists' efforts to neutralize the power imbalances between themselves and the clients by minimizing the clients' mental health problems, stressing the conventionality of the relationships and not testing the appropriateness of the relationship with their supervisors and ii) a shifting identity of the therapist between hero, victim, perpetrator which permeated their accounts as the relationship moved from success to failure. In order for a sexual boundary violation to occur, the therapist needed to generate a sense of equivalent status between themselves and the client. As the relationships failed, the therapists' accounts of the clients shifted and the inequality of the relationship re-emerged. The results are discussed in terms of implicit theories and the

implications for both training and supervision in the prevention of sexual boundary violations.

INTRODUCTION

Having sexual contact with a current client has come to be regarded as one of the most heinous ethical breaches that a psychological therapist can commit. For clients, sexual contact with therapists has been associated with long term negative psychological impact (e.g. Pope, 1990; Simon, 1995; CHRE, 2008). For therapists, there is 'the very real possibility of losing everything: profession, reputation, family, health, income, and life savings.' (Simon, 1999, p.31.).

All major western mental health professional bodies have explicitly proscribed sexual contact with current clients (Sarkar, 2004). Attitudes to sexual contact with former clients are more varied, but professional and regulatory disapproval has grown (Gabbard, 1994b; Sarkar, 2009). The potential damage was seen as arising from the unequal power relationship between therapist and former client, and possible misuse of knowledge and influence derived from the professional relationship (Halter *et al.*, 2007). For UK professional regulatory bodies, the burden of proof increasingly lay upon the professional to evidence that a relationship with a former client was not damaging (General

Medical Council, 2006; British Psychological Society, 2006).

Despite the explicitness of professional proscription, therapists continue to be convicted of sexual relationships with their clients. Anonymous self-report surveys have suggested that about 5-6 percent of therapists have at least one sexual relationship with a client in their career (Lamb & Catanzaro, 1996). In the only UK based survey to date, 3.5 percent of 581 psychologists returning a questionnaire reported sexual contact with a current or discharged patient (Garrett & Davis, 1998). The systematic sources of bias in these self-report surveys, such as the self-selection of participants, the social desirability of disguising sexual boundary violations, and the potential penalties of disclosure, were all likely to produce under-reporting (Halter *et al.*, 2007).

Research into why these violations of professional boundaries occur has implicated a wide variety of therapist, client and situational factors. A common finding was that therapists who have sexual relationships with their clients were mostly male, and were typically older

and more experienced therapists (Sarkar, 2004). Personal experience of transgressive relationships, in the form of sexual abuse as a child, or a sexual relationship with a professional educator, has also been cited as a factor (Celenza, 1998; Garrett & Davis, 1998; Jackson & Nuttall, 2001; Lamb & Catanzaro, 1996; Pope, Levenson & Schover, 1979).

Theoretical accounts of sexual boundary violations have tended to focus upon the behavioural antecedents of sexual contact, or upon the unconscious drives of the therapist. At the level of offence processes, the 'slippery slope' model suggested that the relationship between therapist and client began with minor boundary 'crossings', such as personal disclosure or non-sexual physical contact and progressed by gradual steps to a sexual one (Simon, 1995). Most theories of therapist-client sexual contact were couched in psychodynamic terms of personality structures and interpersonal interactions. Sexual boundary violations were generally understood as 'enactments', the acting out of unconscious impulses (Gabbard, 1994a). Sexual attraction itself was a commonly reported element of therapeutic relationships (Garrett & Davies, 1998). Therapists who acted upon it might mistake the fantasy element of the

therapeutic relationship for reality, and might have difficulty in acknowledging hostility in themselves or their clients, particularly if they relied upon relationships with clients to manage their own low self-esteem (Celenza, 1998).

Working with Gabbard, Celenza (2003) has made the only identified attempt to link several factors into a comprehensive, multi-factorial theory that included both aetiological characteristics and the immediate offence chain. Their account included a role for situational factors (life crises such as divorce or bankruptcy), intrapsychic factors (unconscious guilt, a grandiose defensive structure, intolerance of aggression) and interpersonal factors (the replication of childhood traumas in the therapy, a rescue fantasy with an abused patient, or the mismanagement of aggression or suicidality) (Celenza & Gabbard, 2003).

Increasing awareness of sexual boundary violations by therapists in the 1980s led to interventions intended to reduce the likelihood of sexual misconduct. For practicing clinicians, the use of supervision to explore risk was advocated. Jackson and Nuttall (2001) have suggested a

number of personal strategies intended to minimise the risk of boundary transgressions, including the practice of self-awareness, active use of supervision and the discussion of boundary crossings with colleagues and supervisors.

Education and training was central to the NHS strategy on reducing sexual boundary violations (CHRE, 2008).

Too much confidence in this approach needs to be balanced against the ability of therapists to elude supervision.

Pope (1990) reported the case of a psychologist who was able, following rehabilitation efforts for sexual boundary violations, to conduct a sexual relationship with a patient whilst under intensive post -rehabilitation supervision.

Sexual boundary violations have therefore been explored to date in terms of their prevalence in anonymous surveys; using correlational methodologies to highlight risk factors; or using descriptive approaches to generate offender typologies. The literature offers no reliable methods of distinguishing therapists who would go on to commit sexual boundary violations from those who would not. Understandably, there are no prospective or cohort studies. As the evidence review for the CHRE process concludes:

'there is no agreement in the literature about which

characteristics in the professional are predictive of sexual boundary violation' (Halter et al., 2007, p70). Moreover, there is a gap between the primarily psychodynamic accounts of boundary violations in terms of personality structure and unconscious motivation, and preventive efforts that tend to characterise sexual boundary violations as errors of knowledge or self-awareness.

In 2008, CHRE argued that there was a need to identify the role of more accessible cognitive processes as a means to underpin preventive strategies (CHRE, 2008). Outside of a psychodynamic framework, there has been little exploration of the experience and understanding of the therapists involved in boundary violations, their perceptions about the pattern of events and its significance, and the way in which they account for and justify their behaviour. The sex offender literature offers a theoretical framework for the role of cognitive processes in overcoming internal obstacles to boundary transgression in the concept of implicit theories. This idea is based upon the repeated observation that the descriptions of their offences by convicted sex offenders are 'odd' in that they are consistently marked by misinterpretation of sexual cues,

minimisation of harm, ideas about children's interest in sex and seductiveness (Gannon, 2009). There remains, however, an unresolved debate about whether these comments are self-serving post hoc rationalisations, designed to bolster self-esteem and reduce shame, or whether they are also the product of sex offenders' personal history, and act not only to rationalise but also to facilitate abuse (Marshall, Marshall, Serran & O'Brien, 2009; Ward, Polaschek & Beech, 2006).

The present study, therefore, sought to access the accounts of therapists who had had sexual relationships with patients, in order to examine the decision-making and justificatory process that accompanied the boundary violations. The study drew upon the notion of implicit theories from the sex offender literature and more general notions of rationalization. Findings from this study could be helpful in terms of further explicating the process by which therapists transgressed boundaries with clients, providing a unique protagonist perspective, and might contribute to preventive work.

METHOD

Participants

Mental health professionals who had been publicly found in breach of professional standards because of sexual contact with a client or ex-client were invited to take part in the study. Three therapists participated: two males and one female, with a mean age at the time of interview of 51. Their professions were clinical psychology, counselling and psychiatry. Two therapists were primarily Cognitive Behavioural in approach, the other psychodynamic. The participants have been given pseudonyms, and references to their professions and disciplining professional bodies excluded in extracts from the interviews. Their circumstances are briefly described below.

Helen conducted a relationship with a current client for a number of months. The relationship was revealed, and Helen was suspended by her employer and professional organisation, but has now resumed work in the mental health field. David had a relationship with a discharged client that lasted for over a year, during which time they lived together and became engaged. Some time after the end of the relationship, the client took legal action that resulted in David's dismissal and exclusion from his professional

organisation. He now works in another field. Chris had a relationship with a discharged female client that lasted for three years, in the course of which they became engaged. The relationship ended when a series of complaints by the client resulted in Chris's suspension by his professional body. Chris has resumed work in the mental health field.

Researchers

In keeping with the tradition of transparency in qualitative research, and in acknowledgement of the importance of researchers' attitudes and biases in shaping the outcome of research, we wanted to say something about our own attitudes to sexual boundary violations. We take the view that sexual boundary violations are not, for the most part, the work of a predatory or damaged group of practitioners, from whom the majority may feel safely distant. Rather we think that, given the right circumstances, most mental health practitioners could be vulnerable to breaching ethical rules. It follows, given our absolute responsibility as professionals to maintain these boundaries, that we need to acknowledge and work to reduce our own vulnerability.

Design

The study was a qualitative one, in which the primary source of data was in depth interviews with participants.

Procedure

Potential participants were identified from disciplinary notices in professional journals and websites. Of the 40 mental health professionals for whom there existed public reports, physical or e-mail addresses were obtained for 24 potential participants and they were sent an invitation letter. The wording of the letter was intended to conceal the topic of the study from non-participants. People who expressed interest were sent further information and a consent form. On return of a signed consent form, a telephone or face-to-face interview was arranged in line with the participant's preference.

Interview schedule

The interview was semi-structured. The prompt questions included:

1. *Please tell me about your relationship with this particular client. How did the relationship start and how did it develop?*
2. *How did supervision and/or views of peers influence what you did at this time?*
3. *How did family, friends, colleagues react to the accusation and disciplinary action?*
4. *What was your experience of the disciplinary process?*
5. *What has happened to you since the disciplinary process? Current role?*
6. *What are your views now about mental health professionals having sexual relationships with clients? If the goal was to prevent them, how might that be done?*

Data Analysis

The interview transcripts were analysed using Interpretative Phenomenological Analysis (IPA) (Smith, Harre & Van Langenhove, 1995). IPA offered the dual strengths of being highly attuned to the individual meaning making of participants, whilst also providing a framework for acknowledging and incorporating researcher views (Smith & Osborn, 2003).

There is no set methodology for IPA analysis (Osborn & Smith, 1998). We employed the general analytical principles suggested by Smith and Osborn (2003) and Willig (2001). This involved working in a detailed way through each transcript and highlighting significant phrases. Later re-readings produced categories that were grouped and 'boiled down' into themes, and linked into super-ordinate themes. The process was repeated for each transcript, generating a combined set of super-ordinate themes, supported by quotations from the transcripts. These were tested and modified in discussion with the project supervisors.

RESULTS

Two key themes emerged from the data relating to 'neutralising the client's 'patientness' and the 'therapist's identity as hero, victim, perpetrator'. In summary, the three participants accounted for their relationships with clients and former clients in ways that neutralised the client's status as a patient, not revealing the origin of the relationship and stressing its conventionality. The subsequent re-emergence of the clients' mental health problems, and the dissolution of the relationships, had significant implications for the

identity of the therapist. These two major themes are described and illustrated below.

1. Neutralising the client's 'patientness'

The therapists tended to see their clients' presenting mental health problems as minor, and well within their capacity to manage.

[the client] was referred to me with depression, anxiety and panic attacks. Very, very typical of primary care presentations. Severe enough to be seen by myself, not severe enough to be referred on to the CMHT. (David)

This view of the client's difficulties was not necessarily shared by observers: Chris's view that the client's mental health problems were 'quite minor...wasn't the [professional body] view at all'. The apex of this professional confidence was David's description of the impact of treatment:

The clinical side of things, it went very, very well...normality had been achieved. (David)

There was now no reason why the client should be seen as vulnerable as a consequence of mental health difficulties. This perceived reduction in mental health problems seemed to be a pre-condition for the contemplation of a relationship, as the client no longer needed to be thought of as a patient, but could be seen as a potential partner:

I mean in a sense my concern about her had reduced over time because she was still alive and I suppose it was sort of like I then started to think of her in a more positive way I suppose and yes and that's why I phoned her. (Chris)

This reflects a levelling out of status between therapist and client that facilitated the crossing of boundaries. In order for a client to be a suitable partner for their therapist, it seemed to be important to be able to think of them as 'not being a patient'. This process might be seen as a way of overcoming internal objections to sexual transgression (Finklehor, 1984). Most therapists would consider it exploitative to enter into a relationship with a vulnerable and unstable patient, but might have fewer

objections to a relationship with a fully recovered, ex-client.

The second mechanism at work was the way in which the relationships with clients were seen in a normalised way, following a predictable and conventional course. Initial meetings took place in non-health service settings: a café (Chris), a gym (David). There was nothing sudden or precipitate about these relationships, no excess of passion. Rather they were consensual and negotiated, moving at an appropriate pace.

I saw [client] two, possibly three times, just a brief acquaintance of, you know, 'Hello. How are you? How's your exercise going?' That sort of thing...What happened was... the acquaintance developed into becoming friendly, friendlier, and certainly by the end of [the year] we'd formed a relationship. (David)

In some ways these were relationships that were anything but clandestine. In two cases the therapists became engaged to their former clients. The relationships were seen as consensual, a meeting of equals. David remarked that the client 'was a trained therapist herself'. Chris stressed

the absence of an age difference, in a way that seemed intended to convey an absence of exploitation:

The patient was the same age as me, so it wasn't, it wasn't as if you know she was a very young person.

(Chris)

There was also something idealised about the relationships. David described the client as a 'fabulous person to live with, bright, intelligent, caring, considerate.' For Chris, 'the first three years seemed to be a very healthy and positive relationship'. In contrast, however, Helen captured a sense of self-deception in this idealisation:

I tried to make the best of it, y'know. And you know, convince myself that it was worthwhile or y'know that it didn't matter if I'd lose my job because we had each other. (Helen),

These descriptions convey the participants' sense of equality in their relationships, in a similar way to the minimization of the clients' mental health problems. Power imbalance was one of the widely cited reasons for avoiding relationships with both current and former clients

(Gabbard, 1994b). David explicitly rejected the idea that this concept applied to his relationship:

There's no indication of any power differential either between [client] over me, or me over [client]. It was a, how can I put it, it was a friendship that developed from an acquaintance, with which the friendship deepened. There were nothing from it to suggest any sort of power imbalance. (David).

For two of the participants, sexual intimacy was described as unimportant:

We had some kind of sexual relationship at a certain point but that certainly wasn't important to me.
(Helen)

This stress on sex *not* being a major part of the relationship appeared to reflect the participants' need to see themselves as not primarily motivated by sexual desire in forming a relationship with a client.

For the two participants in relationships with former clients, their sense of the legitimacy of the relationships was partly undermined by awareness that they avoided disclosing the origins of the relationship.

At this stage wasn't discussed with my supervisor. Although it was fairly common knowledge, it wasn't, I didn't, I never disclosed that [client] had been a client of mine. (David)

There was a sense of these relationships being technically within the rules, but not meeting the higher standards of conduct that might be expected by colleagues and others:

I mean it was legitimate in terms of [professional body] rules, what I thought of how generally people interpreted them, but at the same time I sort of knew that you know if I discussed it with certain colleagues they would frown upon it. (Chris)

These acts were interpreted as forms of concealment: as ways of denying the problematic basis of the relationships. Holding secrets from supervisors has been identified as one feature of the enactment of boundary violations (Gabbard,

1997). For Helen, the illicitness of the relationship was inescapable, and required a more conscious process of self-deception:

I think I dissociated to a certain extent. Pretended as if this was it for me. Of course it wasn't...
(Helen).

When it happened, disclosure was not planned, but was brought about by events. For two participants, it was the re-emergence of the former clients' mental health problems that enforced disclosure, re-identifying them as patients:

I'd disclosed it to my employer because one of the difficulties was, that she may very well have needed hospitalising. (David)

The re-emergence of the clients' mental health problems was 'a bolt out of the blue' (David), experienced as a sudden, blinding revelation in which the participants' situation became shockingly apparent:

So I asked him to go and then he went with a carrier bag full of medication and pills and I thought 'Oh my

God'. Then I was frightened. I thought 'Oh my God, they'll find him on the moor somewhere and then I'll hang'. (Helen)

Initially presented as mild and amenable to treatment, the clients' mental health problems were now portrayed in dramatic images of madness and instability: inpatient admissions, Jeckyll and Hyde unpredictability, the presence of helicopters and dogs. The clients were now seen as unpredictable and manipulative, mad or bad:

She was on the make, basically. (David)

In this mode, for two of the participants, the client was seen as a threat, and the relationship not one of care-giving but of possible destruction:

She would try and draw me back into the relationship but, but at the same time would be trying well to destroy me I suppose. (Chris)

With the clients now firmly re-identified as 'patients', the therapists reasserted the boundaries, and ended the relationships:

I knew if I wanted to move at all I had to break all the ties, so that's what I did. I told him that I didn't want to see him anymore. (Helen)

The therapists all saw themselves as taking control over the ending of the relationship; a significant change in tone for relationships that had been characterized as being between equals. The therapists' final view of the clients displayed a lot of variability. Chris saw the failure of the relationship in terms of the client's vulnerability and the interaction between them:

I suppose the way I understand it is that sort of although she wrote these things which weren't true, basically she was fearful of getting married, and yet she wasn't able to be straight with me I guess.

For Helen, the client bore a heavier responsibility for events, but it was also possible to acknowledge his vulnerability:

I don't hate him cos underneath all this manipulation was lot of childishness really. He was a big bloke and

he portrayed himself as being stronger than he actually was, but he was quite vulnerable himself.

Whereas for David it was difficult to go beyond the client's culpability:

... she was a highly reprehensible individual who had changed her name, had been involved with this sort of thing before.

The participants' views on the advisability of relationships with clients or former clients were consistent with these interpretations of culpability. Where the client was seen as primarily responsible, avoiding relationships with clients was seen as a question of self-protection:

Never go anywhere near an ex-client. (David)

Where responsibility was seen as shared, the product of an interaction, avoiding relationships with clients was also a means of protecting them:

So I can say in hindsight I've done wrong but and I think in order to protect clients, in order to protect clients from therapists and there are predatory therapists no doubt, which most of the issue is about, there has to be some guidance that protects clients from such therapists really. (Chris)

2. Identity: Therapist - hero, victim, perpetrator

The second master theme traces the impact of the relationship upon the participants' identity and sense of themselves as a professional. Initially, the therapeutic relationship with the client was a demonstration of competence, and the clients were seen as open to professional knowing:

Her HONOS scores, what do you call it, the CORE scores, the self-report measure, everything, she was well below the clinical cut-off point. (David)

The confidence with which the therapists allocated both diagnostic categories and levels of severity to their clients, was a manifestation of this professional gaze. Paradoxically, the construction of a conventional

relationship with a well person rested upon the therapist being effective and knowledgeable. In the self-image that was reflected back to therapist in the clients' adoring eyes, this was what they saw: the therapist as hero.

Yes, she'd made, certainly from a personal point of view, the clinical side of things, it went very, very well ... Normality had been achieved. Some week or two later she wrote myself a thank you letter, wrote a letter to the GP, all that sort of stuff. (David)

The therapist's professional identity was tied to seeing the client as recovered; the 'appeal which the gratifyingly improving patient makes to the narcissistic residue in the analyst's personality, the Pygmalion in him' (Searles, 1959, p.187).

As the clients' 'patientness' re-emerged, they became mysterious again, their motivation opaque. For David, there were things about the client that had 'never come to light', that were beyond his professional experience: he had 'never seen anything like it before clinically'. Rather than knowing, the professionals came to see themselves as 'naive and in the dark and a bit blinded.' (Chris)

The cost of the shift from knowing clinician to naïf was a loss of professional confidence:

So I was sort of shocked, partly that I misjudged her personality so much and that she obviously had much larger problems than I anticipated. (Chris)

A further effect was a shaking of participants' belief in the robustness of clinical structures. All three participants expressed doubt about whether supervision could have made a difference:

It would have to be a good supervisor you know? Cos I was ill at that time.
(Helen).

For one participant, events threatened their confidence in psychology as an evidential discourse, its forms of knowledge becoming inferior to legal discourses:

No matter how well you think you know somebody, there were an awful lot in [client's] background that never

came to light until it been investigated by a
solicitor and a barrister. (David)

For all of the participants, the impact of the disciplinary
investigation and inquiry was devastating, both
immediately:

I was obviously suspended for a year. So, you know, I
had lost my income, I'd lost my house. Well, I lost my
phone as well. (Chris)

And in its longer term implications for their future
career:

...you lose your professional network, your social
network shrinks, and you become a salesman because
nobody else will employ you, because I was dismissed
from the NHS.

Colleagues' response was variable, with two participants
enjoying good support, the third suspicion. Participants
saw themselves as marked by the offence, as though it was
visibly apparent:

Oh, I was frightened! I thought they could see from the outside that I had been suspended really. (Helen)

They saw themselves as rejected by professional organizations, almost shunned:

I've forgotten what they call it now, gross professional misconduct, and nobody will touch you with a barge pole. (David)

The effect was seen as a long term one:

I'm forever vulnerable basically, in the sense I can never run for high office because this will be a black mark on my career forever. (Chris)

Loss of professional confidence, external criticism and rejection, as well as loss of the relationships, had a considerable impact on the way in which the participants saw themselves and their actions. Two of the participants saw themselves as victims, the third as part victim, part perpetrator. Their narratives are described below.

Helen described a difficult prior relationship that had left her highly vulnerable:

It would never have happened if this ex-partner wouldn't have traumatised me so much.

She thought that her own mental health problems reduced her ability to manage boundaries. Pressure from the client was experienced as finally overwhelming:

So how do I look at my boundary violations? I was ill, I was very ill. I could function, without pressure I could function, but he put a lot of pressure on me and that's what I couldn't, I wasn't strong enough to resist that.

The difficulties were compounded by lack of support from colleagues:

No-one said anything, nothing. 'What's happening? How are you coping? What are you going to do?' Nothing, nothing, nothing. I felt as if I had to keep it all under control. Which I managed to do for some time,

until this client started pushing me and then I lost it.

The lack of empathy from the disciplinary committee reinforced the trauma:

I think it's important that when the [professional body] disciplines a person then they should be a bit more empathic because that was very clinical but not understand.

David's story was of someone who had done 'nothing untoward', and had been wrongly condemned by employers and professional organisations. He saw himself as the sustained victim of attack by the client, both in terms of unfounded allegations and physical violence. David presented himself as always having followed the rules. He saw his behaviour as transparent:

I'd self-disclosed. Everything that they wanted to know. There was a letter of support from [the client], letters from GPs. I had an unblemished career.

Despite this probity, David saw himself as condemned by employer and professional body through unfair processes, without 'a shred of evidence'. The motives for the unfairness remained inexplicable:

Oh, I absolutely have no idea other than, certainly my line, had it gone to a civil hearing, all I can assume is that my line manager, my clinical supervisor and the [clinical manager], wouldn't have wanted to appear in a civil court for some reason.

If the therapist identified themselves as the victim, then there was no scope for contemplating negative consequences for the client:

The only consequence for her...I've got absolutely no idea how or if she has benefited. I can only assume that she will have had some money at the end of the day. (David)

For him? No. He's back with his partner. His partner's a bit wiser. But for him, no. (Helen)

The closeness of the participants' identification with the victim position seemed to leave little room for a more nuanced understanding either of their role in the relationship or its potential impact upon the client. If these two accounts seemed to present a very fixed view of the role of the therapist, Chris's story was more complex. Whilst maintaining the view that his conduct whilst the client's therapist was appropriate, and criticising his professional body for taking a simplistic and inconsistent view of boundary violations, Chris made a connection between the therapeutic relationship and subsequent personal one:

If I hadn't met her through therapy I guess I wouldn't, if I'd met her in a café or something I don't know if I would of taken an interest in her.

There was a recognition that the breakdown of the relationship was not the result of a pathological act by the client, but was a product of their interaction. Whilst very conscious of the immediate and lasting impact upon him, being 'forever vulnerable', Chris also envisaged lasting distress for the client. The psychological cost of

this position was that it involved Chris accepting a degree of culpability for the outcome:

So I can say in hindsight I've done wrong ... I do regret what I've done. Obviously, it's easy to regret things when you've had enormous negative impact on one's life and standing and everything basically... So I suppose I do have quite a few regrets and I wished it had been different but I can only say that in hindsight really.

Both David and Chris sought to distinguish themselves from therapists who have multiple relationships with clients, whom Chris described as 'predatory therapists'. In the victim position, this strict differentiation protected the therapist from viewing themselves as a perpetrator:

Therapists, nurses, doctors forming relationships with current clients, that's an absolute no-no and forming relationships with ex-clients ... in my mind they are two separate things (David)

For Chris, however, having accepted some complicity in a relationship that he saw as damaging, the absolute distinction between relationships with current clients and with former clients was no longer available to protect against a feeling of wrongdoing:

In terms of more psychological or psychotherapeutic things I think the distinction largely disappears and the safest recourse I suppose is to say that one should never have a relationship with an ex-patient who, you know, you've given psychotherapy to.

Therefore, the therapists accounts were permeated throughout with changing notions of identity which varied according to the state and stage of the relationship being described as therapist's conceptualised themselves as either hero, victim or perpetrator.

DISCUSSION

Summary of findings

This study aimed to examine how mental health professionals accounted for sexual relationships with

clients and former clients. Two major themes emerged from interviews with three disciplined therapists. *Neutralising the clients' 'patientness'* suggested that the therapist's perception of the client's mental health problems was central to the initiation and maintenance of the relationship. When the problems were seen as minimal, boundaries were dissolved, and a conventional relationship without perceived power imbalances was possible. The presentation of the relationship as entirely conventional seemed forced, a tension that was apparent in their reluctance to disclose the origins of the relationship. When disclosure was made, it was involuntary, brought about by events. The client was then seen as a destructive force, associated with powerful images of madness, and the therapist's survival required the reinstatement of boundaries. Put simply, in order to have a relationship with a current or former client, it was necessary for the therapists not to see them as a patient.

The second major theme, *therapist: hero, victim, perpetrator*, followed the implications of the travails of the relationships for the therapists' personal and professional identity. The start of the relationship seemed to reconfirm the professional competence and identity of

the therapist: the 'hero' position. Its unravelling was not only a personal blow to the therapists, but also threatened their sense of themselves as capable clinicians. For two of the therapists, their construction of events located them firmly as 'victims', either of prior trauma or unfair processes. They saw the clients as deceitful and manipulative, and did not believe that they had experienced negative consequences from the relationship. The third therapist believed that the client would suffer negative consequences, and saw himself as in some ways culpable.

Links with existing literature

These results find some reflections in existing literatures. For example, the progress of the relationships suggested a pattern of non-sexual boundary violations preceding the sexual relationship, in a way that fits with Simon's 'slippery slope' model (1995). The dynamics of the relationships also echoed some of the themes in the literature. Helen's relationship with the client, in which her vulnerability and need for help were presented as greater than the clients, was reminiscent of the reversal of roles that has

sometimes been observed to precede sexual contact between therapist and client (Gabbard, 1994a).

As the introduction highlighted, the process by which therapists overcome internal obstacles to having sexual relationships with clients has not been widely explored in the literature. The argument that sex with a client could be seen as a therapeutic intervention, for example by McCartney (1966) or Shepard (1971), has never been more than a fringe view. In this study, some of the views advanced by participants could be described as being consistent with implicit theories that tended to enable sexual relationships with clients, including the permissive attitude to non-sexual boundary violations and the denial of harm to the client. The latter was made in the face of evidence that participants had been obliged to research as part of the disciplinary process, and therefore seemed particularly self-serving. The idea of power differentials in sexual relationships between therapists and clients has been described before, for example in cases where the erosion of power differences was an explicit therapeutic philosophy (Gabbard, 1997; Gartrell & Sanderson, 1994). The novel finding in this study is the idea that strategies to equalize the relationship are important in establishing and

maintaining the relationship, and that when they cannot be supported, when the client's mental health problems are inescapable, then the relationship cannot continue.

Whether these strategies are enabling scripts or post-hoc rationalizations intended to minimize shame, the debate that surrounds implicit theories in the sex offender literature, cannot be resolved with this small sample of retrospective accounts, but the suggestion here is that it is worth further investigation. The second major theme that emerged from the study echoes suggestions in the literature that both personal and professional identity are closely intertwined in the course of the relationship between therapist and client.

Clinical Implications

This study has generated material that might be helpful in helping professionals to avoid sexual boundary violations through training and supervision. It provides a picture of the participants' reflections on their sexual contact with clients that could be usefully incorporated into training materials, perhaps by providing case vignettes for discussion. Perhaps more important is the way it

emphasises again the important role of supervision. The participants in the study sustained a normalising view of their relationships with clients partly by not testing it in supervision. Even the two therapists who were involved in relationships with former clients that they regarded as legitimate, were not open with supervisors about the origins of the relationships. In the absence of a definitive prohibition on relationships with ex-clients, there is a suggestion here that a relationship that we are not willing to discuss with our supervisors should be a matter of concern. This finding supports the view that supervision is most valuable when it is used as a forum for discussing the reactions that we have to clients which we feel least able to share (Gabbard, 1997). The challenge to supervisors is to make supervision a place where those difficult explorations can take place (Bridges, 1998).

Limitations and future research

The three therapists taking part in this study cannot be seen as representative of the wider population of mental health professionals committing sexual boundary violations. IPA does not seek to generate a representative sample: the aim is to produce an in-depth analysis of a small number of

participants' accounts. The results are a co-creation between the participants and the researchers. Any conclusions drawn, then, are specific to this group of participants and us, and we must be cautious about generalizing more widely. However, the emergence of similar themes within a sample may be relevant to other individuals from comparable populations (Smith & Osborn, 2003). We hope, therefore, that these findings contribute to a fuller understanding of the processes involved in sexual boundary violation. In terms of making a contribution towards the construction of a theory, these detailed findings could be seen at the level of phenomenon observation (Ward & Hudson, 1998). Such work helps to identify possible clinical phenomena that formal theory then sets out to explain (Davison & Neale, 1996).

There are a number of important research challenges for the future. The piloting and evaluation of training programmes intended to reduce the occurrence of sexual contact between therapist and client is a clear priority, with a focus upon the particular contribution of supervision. This study has begun to identify a role for therapists' beliefs and understandings in sexual boundary violations. Further detailed qualitative studies would be needed to expand the

range of narratives. There is also a need to establish whether they play a part in enabling boundary violations, or operate only retrospectively. This work could be helpfully complemented by exploring the factors that enable therapists *not* to act upon sexual attraction to clients, on which initial work is underway (C. Martin, personal communication, 5 February 2009).

The contribution of this study to thinking about sexual contact between therapists and clients is in its detailed observation of the narratives that therapists constructed around the nature of their relationship with clients. Where the existing literature suggested important roles for unconscious conflict, and elucidated some of the behavioural changes that mark the 'slippery slope', this study has generated some suggestions about the more conscious processes of meaning-making that may accompany sexual boundary violations. For these participants, the reduction of perceived power imbalances between themselves and the clients, the producing of a kind of equivalent status, seemed to be a necessary step in rendering a relationship with a client an acceptable action. Minimising the client's mental health problems; stressing the therapist's own vulnerability; emphasising the

conventionality of the relationship: all of these attributional strategies seemed to be geared towards reducing any exploitative difference in status.

Key practitioner messages

- in accounting for their sexual boundary violations, this small sample of therapists minimized the power imbalances between themselves and their clients
- minimizing the client's mental health problems; stressing the conventionality of the relationship; stressing the therapist's own needs - all contributed to the neutralization of the client's patient status
- a relationship with a former client that we are *not* willing to discuss with our supervisor should be a cause for concern

REFERENCES

Bridges, N. (1998). Teaching psychiatric trainees to respond to sexual and loving feelings: the supervisory challenge. *Journal of Psychotherapy Practice and Research*, 7, 217-226.

British Psychological Society, (2006). *Code of Ethics and Conduct*. Leicester: British Psychological Society

Celenza, A. (1998). Precursors to therapist sexual misconduct: Preliminary findings. *Psychoanalytic Psychology*, 15(3), 378-395.

Celenza, A. & Gabbard, G. (2003). Analysts who commit sexual boundary violations: A lost cause? *Journal of the American Psychoanalytic Association*, 51(2), 617-636.

CHRE (2008). *Learning about Sexual Boundaries between Healthcare Professionals and Patients: A Report on Education and Training*. London: CHRE.

Davison, G. C. & Neale, J. M. (1996). *Abnormal Psychology* (6th ed.) New York: Wiley.

Finklehor, D. (1984). *Child Sexual Abuse: New Theory and Research*. New York: Free Press.

Gabbard, G. (1994a). Psychotherapists who transgress sexual boundaries with patients. *Bulletin of the Menninger Clinic*, 58(1), 124-35.

Gabbard, G. (1994b). Reconsidering the American Psychological Association's policy on sex with former patients: Is it justifiable? *Professional Psychology: Research and Practice*, 25(4), 329-335.

Gabbard, G. (1997). Lessons to be learned from the study of sexual boundary violations. *Australian and New Zealand Journal of Psychiatry*, 31, 321-327.

Gannon, T. (2009) Social cognition in violent and sexual offending: an overview. *Psychology, Crime & Law*, 15 (2), 97-118.

Garrett, T. & Davis, J. (1998). The prevalence of sexual contact between British clinical psychologists and their patients. *Clinical Psychology and Psychotherapy*, 5, 253-263.

Gartrell, N. & Sanderson, B. (1994). Sexual abuse of women by women in psychotherapy, counselling and advocacy. *Women & Therapy*, 15(1), 39-54.

General Medical Council, 2006. *Good Medical Practice*. London: General Medical Council

Halter, M, Brown, H & Stone, J. (2007). *Sexual Boundary Violations by Health Employees: An Overview of the*

Published Empirical Literature. London: Council for Healthcare Regulatory Excellence and Department of Health.

Jackson, H. & Nuttall, R. (2001). A relationship between childhood sexual abuse and professional sexual misconduct. *Professional Psychology: Research and Practice*, 32(2), 200-204.

Lamb, D. & Catanzaro, S. (1996). Sexual and nonsexual boundary violations involving psychologists, clients, supervisees, and students, implications for professional practice. *Professional Psychology: Research and Practice*, 29(5), 498-503.

Marshall, W., Marshall, L., Serran, G. & O'Brien, M. (2009). Self-esteem, shame, cognitive distortions and empathy in sexual offenders: their integration and treatment implications. *Psychology, Crime & Law*, 15(2), 217-234.

McCartney, J. (1966). Overt transference. *Journal of Sex Research*, 2, 227-237.

Osborn, M. & Smith, J. (1998). The personal experience of chronic benign lower back pain: an interpretative phenomenological analysis. *British Journal of Health Psychology*, 3, 65-83.

Pope, K. (1990). Therapist-Patient sex as sex abuse: six scientific, professional and practical dilemmas in addressing victimisation and rehabilitation. *Professional Psychology: Research and Practice*, 21(4), 227-239.

Pope, K. S., Levenson, H. & Schover, L. R. (1979) Sexual intimacy in psychology training: results and implications on a national survey. *American Psychologist*, 34, 682-689.

Sarkar, S. (2004). Boundary violation and sexual exploitation in psychiatry and psychotherapy: a review. *Advances in Psychiatric Treatment*, 10, 312-320.

Sarkar, S. (2009). Life after therapy: post-termination boundary violations. *Advances in Psychiatric Treatment*, 15, 82-87.

Searles, H. (1959). Oedipal Love in the Counter Transference. *International Journal of Psychoanalysis*, 40, 180-190.

Shepard, M. (1971). *The love treatment*. New York: Peter Wyden.

Simon, R. (1995). The natural history of therapist sexual misconduct: identification and prevention. *Psychiatric Annals*, 25, 95-99.

Simon, R. (1999). Therapist-patient sex: From boundary violations to sexual misconduct. *The Psychiatric Clinics of North America*, 22(1), 31-47.

Smith, J. A., Harre, R. & Van Langenhoove, L. (Eds.) (1995). *Rethinking Psychology*. London: Sage Publications Ltd.

Smith, J. A. & Osborn, M. (2003). Interpretative Phenomenological Analysis. In J. A. Smith (Ed.) *Qualitative Psychology: A Practical Guide to Research Methods*. London: Sage Publications Ltd.

Ward, T. & Hudson, S. (1998) The construction and development of theory in the sexual offending area: A metatheoretical framework. *Sexual Abuse: A Journal of Research and Treatment*, Vol. 10, No, 1, 1998, 47-63

Ward, T., Polaschek, D. & Beech, A. (2006). *Theories of Sexual Offending*. Chichester: John Wiley & Sons Ltd.

Willig, C. (2001). *Introducing Qualitative Research in Psychology*. Buckingham: Open University Press.