THE WAGES OF SEEKING HELP: Sexual Exploitation by Professionals

CAROL BOHMER

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Westport, Connecticut
London

Library of Congress Cataloging-in-Publication Data

Bohmer, Carol.
The wages of seeking help : sexual exploitation by professionals / Carol Bohmer.
p. cm.
Includes bibliographical references and index.
ISBN 0–275–96793–X (alk. paper)
1. Sexually abused patients. 2. Medical personnel and patient. 3. Medical personnel—Sexual behavior. 4. Sexual abuse victims. I. Title.
RC560.S44 B67 2000
616.85´83—dc21 99–045991

British Library Cataloguing in Publication Data is available.

Library of Congress Catalog Card Number: 99–045991
ISBN: 0–275–96793–X

First published in 2000

Praeger Publishers, 88 Post Road West, Westport, CT 06881
An imprint of Greenwood Publishing Group, Inc.
www.praeger.com

Printed in the United States of America

The paper used in this book complies with the Permanent Paper Standard issued by the National Information Standards Organization (Z39.48-1984).

10 9 8 7 6 5 4 3 2 1

Copyright Acknowledgments

Portions of Chapter 3 were previously published as "Victims Who Fight Back: Claiming in Cases of Professional Sexual Exploitation," *Justice System Journal* 16.3 (1994): 73–92, and are reprinted with permission of the publisher.

Portions of Chapter 4 were previously published as "Failure and Success in Self-Help Groups for Victims of Professional Sexual Exploitation," *Journal of Community Psychology* (July 1995): 190–199.

Every reasonable effort has been made to trace the owners of copyright materials in this book, but in some instances this has proven impossible. The author and publisher will be glad to receive information leading to more complete acknowledgments in subsequent printings of the book and in the meantime extend their apologies for any omissions.

To the memory
of
my father

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ACKNOWLEDGMENTS

I would like to thank all the people who helped me in the several years it took to write this book. Special thanks go to the students who provided research: Else Slepecky, Lauren Weldon, Gail McGuire, Valerie Rake, and Jelena Batinic were all of great assistance. It is impossible to name all those who gave so freely of their time and effort, but Gary Schoener deserves to be singled out for the patience and enthusiasm with which he answered my many questions over the years. Many other professionals gave generously of their time, for which I am immensely grateful. Those many people who were exploited by professionals and who made the effort to tell me of their usually painful experiences provided me with invaluable material. Without their courage and willingness to share, this book could not have been written.

I would like to thank my family for their support, and those friends who encouraged me to keep going. You know who you are.

I would also like to acknowledge the Graduate School of Public and International Affairs, University of Pittsburgh, and Ohio State University for the research support they provided me.

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INTRODUCTION

> "Tangled Case of Sexual Molestation Pits a Doctor against 8 Poor Women"
>
> —Lewin, 1995
>
> "Psychiatrists and Sex Abuse: State Regulation Marked by Delay, Confusion, Loopholes"
>
> —Lehr, 1994

The last couple of decades have brought to public attention several issues of violence and exploitation against women. Domestic violence and rape have attracted the most attention, both from feminists and, more recently, from the general public. But other problems with women as their primary victims have not received much public attention.

Professional sexual misconduct (also called exploitation or abuse) is such an issue. Over the last few years we have learned that all professional relationships are not always the source of comfort and help they have been held out to be. For some, it appears that the cure may be worse than the disease. A patient who gets involved in a sexual relationship with her therapist "for her benefit" finds that the benefit was all for the therapist. An emotionally distraught divorce client receives demands for payment in sex as well as money for her lawyer's services. A woman goes to a clergyman for pastoral counseling and gets propositioned. A gynecological exam becomes the occasion for a doctor's sexual gratification.

Incidence studies have shown that 4–13 percent of all therapists engage in sexual contact with their patients, while the figure for lawyers is 7 percent (Schoener, 1989b; Murrell et al., 1993), and one estimate of priests puts the figure at 5–10 percent (Greeley, 1993). Approximately 80 percent of the perpetrators are male and the victims female, and a large number of the

perpetrators are repeaters (Bouhoutsos et al., 1983; Holroyd and Brodsky, 1977; Gartrell et al., 1986).

There are a couple of reasons that this is a problem whose victims are primarily women. Despite inroads by women into the professions, more professionals are still male and therefore potential exploiters. In addition, women are more inclined to seek the help of professionals, especially medical and therapeutic professionals.

We as a society are ambivalent about seeking help. We believe that it is OK to make efforts to help oneself in times of difficulty, as witness the legions of self-help books on the shelves of bookstores. It is also OK to seek out others who are suffering from the same difficulty, as we can see from the church basements and other public spaces that are packed with support groups for every conceivable problem, as well as their cyberspace counterparts, Internet chat-rooms.

What is much less OK is to seek out therapeutic help. When it is revealed that a public figure, especially a politician, has sought psychiatric help, the result is punishment or, at best, a lack of understanding for his or her "weakness." While this reaction seems, at present, to be stronger against men, that may be simply because fewer women are political figures. Nevertheless, it typifies public attitudes toward help-seeking behavior for "mental" problems.

The help-seeking aspect of this problem and society's reaction to it are central to an understanding of how professional sexual misconduct is framed and perceived by the public. Women are not the only victims of the behavior; nor is it by any means confined to therapists. However, social attitudes and bureaucratic responses are tainted by our views of therapy and of women who seek help. Women who are sexually exploited by professionals are twice punished. The first time they are punished for having sought help and having thus "asked for" the sexual behavior. They are punished a second time in their efforts to claim redress for the exploitation. For many, the process of obtaining redress is too arduous or traumatic even to undertake it; those who do make a public claim find themselves engaged in a long, unpleasant experience with major financial and emotional costs.

The literature on rape and domestic violence is replete with evidence that blaming the victim is commonplace, especially when the issue of consent is in question, as in acquaintance rape. These punitive attitudes seem to have softened a bit lately in the case of domestic violence and rape. Mandatory arrest of batterers and the passage in 1994 of the Violence Against Women Act are two examples of the increasing recognition of the legitimacy of domestic violence and rape as social problems.

Despite the increased public attention to these other issues affecting women, it is apparent that professional sexual exploitation must go through the same process of obtaining recognition by the public as well as

those directly concerned with the issue. Claims-makers have also had to respond to arguments that this is a private issue of consensual sex, without the evidence of violence that can negate claims of having "asked for it" or "wanted it," as is more often the case in battering and rape. Embedded in these arguments is our society's profound ambivalence about sex and our complex and often contradictory attitudes toward appropriate female behavior.

So far, claims-makers have not been very successful in gaining public recognition for professional sexual exploitation. Most people have never even heard the term and do not know what it means. Nor have efforts to initiate social change from either the public or the relevant professional community had more than mixed success. One of the foci of this book is to examine the reasons this is so.

The rhetoric of power and dominance has been an important element in the discourse of the women's movement, and it is particularly important in an explanation of the history and construction of professional sexual misconduct. It also illustrates the connections between professional sexual misconduct and other problems primarily affecting women as well as differences among the problems.

Power is central to the construction of professional sexual exploitation on three different levels. At one level, since we are speaking of a claim most often made by a woman against a man, there is the power inherent in that relationship. At a second level, doctors, lawyers, and the clergy (the professionals most frequently accused) are among the highest-status members of our society. At a third level, allegations of professional sexual exploitation are sometimes made against men who hold social power within their profession in addition to the power generated by their gender and their profession (Noel with Watterson, 1992; Walker and Young, 1986). These three levels at which power is central distinguish professional sexual exploitation from other social problems in which female victims predominate. For example, most perpetrators of rape are not particularly powerful individuals themselves and therefore have the protection only of their gender, rather than their gender and their social position of power.

The social roles of a person in need of help and a person providing that help exacerbate the power imbalance, especially when the patient or client is female. In fact, the fatherly professional responding to the needs of the childlike patient or client is the archetypical patriarchal relationship. It can be argued that the power imbalance is inherent in the relationship rather than in the gender of the respective participants in it, though its source is the classic patriarchal power relationship of male professional and female patient or client. Thus, the power imbalance survives the entrance of women into the professions under discussion.

Like the construction of other social problems, those framing the problem are both professionals who deal with it in their work and victims

themselves. But in this case the very people who would, in other social problems, be among the claims-makers (the professionals) are themselves the "cause" of the "problem." This leads to divisions within the professions because members of the professions are particularly needed in constructing the problem to provide "expert" status and, in addition, to enhance the credibility of the claims. But when professionals do lend status and credibility in the construction of the social problem, they are thereby required to criticize their colleagues, something many professionals are reluctant to do. By contrast, professionals constructing other social problems are not caught in this bind. For example, child abuse was originally constructed by a small group of doctors who publicized the need for their colleagues to recognize the signs of abuse in their patients that they had previously ignored (Nelson, 1984). In that case, the doctors were encouraged to become involved in exposing the problem, not accused of causing it.

Because the issue of psychological harm is a central element of the claim, professionals are needed even more than they are in the case of some other problems, like child abuse and even woman-battering and stranger rape, because in those cases at least some components of the trauma are visible. In cases of nonviolent professional sexual exploitation, the problem needs to be framed in ways that stress the harm caused; otherwise, it will simply be seen (as it may be anyway) as just a romantic relationship between professional and client/patient. Even in the case of sexual harassment, in which the relationship may be viewed as an ordinary sexual encounter, claimants can often provide externally verifiable evidence such as being fired from a job or failing a course in which the victim had previously been doing well. The case of hostile environment sexual harassment (where the creation of a sexually offensive atmosphere is central to the claim) is more similar to that of professional sexual exploitation. Outsiders may not "get" why the victim felt she had to leave the job or the school when the damage on which she bases her claim is less tangible. This is even clearer in the case of professional sexual misconduct. Since the victim was already in need of professional help, she is defined, at best, as "troubled" and, at worst, as "crazy." The negative effect of professional sexual exploitation on her psychological condition can usually be fully measured only by another professional.

Many claims-makers in professional sexual exploitation, including professionals, are themselves victims of professional sexual abuse and, therefore, mostly women. Because women have a lower status in the professions than their male counterparts in general, female professionals have a hard time being taken seriously in their efforts to frame the social problem. As we have seen, most of the professionals who engage in professional sexual exploitation are men. So are the most powerful members of the professional organizations. For the most part, women are marginal

in their professional organizations. Thus, when a woman professional expresses her concern about the existence and extent of the problem, she has less credibility than her male counterparts and risks further marginalization in the organization.

The experience of Nanette Gartrell and her female colleagues (1987) in trying to get the American Psychiatric Association (APA) to conduct an incidence study of sexual exploitation among psychiatrists provides a telling illustration of the difficulties involved in persuading male-dominated professional organizations to address the problem. They recount extensive resistance on the part of the APA to respond to the call by the Committee on Women of the APA to undertake the study. Two years of efforts by the Committee on Women failed to persuade the APA to sponsor the survey, so the study was ultimately conducted independently.

A SHORT HISTORY OF PROFESSIONAL SEXUAL MISCONDUCT

Professional sexual exploitation has been the subject of regulation since it was first mentioned in the Hippocratic oath in about the fourth or fifth century B.C. (Schoener, 1995). The relevant part of the oath reads: "In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction, and especially from the pleasures of love with women or with men, be they free or slaves" (*Stedman's Medical Dictionary*, 1990: 716–17).

Despite this ancient and respectable origin, until recently, sexual exploitation by professionals of their clients and patients was abhorred by some, accepted as therapeutic by a few, and unacknowledged by most. In recent years, however, the subject has become one of professional concern and has received some publicity in the media. In fact, many claims-makers have used its long history of neglect as a rallying cry for activism: "[T]wenty-four centuries are enough," they say (Schoener, 1995).

The issue became more focused with the development of Freudian psychology. This had to do with its emphasis on the relationship between therapist and patient, its description of the concept of transference, and the apparent evidence that Freud and his colleagues themselves seem to have had various forms of sexual relationships with their patients.

Freud provided an intellectual/therapeutic framework for the construction of the behavior as a social problem by his discussion of the phenomenon of transference. He pointed out that his female patients had romantic and erotic feelings toward him (Freud, 1958). According to psychoanalytic theory, these feelings are transferred from someone in the patient's past onto the therapist. Likewise, the therapist brings to the relationship his own set of feelings (known as countertransference), which come from his own early experience as well as in response to the patient's feelings for

him. Thus, these feelings on the part of both therapist and patient are connected to the therapeutic process and are not the same as feelings that exist in ordinary relationships. For this reason, a therapist who engages in a sexual relationship with a patient is taking advantage of a phenomenon caused by the therapy itself, which can greatly interfere with any benefits of the therapy. Despite Freud's warnings against it, some of his colleagues and followers (including Ferenczi, Jung, and Horney) did experiment with physical contact with patients (Schoener, 1989b).

The issue was not raised as an ethical dilemma for therapists but rather as a complicating feature of treatment. With the emphasis on transference, it is possible to see the "problem" as a manifestation of the patient's illness rather than as inappropriate behavior on the part of the therapist (Davidson, 1977). Professional sexual exploitation occurs when the therapist acts on the feelings of "love" the patient exhibits for him as if they were real, rather than part of the therapeutic process. The use of sex by doctors as a medical procedure for their patients has had a checkered, if little known, history. Late in the last century, doctors were provided with a mechanical device to relieve tension in their female patients: the vibrator (Maines, 1999). This device was a substitute for a service they were apparently already providing manually as a way of dealing with what Freud and others considered a major disease of women: hysteria or "neurasthenia." For the doctors, we are told, this was not a matter of their own sexual pleasure but something they did "because they felt it was their duty" (Angier, 1999).

Ironically, professional sexual misconduct was most recently framed as a social problem as a result of the popularity of various trendy forms of therapy of the touchy-feely kind in the 1960s and 1970s. The human potential movement, which included encounter groups and alternative therapy, among other things, blurred the lines between therapist and patient. As part of that movement, there was some debate in the profession, with a few voices arguing that sexual contact between patient and therapist might be therapeutically helpful or at least should be studied in an unbiased manner (McCartney, 1966; Shepard, 1971). These claims of acceptability by even fringe members of the profession gave great impetus to those constructing professional sexual exploitation as a social problem. The strength of the backlash against the suggestion that patient–therapist sex might have a place in therapy is illustrated by the inability of a psychiatrist named Clay Dahlberg to get an article (which did no more than advocate further study) published in the professional journals. Dahlberg's article described cases of which he had clinical knowledge in which he argued that the effect of therapist–patient sex ranged from "relatively harmless" to "frankly destructive" (Dahlberg, 1970: 107, 111). He was in no way endorsing the practice, merely its study, but nevertheless, no journal would publish his article. Some of the backlash might also have been the

result of a need on the part of mainstream therapy to distance itself from the "new" therapies that were springing up all over and gaining more acceptance than the traditionalists wanted. McCartney and Shepard were both ultimately expelled from the profession, though Shepard denied that he himself had engaged in sexual relations with his patients.

The development of sex therapy and the use of sexual surrogates also contributed to the idea that therapist–patient sex might have positive benefits. As long as the therapy is about improving the sexual functioning of a patient, it is very difficult to delineate clearly the line between therapy and sex. The use of sex surrogates is important here; it raises the specter of a therapist's "pimping" for his patient, while any sex therapy that the therapist does himself has overtones of exploitation.

Masters and Johnson, who pioneered the treatment of sexual dysfunction, spoke out very early against sexual relationships between therapist and patient (Masters and Johnson, 1970: 388–91; 1975). In fact, their discussion of the subject in their 1970 book appears to be the first time it was suggested that therapist–patient sex was not limited to those who could be dismissed as pseudotherapists. However, it took a long time after this for the profession to come out publicly and denounce professional exploitation, as well as to admit how widespread it was.

In the late 1970s and early 1980s, the momentum against professional sexual misconduct began to build both in the profession and among the general public. One of the major triggers for this concern was the publication of a book by Julie Roy, who described her sexual exploitation at the hands of her psychiatrist (Freeman and Roy, 1976). In 1985 Seymour Zelen said that "(s)exual abuse of patients has come out of the closet" (Zelen, 1985). This public attention also coincided with the dissemination of a number of incidence studies that provided claims-makers with ammunition on which to base their claim that the problem was widespread (Schoener, 1989b).

More recently, the social construction of professional sexual exploitation has been extended in two major ways. First, other professions in which there is a close professional–client relationship—from the clergy to lawyers, massage therapists to social workers—were included in the claims. The process has not, so far, succeeded in the case of lawyers. Many lawyers still believe that sex between client and lawyer is, at least some of the time, quite acceptable. In addition, there is a strong feeling that specific rules against sexual behavior violate attorneys' right to privacy and freedom of association (Firestone and Simon, 1992).

The second way in which the claims were extended was in the definition of the relationship. A therapist is now prohibited from engaging in sex with a patient even after therapy has terminated, though disagreement remains whether a sexual relationship is ever ethical with a former patient and if so, what the appropriate period is after the end of therapy (Lazarus,

1992). Current definitions of professional sexual misconduct (or exploitation or abuse) encompass sexual relationships (whether intercourse or other sexual activity, whether forced or not) in the professions. Definitions vary in their specificity depending on the purpose for which they are designed. For example, the American Psychiatric Association in its handbook on the principles of medical ethics says simply that "(s)exual activity with a current or former patient is unethical" (*The Principles of Medical Ethics*, 1993: 4). Some researchers use a broader definition in which professional sexual contact is defined as "behavior which is primarily intended to arouse or satisfy sexual desire" (Vinson, 1984: 30). In those states that have made sexual exploitation a criminal offense, the definition usually covers "(a)ny person who is or who holds himself or herself out to be a therapist and who intentionally has sexual contact with a patient or client during any ongoing therapist–patient or therapist–client relationship" (Wisc. Stat. Ann. s.940.22[2] 1990).

While inappropriate sexual contact takes place in other work-related settings, professional sexual exploitation is distinguished by the central element of confidentiality and trust in the relationship. Breach of confidentiality is an important element in the social construction of this problem. Inappropriate sexual behavior in other professional situations where confidentiality plays a smaller role, for example, professor and student or employer and employee, shares many features of professional sexual exploitation, especially the abuse of power. The legal remedies are different (and perhaps also the social and psychological ramifications), however, and it may be for this reason that this behavior has usually been constructed as sexual harassment rather than professional sexual exploitation.

THE SOCIAL MOVEMENT

Part of the explanation for professional sexual misconduct's relative lack of salience as a public issue lies in the lack of a social movement to put it on the public agenda. As a social movement, professional sexual misconduct is fragmented and not very well organized. Its activists number only in the few thousands and include primarily those people who have themselves been abused by a professional and a relatively small number of those with a professional interest in the issue. Those who have been abused by members of the clergy represent the most organized of the activists, and there are now several networks of varying levels of organization to cater to their needs. Those who have been exploited by therapists are less organized. There are some support groups in various parts of the country and one mostly local network. While these networks purport to represent all those who have been abused by professionals (and in some cases other victims also), there appears to be relatively little overlap between those abused

by the clergy and those abused by therapists and other professionals. Not surprisingly, we shall see that these limitations of the movement have major ramifications for the "success" of the movement.

CONCLUSION

Despite its surface similarities to other issues of violence and exploitation against women, this problem seems to languish in the netherworld as an issue of great importance to a few but no importance to most. Most people outside the field do not know what the terms "professional sexual misconduct" or "professional sexual exploitation" mean. The support groups and organizations are not very successful and have not been able to attract a large membership or the interest of government agencies. No public figure has come forward as a spokesperson for the problem.

Subsequent chapters examine the construction of professional sexual misconduct as a social problem and explain some of the reasons for its lack of salience. The issue is tied into the current ambivalence in our society about sexual behavior, as well as about seeking help for psychological problems. Professional sexual exploitation is examined from the perspective of the individual victim, the organizations, and the legal system. The final chapter discusses what could be done to change the way it is framed and handled. Many of the insights are applicable in a broader context. They illustrate how women, sex, and help-seeking are perceived in our society in the 1990s.

—2—

FRAMING PROFESSIONAL SEXUAL MISCONDUCT

> [H]e said that he loved me. He said that he would help me to feel like a woman. . . . I felt like it was part of my treatment. . . . I felt comfort and solace. . . . I worshipped Dr. F____, and I felt he had all that was good and that was healing.
>
> —A woman who had sex with her analyst.
> *Board of Registration in Medicine* v. *Joel Feigen, M.D.*

INTRODUCTION

The meaning of social events is not self-evident; it assumes meaning through social construction (Spector and Kitsuse, 1977). Social construction has enormous implications for an event's recognition as a social problem, that is, how it is perceived and what is done about it (Best, 1989, 1990). For an event to become a social problem in the eyes of the public and those who would be in a position to "do something about it," it needs to be framed in an appealing way. This chapter examines different ways in which professional sexual exploitation is presented and the implications of these various constructions for its social problem status. The quote that begins this chapter illustrates several possible frames of reference; sex between the therapist and his female patient was seen by her as treatment, healing, solace (medical care), love (gender roles), and worship (power relations).

There are two major sources for the frame of reference used to define and respond to professional sexual exploitation: the women's movement and the medical consumer movement. Frames that come directly out of each of those movements cover only some aspects of what is seen as professional sexual exploitation (or misconduct or abuse). An expanded frame being developed by activists in the field combines the two strands

of the problem and expands on it. It constructs the problem within a medical/professional/power framework that addresses gender indirectly by the use of power as a central element of that framework. Power can be seen here as both a proxy for gender and a means of including both male and female victims. This process is called domain expansion by social problem theorists (Best, 1990). As a mobilization technique, social movement theorists describe the process of aligning values and interests as frame extension and frame amplification (Snow et al., 1986).[1] It is a strategic process by social movements (or claims-makers) to position the issue more effectively in the public arena.

As we see in later chapters, efforts to construct an effective claim for the issue of professional sexual exploitation have not so far been very successful (see Snow and Benford, 1988; Snow et al., 1986). The issue has received only sporadic media attention. Efforts to change the law and public policy have had mixed success. Some states have passed special legislation to criminalize the behavior, but there have been very few prosecutions under the statutes and usually only in the most egregious cases (Noel, 1992; Bohmer, 1995b). Professional and regulatory organizations have made it clear that sexual behavior between a professional and a patient or client is inappropriate and a matter for their control. For the most part, however, such bodies are reluctant to take strong action (Bohmer, 1995b; Lehr, 1994). The issue appears to be one of low hierarchical salience for the potential audience (Snow et al., 1986). It is considered insufficiently serious in contrast to other, related issues that are seen as "much worse," like medical malpractice and violent crime, which cause physical, rather than psychological, harm.

Johnson et al. (1994) argue that "status movements take action about 'other people's business' because that business often poses a threat to how the mobilizing group defines itself" (23). Professional sexual misconduct is not at present seen as a threat to the various potential mobilizing groups (feminists, medical consumers, and religious groups). McCarthy (1994) points out that "a frame must resonate with the experience of a collectivity and be accessible with its mix of crosscutting identities" (134). Relatively few people, however, see themselves as potential patients or clients in the mental health setting, and many members of religious congregations see clergy abuse as something that happens to children and in other denominations. So the problem of professional sexual misconduct remains "other people's business," of importance only to those who have suffered because of it. Seeking help is, in general, viewed as an expression of weakness and therefore something many people have no wish to identify with. As one writer puts it: "Although educated people may support the idea of therapy in public, in reality the stigma associated with seeking therapy remains culturally entrenched" (Pagano, 1997b).

The problem of defining professional sexual misconduct is compounded by the limitations of the different frames. If it is framed as a fem-