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A HANDBOOK FOR PROFESSIONALS ON SEXUAL EXPLOITATION BY COUNSELORS AND THERAPISTS

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It's Never OK:
A Handbook for Professionals on Sexual Exploitation by Counselors and Therapists

Edited by:
Barbara E. Sanderson

Minnesota Department of Corrections

Funds for this project were provided in part by the U.S. Department of Justice, Office of Justice Programs, through the Victim of Crime Act of 1984. The contents do not necessarily reflect the views and policies of this grantor agency.

It's Never OK: A Handbook for Professionals on Sexual Exploitation by Counselors and Therapists

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First Printing: March, 1989

Published by the Task Force on Sexual Exploitation by Counselors and Therapists
Minnesota Program for Victims of Sexual Assault Minnesota
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450 North Syndicate Street
St. Paul, Minnesota 55104
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Typesetting and printing by the men incarcerated at the Minnesota Correctional Facility—Stillwater.

Acknowledgments

The Task Force on Sexual Exploitation by Counselors and Therapists expresses its thanks to the following:

- The present and past staff of Walk-In Counseling Center in Minneapolis and other helping professionals in Minnesota for their pioneering work with sexually exploited clients;

- State Senator Donna Peterson, State Representative Lee Greenfield, Peggy Specktor, and Bill Nieman for designing the comprehensive legislation that created the task force;

- The sexual assault and battered women's movements for preparing the way for Minnesota to understand the issues related to sexual exploitation;

- The victims of sexual exploitation and the psychotherapists and advocates who helped these victims to recover for sharing their experiences and insights;

- The Minnesota Department of Corrections for giving the task force a home and supporting its efforts through funding, staffing, and commitment to the issues;

- Barbara Sanderson for her leadership in all aspects of the work of the task force;

- Everyone who testified at its public hearing and all of the speakers and participants in the first national conference on sexual exploitation and other seminars for helping to shape the thinking of the task force;

- State Senators Donna Peterson and Allan Spear, and State Representatives Lee Greenfield, David Bishop, Bert McKasy, and Dennis Ozment who served as the chief authors of task force legislation, and to the many other state legislators who provided leadership in the passage of these bills;

- The Ramsey County Community Human Services Department for providing a copy of the sexual exploitation prevention policy for inclusion in the handbook;

- The Minnesota Legislature for passage of task force legislation, including partial funding of the project; and

- The federal government for providing Victim of Crime Act monies to complete part of the work of the task force.

The editor offers thank yous and kudos to the following:

- The members of the task force and its work groups who gave so unselfishly of their time and energy and whose ability to embrace complexity and to maintain their senses of humor has fueled this project;

- The public and private agencies who released their employees to participate in the work of the task force;

- Nancy Malmon for all of the extra time she spent as chairperson of the task force and for her TLC and good humor;

- Peggy Specktor for sharing her knowledge of the political process and for setting high standards for the work of the task force;

- The authors who contributed their knowledge and wisdom to this publication;

- Carol Sommers, Judy Malmon, Dan O'Brien, and Peg Thompson for their extensive help in editing this handbook;

- Sue Craig for the many hours she spent at the computer working on this handbook;

- Orville Pung, Bruce McManus, Tom Lawson, Dottie Bellinger, Cheryl Purmort, and Ethel Jackman for their support and assistance during this project; and

- The Democratic and Republican state legislators who have helped to make this work possible.

Members of the Task Force on Sexual Exploitation and Workgroups

Chairperson

For the entire three years of the task force, Nancy Malmon, Minneapolis, served as the Chairperson.

1984-5 Membership

In its first year, the task force was composed of 25 members and included 31 additional people on its five work groups. For a listing of these task force and work group members and other resource people for that year, see the Task Force on Sexual Exploitation by Counselors and Therapists Legislative Report 1985 (Appendix D).

1985-6 Membership

During its second year, the task force utilized eight work groups. These task force members and additional work group members are listed below with the professional positions they held at that time.

*Task Force Member
**Ex-Officio Task Force Member
***Chair or Co-Chair of Work Group

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1986-7 Membership

During its last year, the task force did not subdivide into work groups and was composed of the people listed below with the jobs they held at that time.

James Alsdurf, Psychologist, Hennepin County Court Services, Minneapolis; **Rebecca Biderman,** Psychologist in Private Practice, Minneapolis; **Nancy Fride Biele,** Executive Director, Sexual Violence Center, Minneapolis; **Steven Cummings,** Contractor, St. Louis Park; **Charme Davidson,** Psychologist, Minnesota Human Development Consultants, Minneapolis; **Barbara Doherty,** Adult Protection Consultant, Department of Human Services, St. Paul; **Michael Earhart,** Psychologist, Jewish Family and Children's Service, St. Louis Park; **Thomas Fuller,** Associate Director, Treatment Unit, Minnesota Correctional Facility-Oak Park Heights, Stillwater; **Carolyn Halliday,** Psychologist, Oak Grove Psychotherapy Associates, Minneapolis; **Greg Heberlein,** Psychotherapist, Dakota Mental Health Center, South St. Paul; **Molly Hurley,** Administrative Assistant, Business Services Center, St. Paul; **Virginia Jacobson,** Program Supervisor/Clinical Social Worker, Ramsey County Mental Health Clinic, St. Paul; **Norman James,** Associate Professor/Psychologist, St. John's University, Collegeville; **Bruce Libby,** Clinical Director, Metropolitan Clinic of Counseling, Richfield; **Lynne Lockie,** Clinical Social Worker, Minneapolis Psychiatric Institute, Minneapolis; **Dorothy Loeffler,** Training Director/Professor/Psychologist, University of Minnesota, Minneapolis; **Richard Lundy,** Psychotherapist, Domestic Abuse Project, Minneapolis; **Nancy Malmon,** Minneapolis; **Virginia Marso,** Attorney, Schmitt, Johnson, Marso, and Janson, St. Cloud; **Pat Meyer,** Consultant, Medina; **Jeanette Hofstee Milgrom,** Director of Consultation and Training, Walk-In Counseling Center, Minneapolis; **Kenneth Pierre,** Psychologist/Priest, Consultation Services Center of the Catholic Archdiocese, Minneapolis and St. Paul; **Cheryl Purmort,** Program Specialist, Minnesota Program for Victims of Sexual Assault, Minnesota Department of Corrections, St. Paul; **Minna Shapiro,** Social Worker in Private Practice, Minneapolis; **Ludwig Spolyar,** Assistant Professor/Psychologist, University of Minnesota, Minneapolis; **Ann Stefanson,** Supervisor, Psychotherapist in Private Practice, Minneapolis; **Myron Stocking,** Psychiatrist in Private Practice, Minneapolis; **Jan Gibson Talbot,** Mental Health/Hearing Impaired State Facility Planner, Minnesota Department of Human Services, St. Paul; **Mary Louise Wise,** Psychologist in Private Practice, Minneapolis.

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Introduction

Barbara E. Sanderson

Formation of the Minnesota State Task Force on Sexual Exploitation by Counselors and Therapists

In 1984 the Minnesota Legislature created the Task Force on Sexual Exploitation by Counselors and Therapists. This group existed for three years and was more successful in creating a variety of solutions for the complex problems related to sexual exploitation than any other group in the country to date. In order to be helpful to other states, we have tried to identify the factors here that led to these successes. We believe that historical factors in Minnesota and the related ways in which the task force was established and staffed have had an important impact on the outcomes.

Minnesota has two of the oldest and strongest statewide sexual assault and domestic violence networks in the country. Over the past 15 years activists in these two areas have educated our already socially concerned legislature about these problems and the need to help victims. Consequently, our criminal sexual assault statutes are some of the most comprehensive in the country. Moreover, they have been fine-tuned over the years to include many vulnerable groups of people. It was a logical next step for counselors and therapists to address the problem of sexual exploitation within our ranks.

In addition, some 13 years ago a Minneapolis agency, Walk-In Counseling Center, recognized a need to help clients who have been sexually exploited by therapists. Without advertising this service the Center has assisted over 1,200 clients in dealing with this problem, providing its staff with more experience than any other agency in the United States. As a result of its work, support/therapy groups for victims and other services have sprung up in the state and many other Minnesota professionals have become concerned and involved in working on related problems.

The legislation which created the task force was constructed in a way that led to the group's success. It mandated that all of the disciplines which might be affected by the work of the task force be represented in its membership. Consequently, the task force included psychologists, psychiatrists, social workers, chemical dependency counselors, marriage and family therapists, nurses, and members of the clergy. Other members were representatives of professional organizations and regulatory agencies, administrators of mental health agencies, victims and other consumers, victim advocates, and concerned laypersons. These participants came from all over the state.

The legislation also gave the task force a long list of topics to address in its work, which helped the group attain a focus quickly. Subgroups were formed to address specific topics while people who were not task force members joined these subgroups. In all, approximately 200 people participated directly in the work of the task force, creating a broad base of support.

Another helpful factor was the time frame imposed upon the task force. The group received its charter only one year at a time and was never intended to be a permanent group. The initial legislation mandated that the group report to the legislature on its work in five months' time. The group was forced to be efficient; at the same time it had the ear of the legislature when its recommendations were ready. The task force's legislative report, no longer available as a separate document, is reproduced as the final appendix to this handbook. It contains valuable information, including definitions used by the task force, descriptions of the issues related to sexual exploitation, the suggested plan of action for the State, a copy of the legislation that created the task force, and the original drafts of recommended laws.

Another factor in the success of the task force concerned the staffing decisions of the department that housed it. Most of the victims assistance programs in Minnesota are located in the Department of Corrections; the task force was placed there in the State's Program for Victims of Sexual Assault. Despite the fact that the legislature did not provide any funds for the task force in its first year and allocated a total of only $30,000 in subsequent sessions, the Department of Corrections deemed the project of such importance that it retained a full-time Coordinator and a half-time secretary for the entire life of the task force. This allowed staff to take a strong leadership role in shaping the work of the task force, in carrying out its plans, and in keeping the communication flowing between the many participants.

Major Accomplishments of the Task Force

The task force recognized that sexual exploitation of psychotherapy clients is a myriad of complex problems and its legislative report recommended a broad range of solutions. The 1985 Minnesota Legislature empowered the task force to carry out its recommendations. These fall into five categories and are listed below:

1. Criminal Penalties—Starting August 1, 1985, it became a felony for psychotherapists to be sexual with their clients and, in some cases, with former clients. This bill amended the criminal sexual conduct code (Minnesota Statutes 609.34) to define "psychotherapist" and "psychotherapy" in a way that would prevent practitioners from changing titles in order to escape prosecution.

   In most cases, accused therapists may not defend themselves with the claim that their clients consented to the sexual acts. People convicted under this statute may serve a prison sentence, be put on probation, pay a fine to the State, or complete some combination of these penalties. Appendix A-1 of this handbook is a copy of the entire Minnesota criminal sexual conduct code. At the time this book went to press, there were only two other states, Wisconsin and Colorado, with criminal penalties for sexual exploitation, although many other states are attempting to pass such legislation.

2. Civil Remedies—Beginning August 1, 1986 it became a statutory cause of action for psychotherapists who had been sexual with their clients, and, in some cases, with former clients. This has made it much easier for victims to sue their exploitative counselors. This law (Minnesota Statutes 148A) also creates a cause of action against employers whose negligence results in the sexual exploitation of a client. Under this provision, injured clients may sue employers who do not do background checks on prospective psychotherapists, do not cooperate with such checks by other employers, or do not take prompt and appropriate action when they know or had reason to know that a psychotherapist in their hire had been sexual with a client or former clients. This portion of the Statute has dramatically changed the behavior of Minnesota employers of psychotherapists, most of whom are now taking an active role in protecting the clients whom they serve. Successful litigants may be awarded specific sums of money from the offending psychotherapist, that person's employer, or both. Because most insurance companies that write polices for individual practitioners specifically exclude sexual exploitation from their coverage, victims may have difficulty collecting these awards. Appendix A-2 of this handbook is a copy of this law and Appendix A-3 outlines how it differs from the criminal law described above. There is also an article detailing employer liability in the Administrative Issues section of the book. At the time this handbook was printed, no other state had a civil statute specifically covering sexual exploitation.

3. Practice Related Consequences for Offenders—The task force noted in its report to the legislature that any practitioner who sexually exploits clients should receive practice related consequences and that it ought to be possible to put chronic offenders out of the business altogether. The only way to achieve these conditions is for the State to regulate the practice of psychotherapy; at that point, most of the psychotherapists in Minnesota were unregulated. Because regulation encompassed far more than sexual exploitation, this issue was handed back to the Legislature, which created the Task Force on the Unregulated Psychotherapist in the Department of Health to deal with it. The ultimate outcome of this process was that the legislature licensed social workers and marriage and family therapists and created a board to register "Unlicensed Mental Health Service Providers."

   The task of this board is to decide who must register and then collect information about these practitioners, so that the legislature can make an informed set of decisions about how to regulate them in 1991, when this board sunsets. Until then, registrants will be held to a basic code of conduct and they may be disciplined or prevented from practicing if they do not adhere to these standards. Sexual exploitation is one of the prohibited behaviors. This board closes the gap so that all psychotherapists will now be accountable to the state for their behavior. The part of this new law which enacts these changes for unlicensed services providers (Minnesota Statutes 148B) is reproduced in Appendix A-4. Contrary to public perception and expectation, the majority of psychotherapists in most states are still unregulated.

   The Task Force on Sexual Exploitation by Counselors and Therapists also encouraged the

licensing boards which existed at its inception (psychology, medicine, and nursing) to become more responsive to victims' complaints and to do a better job of policing their professions. Many related changes have already taken place and there is need for many more. The same sorts of additional responsibilities were promoted for state and private agencies which regulate institutions that provide counseling services. The task force also worked with other groups to create the Office of Ombudsman for Mental Health and Mental Retardation, a State agency which assists institutionalized clients.

4. Public Education—No matter what laws the State passes, most clients are alone with their counselors when they receive services; therefore, it is essential that they receive enough information to know what behaviors are sexually exploitative and to view themselves as consumers who deserve competent, ethical treatment. The work of the task force received a great deal of media attention, which helped to educate the public. The task force created an educational brochure for therapy consumers. It is important for the public to understand that victims of sexual exploitation in Minnesota now have a number of options to pursue. This information, prepared by the task force, is contained in a booklet for victims and victim advocates. To obtain copies of the brochure and the booklet, see Appendix C-1.

5. Professional Education—In 1986 the task force held the first national conference on sexual exploitation. Over 200 people attended from 27 states. In its third year, with the help of a federal Victim of Crime Act (VOCA) grant, the task force conducted statewide professional education on sexual exploitation. Regional training seminars were held in six cities and a wide variety of professionals received basic training. A statewide advanced, follow-up seminar was held subsequently. Specialized training was also provided for staff and volunteers from community-based sexual assault centers, often the first place victims go for help.

Most of the relevant professional organizations in Minnesota have requested and received training sessions on sexual exploitation, as have many hospitals and agencies. This handbook is the final product of the task force, although work on sexual exploitation continues through the Minnesota Program for Victims of Sexual Assault.

At its final meeting in 1987, the task force decided that its greatest accomplishment was in making a covert problem overt, depowering the secret of sexual exploitation. This, in turn, has empowered consumers (including victims), administrators, therapists, and institutions that train therapists to take appropriate action to prevent sexual exploitation and to deal with it effectively when it occurs.

On the other hand, the task force concluded that there was a major area of work left to cover. Very few of the colleges and universities that train counselors and therapists have assumed responsibility for providing entry level education and clinical supervision that address the complex issues of sexual exploitation and related topics.

Creation of This Handbook

Many of the articles in this handbook were created in an unusual way, incorporating the work of multiple authors. Task force members realized that few or no resource materials existed for many of the topics related to sexual exploitation. We knew through our experiences in Minnesota that many people had information which could be turned into resource materials. Working groups were formed to discuss specific topics, in reference to which individuals would verbalize what they had learned from their experiences. These thoughts were transcribed and then one of the group (usually the first author named) collected them into a coherent article. The small groups worked these first drafts over until they were satisfied with them, after which the entire task force reviewed the articles.

The body of this handbook is divided into three sections. In the first, there are articles on **Therapeutic Issues** related to sexual exploitation. Included here are materials about working with victims and with perpetrators and about clinical supervision. The second section, **Issues for Institutions That Train Counselors and Therapists,** addresses the academic and clinical responsibilities of colleges and universities. The final section, **Administrative Issues,** contains information for employers of psychotherapists to use in the prevention of sexual exploitation and in confronting the problem once it has occurred. The extensive appendices of this handbook include copies of the new Minnesota laws, information on how to obtain additional materials on sexual exploitation, and other items of interest.

A Final Note

For people addressing topics on the cutting edge of their profession, there is a seductive pull to think of themselves as experts. The task force has made a conscious effort to avoid this trap for two main reasons. First, this area of concern and exploration is too new to have any real experts. Second, expert status can be stultifying and can prohibit continued thought and growth in the field. Consequently, the articles in this handbook should be viewed as working hypotheses, prepared by people who presumably have more experience than most professionals in this newly identified area of study, but who do not consider themselves experts.

Also, it is important to remember that all of the members of the task force and its work groups as well as all of the other contributors to this handbook are human and subject to the same corruptibility that anyone else faces. Most people worked on this project out of a strong sense of ethics and professional responsibility, but it is possible that a few of the contributors, in participating, sought either help or a cover for their perpetration. Consumers of psychotherapy services are encouraged to exercise the same cautions with anyone named in this book as they would with other helping professionals.

Best wishes to all who attempt to deal with these challenging problems. We hope the ideas contained in this handbook will be springboards for your own hypotheses and that you will share your work with us.

Barbara E. Sanderson, M.A., Administrator, Psychotherapist, Director of the Minnesota Program for Victims of Sexual Assault, MN Department of Corrections; Coordinator, Task Force on Sexual Exploitation by Counselors and Therapists, St. Paul.

Therapeutic Issues

Introduction

Mary Louise Wise

This introduction to the therapeutic issues section includes an invitation to readers to participate actively in the content presented, a note on terminology, an overview of the content, and information on the origin and development of the articles. The introduction offers a few glimpses of the continuity, diversity, and richness in the articles about the therapeutic issues that must be faced in dealing with sexual exploitation by counselors and therapists.

An Invitation to Readers

Acknowledged throughout the articles is the potential corruptibility that everyone faces in therapist-client relationships. Every therapist or counselor is vulnerable to the complexities, subtleties, ambiguities, and questions that arise naturally in the relationship boundaries between therapist and client. Although guidelines and principles are known, a strong need exists for awareness of the ongoing risks and responsibilities inherent in every interaction that occurs. Since potential corruptibility is inherent in the nature of the therapeutic relationship, neither individual standards nor good intentions will necessarily protect the therapeutic relationship.

The diversity of perspectives and presentation in these articles provides the reader with multiple angles of access to the information shared, and helps focus the reader's attention in a dynamically interactive way with the information, rather than in a way that assumes a static body of knowledge and understanding of therapist-client sexual abuse. In addition to the diversity among the authors, readers enter this written resource with a multiplicity of professional backgrounds and opinions. Each reader varies in experiences with situations of therapist-client sexual abuse, in feelings toward clients who have been abused by therapists/counselors, in feelings toward therapists who have abused clients, and in opportunities for educational or interventional roles with clients, therapists, and/or agencies. The diversities among writers and readers help protect us from tendencies toward "group-think" and from too much eagerness to believe in the existence of complete answers.

In approaching the materials interactively, the reader is invited to participate at the growing edge of knowledge and experience in this area of professional concern, and to challenge his/her own perspectives and feelings to this section on therapeutic issues.

A Note on Terms and Their Implications

A focal agreement for members has been the position that it is the therapist's/counselor's responsibility to ensure a proper and effectively therapeutic relationship for the client. In addition to this understanding and commitment, the complexity of the therapeutic relationship between therapist and client is also recognized. This complexity of relationship is reflected in the different terms/phrases that refer to therapists and clients. The various wordings emphasize a variety of aspects of the relationship experiences of clients and therapists. For instance, the term "sexually exploited clients" emphasizes the therapist's abuse of power in the therapeutic relationship, whereas "clients who have been involved with therapists" brings to light the relationship significance the client may have experienced with the therapist, as implied by the word "involvement." Comprehending the use of both phrases/implications centers attention on the ambivalence a client may feel after experiencing abuse by a significant caregiver, similar to and perhaps a re-enactment of betrayal and abuse by a parent. Sensitivity to and understanding of these complexities and subtleties may be important for the client's therapeutic recovery and healing from the therapist's abuse.

Likewise, the term "therapist perpetrators" and phrase "therapists who have become sexually involved with clients" carry a different impact in implication. This point raises valuable questions and challenges the reader's exploration of attitudes and feelings about therapists who have abused clients.

Overview of the Content

The 12 articles on therapeutic issues are organized into three sections, which are described below:

(1) Conceptual Understanding of the Dynamics of Sexual Exploitation of Clients by Therapists and Counselors: Three articles comprise this section. The first article, "Basic Strategies for Working with Sexually Exploited Clients", by Milgrom and Schoener, presents some basic guidelines for therapists which are based on their experiences of the reactions, concerns, and problems the client faces. "Sexual Exploitation of Clients by Therapists: Parallels with Parent/Child Incest", by Luepker, presents the similar issues between these two types

of sexual abuse, offers clarification of the impact of therapist abuse on clients, and highlights implications for helping clients who have been abused. The third article, "Supervision Strategies to Prevent Sexual Abuse by Therapists and Counselors", by Thompson, Shapiro, Nielsen, and Peterson, acknowledges the natural and inevitable development of boundary problems in any therapeutic relationship, offers a dynamic supervision model that maximizes the possibility for healing and growth in the therapy setting, and offers specific supervision strategies that help prevent natural boundary problems from becoming occasions for client victimization.

Primary to all three articles is the emphasis on differential power between therapist and client, and the crucial ownership by the therapist for maintaining responsible boundaries in the therapeutic relationship.

(2) Issues in Assisting Clients Who Have Been Sexually Exploited by Therapists and Counselors: The three articles in this section provide information about the varieties of assistance that clients may need, special problems and issues of clients who are in therapy, and suggestions for therapists in understanding therapeutic approaches which have been helpful to such clients. In "Advocacy in the Process of Assisting Sexually Exploited Clients", Milgrom describes the advocacy role and the skills necessary for being an effective advocate. The advocacy process is described, beginning with the realizing that victimization may have occurred, assessing of the situation, exploring options for addressing exploitation, providing supportive help while the client takes action, and following through afterward. "Group Treatment for Clients Who Have Been Sexually Involved with Their Psychotherapists", by Luepker and Retsch-Bogart, presents summarized data from group therapy clients, including information on presenting problems, goals of clients, and group issue themes. The third article, "Therapeutic Approaches for Clients Who Have Been Sexually Abused by Therapists", by Thompson, Benoist, Percy, and Stefanson, discusses special problems that arise when a client who has been sexually abused by a therapist reenters therapy. With each problem area, the writers present the nature of the problem area, trace its origin in the abusive therapeutic relationship, and suggest some therapeutic approaches for helping the client in that area.

(3) Issues in Working with Therapists and Counselors Who Have Sexually Exploited Clients: The six articles included in this area focus on supervision approaches, assessment procedures, and therapeutic issues for professionals working with therapists/counselors who have abused clients.

The first article in this section, "Supervision Approaches in Cases of Boundary Violations and Sexual Victimization by Therapists", by Nielsen, Peterson, Shapiro, and Thompson, stresses the importance of conceptualizing boundary issues as an integral part of the therapeutic and supervisory process. Boundary violations are presented as a continuum with five levels from least to most severe. Examples of boundary violations are discussed and supervision approaches are proposed. In "Working with Therapist-Perpetrators: An Introduction", the Therapeutic Issues Work Group discusses legal and administrative issues involved in the laws and regulations dealing with therapist-perpetrators.

Three types of assessment are considered: legal and administrative review; clinical evaluation regarding continuation or termination of practice; and clinical assessment of therapy and/or supervision if the therapist is to be rehabilitated. Thompson's article on "Assessment of the Counselor or Therapist Who Has Become Sexually Involved with a Client", focuses on the assessment of the therapist-perpetrator, and describes the particular process of assessment, apart from decisions to be made about licensure, practice, therapy, punishment, or supervision. The article presents the goal of assessment, the skills needed for the assessment process, and key areas to be addressed.

The fourth article, "Working Therapeutically with Therapists Who Have Become Sexually Involved with Clients", by Gonsiorek, describes issues in providing psychotherapy for psychotherapists who have sexually abused clients, given that they have been assessed as appropriate for treatment. Gonsiorek describes treatment for therapist-perpetrators in early, middle, and resolution phases of therapy, including the common themes that arise in each stage, indicators for therapeutic progress, and suggestions for the treating therapist.

"Countertransference Issues for Therapists Working with Sexually Exploitative Therapists", by Stefanson, identifies countertransference issues that arise during assessment of therapist-prepetrators, and during psychotherapy. Stefanson offers suggestions for addressing countertransference in regard to effectiveness in assessment or therapy, and in regard to the well-being of the therapist working with the therapist-perpetrator. These two articles present some of the differing ideas on the issue of whether a therapist can be effective both as assessor and psychotherapist for a particular therapist-perpetrator.

"Sexual Exploitation by Psychotherapists: Some Observations on Male Victims and on Sexual Orientation Concerns", by Gonsiorek, presents some observations the author and colleagues have made about men who have been exploited by psychotherapists and on sexual exploitation situations in which therapist and client are of the same sex.

A Note on the Diversity of Opinions Presented

The diversity in the styles of these articles reflects not only the variances in the writing process, but also some differences in opinions and perspectives among the contributors. The presentation of these differing points of view reflects two general perspectives of task force members: (1) that all of the writers view their perspectives and information as working hypotheses, addressing a very newly-studied area of professional concern; (2) that there are no "experts" in this field; rather there are people with varying experiences in facing the problem of sexual exploitation by therapists and counselors. Resulting from these perspectives are the writers' willingness and commitment to share what they know, trusting that the reader will receive their work as an opportunity to participate in understanding the complex issues and problems explored in the articles.

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Conceptual Understanding of the Dynamics of Sexual Exploitation by Therapists and Counselors

Assisting Victim-Survivors of Client-Therapist Sex*

Jeanette Hofstee Milgrom
Gary Schoener

Introduction

Since 1974, over 1,000 clients who alleged sexual involvement with a current or former counselor or psychotherapist have been seen at the Walk-In Counseling Center (WICC) in Minneapolis. Support groups for victims were first offered there in 1976.

This article contains clinical hypotheses, not facts, which may assist therapists who treat sexually exploited clients. It suggests some basic guidelines for treating therapists, relates common experiences of sexually exploited clients, discusses practical problems which such clients face, presents therapeutic suggestions, and describes a model for a facilitating processing session between client and exploitative therapist.

Some Basic Guidelines for Therapists

Avoid Making Assumptions about the Sexual Behaviors or Verbal Advances Which Occurred

If, and when, the client is willing to discuss the sexual encounters, explore what specifically was involved. Many sexual encounters with therapists do not involve intercourse but involve kissing, breast or genital fondling (with or without orgasm), oral sex, and anal sex, with either party playing various roles. Therapists may experiment with clients sexually, engaging in sexual acts they would not do in other relationships.

Avoid Making Assumptions about How the Sexual Involvement Affected the Clients

Many clients have very ambivalent feelings about their sexual or romantic experience with a past therapist. Don't expect consistency from session to session. Allow the feelings to unfold and do not force a resolution of mixed or confusing feelings. Try to give reassurance and permission to talk about the positive and negative feelings which may be present.

Examine the Nature of the Relationship Carefully

Was this experienced by the client as a love affair, perhaps with meetings outside of the therapy sessions and promises of an ongoing affair or marriage, or was the sex introduced as a therapeutic technique? When and how did the romantic talk or sexualizing of the relationship begin? How did it develop? Words and fantasies are important as guideposts. Seductiveness by the therapist, even if not acted upon, can be destructive or confusing. What boundaries or rules were broken and when did the relationship start moving away from an appropriate client-therapist relationship?

Explore How the Client Feels about Seeing Another Therapist

Most clients are understandably cautious, fearful, and/or ambivalent about reentering therapy. They feel betrayed by the previous therapist and distrustful of therapists in general. New therapists should state clearly that they do not get romantically or sexually involved with clients and be clear about the limits they place on touching clients. They should also emphasize the limit-setting that clients can do:

1. Ask questions if they don't agree or feel uncomfortable;
2. If uneasiness isn't relieved, request a session with a co-therapist or consultant; or
3. Request a referral to another therapist.

Focus Initial Intervention on Any Crisis Issues

First of all, is the client at risk, i.e., suicidal? Second, what real-life issues are facing the client, including issues related to complaints which have been filed, planned confrontations with the therapist/relatives, etc. Third, assist the client in dealing with emotional pain, grief, anger, feelings of victimization, etc. Any exploration of personality dynamics of the client can occur later.

Common Experiences of a Client Who is Sexually Involved with a Therapist

Guilt and Shame

Guilt and shame may be felt about the sexual involvement per se, or guilt may be felt in connection with a relationship with a spouse or significant other.

* This is an abbreviated version of two earlier monographs published by the Walk-In Counseling Center (Schoener, Milgrom, Gonsiorek, "Responding Therapeutically to Clients who have been Sexually Involved with their Psychotherapists," 1983: and Schoener & Milgrom, "Processing Complaints of Therapist Sexual Misconduct," 1984) which were edited with the assistance of Peg Thompson, Ph.D.

Many clients, if not all, slip into a posture common to victims—blaming themselves. Guilt may center on feelings of having been seductive or having ruined the therapist's life or career. Some clients are almost obsessed with feelings of responsibility to the point of totally ignoring the fact that the professional therapist is supposed to be in charge of the treatment and act only in the client's best interest. Many therapists are masters of guilt induction and/or of getting clients to protect them and take care of them. Some clients are intrapunitive or self-blaming, so that the level of guilt and shame experienced can be extreme and last for months, or even years.

Grief

The loss of the therapeutic and/or personal relationship (either because the client breaks off the relationship, or the therapist does) often leads to grief reactions in clients. Whatever else it was, the relationship with the therapist may have been a very significant love relationship for the client. The loss of the relationship can lead to the type of grief often experienced when significant relationships end. Several clients describe the type of grief experienced when a loved one dies. Some clients are unable to handle this grief and refuse to separate from the therapist. The longer and more intense the relationship, the more grief clients seem to experience.

Anger/Rage

The client may feel angry about a variety of things: violation of trust; exploitation; having been deprived of much-needed therapy during a vulnerable period in his/her life; having left therapy worse off than before because of the new burden of confusion, guilt, and shame; having wasted a critical period in his/her life by focusing on a relationship which couldn't last; the therapist setting up all the rules and successfully controlling them; etc.

Depression and Loss of Self-Esteem

Since depression and low self-esteem are two of the most common problems which lead people to seek therapy, it is sad when therapy adds to these problems. Persistent feelings of guilt or anger which are turned inward because there's no easy avenue for direct expression can add to, or even bring about, depression.

Some exploitative therapists interpret a client's unwillingness to become sexually involved as "an inability to love" or as an "inability to trust and accept love." The client's anxiety about intimacy with the therapist is interpreted as further evidence of a neurosis.

Even after termination, clients may feel badly about not having been able to accept the love of the therapist. On the other hand, one client said that she was angry at herself "...for having been so vulnerable, trusting, and emotionally involved with such a venomous creature." She was embarrassed about entries in her diary which portrayed the "schoolgirl" infatuation she felt at the time.

Many clients do not even give themselves credit for having pulled out of the relationship but rather continue to put themselves down for having succumbed in the first place.

To complicate things still further, some clients, in the course of therapy, go through a stage of improving their self-concept via identification with the new therapist. The clients' personal values may shift towards those of the therapist. Even in the exploitative situation, some of these values and/or some of the personal changes made may have been quite healthy ones. In an attempt to rid themselves of the connection with the exploitative therapist, clients may try to reject even healthy changes at first.

Ambivalence and Confusion

Persons entering therapy normally have confused feelings about some things in their lives and look to therapy for reality-testing. Sexual involvement with a therapist adds to this confusion and can lead to marked ambivalence as various feelings come into conflict.

For example, it is common for clients to feel anger along with gratitude or other positive feelings. Most feel that the therapy was not all bad. Most have some feelings of wanting to see the therapist again to try to clear up this ambivalence. Most would like to confront the therapist and put him/her on the spot to explain his/her behavior. They ask questions like, "Did he really care about me?"; "Was I just a sex object?"; "Is he sick—is he evil?"; "Was I special, or were there others?"; "Why me—why was she attracted to me?"; "What does this say about me?".

Some clients are virtually certain that they were the only client who was involved with the therapist, although in the vast majority of cases this was not true. Clients sometimes become outraged when they learn they weren't "special." Some saw the relationship as one that was "made in heaven," or feel that they would have found

the therapist emotionally and/or sexually attractive had they met socially, while others indicate that had they met socially the therapist wouldn't have seemed attractive to them. Because of this ambivalence and confusion, client's feelings may vary day to day or even hour to hour.

Fear

Many clients fear their own impulses to phone the therapist (to express anger, concern, or regret). They fear rejection by spouses, lovers, family, and the community at large for having been involved in an illicit sexual relationship, much as rape and incest victims do. Many fear expressing their anger, expecting that they will be labeled "castrating" or vindictive, that they will not be believed, or that others will be less likely to help them.

Many clients are fearful of abusing therapists' reactions to their reporting the abuse—fear that they will commit suicide or have their careers ruined, or that they will somehow take revenge on them. While realistically any of these are possible, clients need reassurance that such developments are unlikely and that, in any event, sole responsibility does not rest with the client.

It should be noted, however, that in a minority of situations, therapists attempt to pressure clients who complain, and in a few cases they have enlisted the aid of other clients in doing so. If a member of a minority group reports abuse by a therapist of the same minority group, community pressure can become an issue.

Massive Distrust

In the aftermath of a sexual involvement with a therapist, a client may be very distrustful of therapists in general, or even of everyone of the same sex as the therapist. Where the therapist has also violated other boundaries, such as confidentiality, trust may be even lower. Sadly, this distrust can, for a time, be extended even to old friends and family.

In working with clients who have been exploited, it is a good idea to recognize, identify, and accept the client's distrust. It is important to establish its parameters, and to commend the client for being appropriately guarded. Even though a subsequent therapist makes it clear that he/she does not become sexually involved with clients and carefully guards the client's confidentiality, that overture will probably not result in the client's complete trust. Nor is it clear that such trust is necessary for a therapist to be very helpful. To invite expression of concerns, confusion, or distrust, periodically ask clients for feedback about interventions and follow-up therapy. It is also helpful to make it clear that therapy is often not the answer to life's problems.

Some Practical Problems the Client May Have to Face

Where To Go for Help

The client's initial decision to go to a therapist may have followed a long struggle about where to go for help. Clients don't know how or where to check out whether therapy involving sex with the therapist is legitimate. When they ask the exploitative therapists, they are often told that it is, that the therapist does this with other clients, or that while it isn't generally okay, in this special case it is.

When the therapist involved is well-known or famous, or came highly recommended by friends or family, it is difficult for the client to challenge this behavior. Many clients wonder if another therapist will believe their side of the story, or even be willing to see them for therapy. They may be especially fearful that another therapist won't respect confidentiality and will contact the exploitative therapist to discuss their "case." Clients assume that professionals "stick together" and "cover for each other."

Being Discounted by Professionals

Client victims are sufficiently fearful of being disbelieved or rejected by the new therapist that they are quite sensitive to any signs of rejection or disbelief. The shock of hearing such a report can cause the next therapist, or the person who originally made the referral to the exploitative therapist, to become very upset. Clients may misinterpret this as rejection of them. The same is true when the person to whom they are telling the story of the sexual involvement becomes very anxious and uneasy.

Overreaction by Friends or Professionals

Sometimes friends or professionals over-identify with the client and get extremely upset or even hysterical. It is important for new therapists to avoid working out anger/frustration with unethical practitioners through a client who is already overburdened. Even clients who are very critical of a previous therapist may defend him/her if another person seems too attacking. Clients need the freedom to explore diverse and often changing feelings. Excessive personal catharsis by friends or

therapists can interfere with this process. This is not to imply that a new therapist shouldn't share their rejection of such unethical or abusive conduct. After registering such feelings, professionals may want to save some of their catharsis for discussions with colleagues.

Fear of Public Exposure

Clients are often fearful of telling family and friends about the situation, and may not even share it in therapy or support groups at first. They fear gossip, the professional grapevine, and unguarded records. They fear having their story end up in the newspaper, and thus are often initially quite fearful of making any official report. In reality, it is rare for a client's name to appear in the public media unless a lawsuit is filed or the client is seeking publicity.

The Stresses of Reporting the Exploitation

If a complaint is pursued through professional or legal channels, the client must face having to spend more personal time (and thus have the exploitative relationship continue to dominate his/her life), to face the reliving of a painful experience, and to face sometimes unpleasant cross-examination. Not surprisingly, clients are angry that they must suffer further to protect the public.

Sharing the Story with Significant Others

Until clients are able to express feelings and share the story with family and friends, they are likely to feel quite isolated emotionally. Even when the story is shared with significant others, clients are often not able to share any positive feelings about the therapist, or the extremes of anger they may feel. Friends and family are often not in a position to fully understand or be sympathetic, and some will blame the client for the situation.

Once the story and/or feelings are expressed to significant others, relationship problems often ensue. Spouses and significant others then must struggle with their own feelings and often need support themselves.

Many people do not understand the extent of the power inequity in the psychotherapeutic relationship and the degree to which the client is vulnerable. More than even in the rape or incest situation the victim may not be seen as a victim.

Some Therapeutic Suggestions

Explore the Experience with the Client to Determine What Issues Need Resolution

Some clients have had brief "affairs" with past therapists and have basically resolved most of their feelings about the situation, but are coming for assistance in reporting it. In most cases, however, where sex has been ongoing or where enmeshment with the therapist has been substantial, the previous therapeutic relationship can be *the* primary problem. In some cases the clients are not even out of the exploitative relationship when they come to see another therapist.

Evaluate the Client's Other Problems

The client may be in a crisis or struggling with a significant depression which itself requires attention. In most instances, clients still have a number of problems their past therapy didn't resolve, as well as other life stresses which need to be dealt with. Even if this is not the case, it is important to try to prevent the client from becoming so involved in dealing with the sexual exploitation that his/her life becomes a sea of pain. Most clients have been able to get to the point where they could put the exploitation in context, get back to their other problems, and even joke about their past therapy.

Assist the Client in Exploring Different Avenues of Complaint

Clients' needs can vary from not having even considered filing a complaint, to assuming that a new therapist will do so, to wanting specific help in doing so. It is important to be well-informed on the various reporting options available to clients. It is worth noting here that in virtually all of the 150 cases where a complaint was made *the clients and/or their significant others reported that the making of a complaint was beneficial to the client's resolution of the experience.*

Support Groups Can Be Helpful

While groups for victims of sexual exploitation are rare, a few therapists outside of Minnesota have attempted to put together small support groups. In the absence of such a group, a women's support or therapy group may be of help. Consumer advocacy groups may also provide helpful support or validation. In other situations, informal support from other victims may be helpful.

Consider a Processing Session with the Therapist and Client

While a client's attorney or a licensing board may discourage this, a properly facilitated session with the client and the exploitative therapist can help restore the client's reality-testing and provide for useful ventilation of feelings. Some clients prefer to confront the therapist by themselves. In several instances they have done this over the phone and taped it so it could be processed later. The WICC approach to processing such a situation is described below.

The Processing Session

A meeting is arranged between the client and therapist to process what happened between them. Usually this is not possible in situations where litigation or a complaint to a professional body is underway. Where legal counsel is involved representing the client or therapist, this is usually prohibited. Nonetheless, where a therapist is employed by a clinic, hospital, drug abuse treatment program, or other community agency, there may be an opportunity to conduct such a session. In some situations, the therapist has requested assistance in untangling such a situation.

Besides the client, the therapist, and a WICC staff member who serves as a facilitator, such a session usually involves one or two of the following parties*:

the therapist's clinical or administrative supervisor; the client's current therapist, or a supportive friend of the client; a colleague of the therapist.

Deciding who to involve in such a session requires a judgment on the facilitator's part as to the likelihood that the presence of a particular person would enhance the meeting or further complicate it. One also has to be concerned with the sheer number of bodies in the room. Several other practical issues which must be dealt with include:

Ensuring that the client is emotionally stable enough to be able to handle such an encounter. The session may be terminated if it gets out of hand.

Obtaining the client's reaction to possible sites for the meeting. In the vast majority of cases, they are held at WICC, which tends to be neutral for all parties, and which reinforces the role of the facilitator of the meeting.

It is difficult to reduce everyone's anxiety and defensiveness. Emphasizing the importance of sorting out what people experienced tends to take the edge off things. It helps to use terms like "your memory" or "your perceptions" to underline the tenuousness of each party's experience of some events.

It is important when organizing the session (usually via phone calls), and again when beginning the session, to explain its purposes; and to assure all parties that it can be terminated if it isn't going well.

Processing sessions are usually scheduled to take about 1½ to 2 hours. In most cases the client is asked to recount his/her memories of a number of events, and the facilitator asks questions to establish a clear picture of the client's version of events. Then the therapist is asked to comment, question, and add to this picture. It has been the experience of WICC facilitators that clients and therapists, when interviewed together in this non-adversarial process, tell remarkably similar stories. While no rigid formula is followed and facilitators try to flow with the sessions, typically the areas covered are:

How they first met;

The original presenting complaint;

Therapeutic contract;

The general course of therapy;

Changes in the therapeutic contract or in either person's view of the therapy;

A step-by-step recounting of boundary breakdown, such as:

- Breaking or changing rules for the client (e.g., home phone calls; after hours appointments; change in fees);
- The client assuming "special" status (e.g., gifts, therapist using the client for support; excessive praise by either party);
- Feelings of attraction by either party and how they were dealt with or acknowledged;

* In rare instances the client does not wish to participate, especially when there has been a prior confrontation between client and therapist, and the facts are no longer in question. In such an event, the meeting involves a WICC staff member, the therapist, and his/her supervisor.

- Seduction or eroticism of the therapy through choice of dress, remarks, etc. on the part of either party;
- Generally physical contact and erotic touching; sexual contact;
- Romantic feelings and their evolution;
- Beliefs/expectations/promises relative to an ongoing personal relationship or marriage;
- Termination or lack thereof of personal and/or professional relationship;
- Residuals and post-therapy contact;
- Current feelings.

At the end of the session the facilitator formulates a summary description of what seems to have happened. In cases where events or facts are in dispute, each person's memory of events is summarized. However, the facilitator attempts to emphasize the agreement between the parties.

At the end of the processing session, the facilitator emphasizes that each party involved needs to go home and allow some time for the feelings to sort themselves out. The facilitator sets up a follow-up contact with the client. When the exploitative therapist is employed, the facilitator usually recommends that the agency obtain further evaluation of the therapist to assist in making follow-up decisions regarding such issues as discipline, therapy for the therapist, and future supervision. When the exploitative therapist's agency plans disciplinary action, the facilitator arranges for feedback to WICC, and to the client, as to what action was taken.

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Sexual Exploitation of Clients by Therapists: Parallels with Parent/Child Incest

Ellen T. Luepker

Before the practitioner can develop effective prevention/intervention strategies to assist client victims of therapist sexual abuse, it is important to have some conceptual framework within which to understand the dynamics of this problem. As a step toward better understanding client sexual exploitation, it can be useful to compare it with the better understood phenomenon of parent/child incest. This article will review some of the parallels between these two types of sexual abuse so that the impact of therapist abuse on clients, and the implications for helping them, may become clearer to human service providers.

Power Imbalance

Just as parents are more powerful than children, there is a similar power imbalance in the client/therapist relationship. In relationships where there are such power imbalances, there need to be clear boundaries to protect the less powerful party. In the child/parent and client/therapist relationship, the more powerful party is expected to take proper care of the less powerful party.

Diminished Capacity To Make Decisions in One's Own Best Interest

The client consults the therapist in a vulnerable state in the belief that the therapeutic contract includes a safe environment. The client furthermore may idealize the therapist and his/her abilities. In this unique situation, many clients do not have their usual ability to make decisions in their own best interest.

Discomfort with Sexual Feelings

Parents may have difficulty accepting the idea that it is normal to experience some sexual feelings toward their children, and may protect themselves from acknowledging these feelings by either distancing themselves emotionally from their children, or acting out sexual feelings. Therapists can also be uncomfortable with sexual feelings toward clients when they occur, and may defend themselves from these or other threatening feelings, either by distancing themselves from their clients, or acting out sexually with them.

Sex As Role Reversal Which Occurs in Context of Other Role Reversals

Just as the primary needs of the parent should be met by persons other than the child, so should the primary needs of the therapist be met by persons other than the client. When sexual exploitation occurs, the therapist's need is met rather than the client's. As in the parent/child relationship, in which sex is but one of several types of role reversals, sex in therapy often occurs within a larger context of role reversals, such as using the client to provide other personal services for the therapist, e.g., shopping or secretarial work.

Sex Among Other Power Abuses

Just as parents who sexually abuse their children may misuse their power in other ways, therapists who sexually exploit their clients frequently do so in the context of other abuses. Common examples are breaches of client confidentiality and insurance fraud.

Secrecy and Isolation

Both parent/child incest and client sexual exploitation usually involve secrecy. This results in emotional isolation, personal shame, distrust in one's own reality testing, and disruption of important relationships with family members and others. Many exploited clients, like incest victims, experience a traumatic disillusionment with the idealized other. In order to recover from this trauma, clients need an opportunity to talk freely about what happened, and yet secrecy precludes this from happening. Also, when the client has already been experiencing some degree of isolation or difficulty in relationships as part of the initial reason for seeking therapy, this secrecy and resulting isolation exacerbate any of these existing problems and create new relationship problems.

High Likelihood the Story Is True

Researchers have noted that children who report incest are usually telling the truth. Practitioners in Minnesota have found a similar high percentage of clients' allegations about their therapists' sexual exploitation to be substantiated.

Mixed Feelings About the Experience

Both types of victims experience complex, intensely mixed feelings toward the parent or therapist. On the one hand, they may experience affection, appreciation, a sense that some attention is better than no attention, and loyalty. On the other hand, they may also feel betrayed, distrustful, confused, responsible for what

happened, fearful of hurting the perpetrator if a complaint is made, and fearful of reprisal if what happened is reported.

Developmental Fixation and Continuing Trauma

The child who experiences incest is deprived of the opportunities of childhood; continues to reexperience the incest trauma in a myriad of ways throughout life; and commonly has long-standing problems achieving self-esteem, forming meaningful relationships, and effectively mastering life-tasks, e.g. education and/or career. Similarly, the sexually exploited client becomes "stuck" at the developmental stage at which he/she originally sought help from the exploitative therapist, thus diminishing self-esteem, and blocking effective free pursuit of other relationships and life tasks in subsequent years.

Associates' Silence Implies Consent

Frequently, incestuous family members and mental health colleagues remain silent and do not act to protect the victim of incest or client sexual abuse. Sometimes the fact that incest is occurring is not clear to family members; they may be only vaguely aware that "something is different." Similarly, sometimes it is not clear that sexual abuse of a client is occurring in a mental health office. Colleagues may only be aware of warning signals, may not recognize these as symptomatic of sexual exploitation and may not ask to seek clarification of what is amiss. Yet sometimes family members do know of the existence of incest in the family, just as mental health colleagues are aware of allegations by clients of sexual expioitation, and yet still say nothing. Reasons for this silence may include a wish to protect the family, organization, or profession at any cost. Sometimes there is fear of ostracism or punishment. In the case of mental health professionals this can take the form of loss of referrals, or fear of accusations of slander. The imagined or real costs to the whistle blower are sometimes too threatening; however, silence implies consent. Silence helps to perpetuate the exploitation. Family members as well as mental health colleagues may later suffer remorse for not having acted to protect the victim.

Response by Others When Perpetrator Is Well-Regarded

When the parent perpetrator of incest is a well-regarded, upstanding community citizen, the shame, guilt, and confusion of the child as well as the paralysis of the community are more intense. When therapists who are sexually seductive are among the community's most highly regarded practitioners, clients' and helping professionals' confusion, disbelief, and paralysis are similarly increased. People ask: "How can such a well-regarded therapist be guilty of this conduct?"

Betrayal When Associates Don't Act

Children suffer when family members and others do not act to protect them from parent sexual abuse. Similarly, clients feel betrayed when colleagues of the therapist either deny that the abuse has occurred, or do not take action even when aware of the problem. Clients ask: "If they knew, why didn't they do anything?" This betrayal frequently feels more painful than the betrayal experienced in the abuse itself.

Need for Outsiders To Break Up Enmeshment

Incestuous families usually require outsiders, such as an arm of the government, to break up the unhealthy enmeshment between parent and child. Similarly, the unhealthy enmeshment between client and therapist requires the intervention of outsiders. For the mental health professions such "outsiders" include: alert peers who can help by identifying early warning signs, supervisors, licensing boards, ethics committees, client support groups, advocates, law enforcement, and the courts.

Implications for Intervention

Professionals have learned the value of education in prevention and treatment of incest victims. Educational presentations and materials on the subject of client exploitation similarly assist people to become better informed consumers of mental health services and to feel less fearful of seeking help, should problems arise in their therapy.

Practitioners have learned to inquire routinely about the possible incest history of a client. It is also important to inquire about a history of therapy abuse.

Helping professionals have learned not to make assumptions about what a child experienced, or what meaning the incestuous experience has for the child. It is equally important to inquire specifically about what the client experienced and its meaning to the client.

Given clients' high level of distrust of subsequent therapists and subsequent therapists' anxiety about hearing the story, it is important for both the subsequent therapist and the client to avoid unnecessary isolation. Professional consultation should be sought to consider

the client's story, options for resolution, and, when possible, protection of other clients. Opportunities for the client to speak with other client victims should be provided whenever possible.

Since clients must first recover from the abuse trauma before they are in a position to make use of help for the problems neglected and exacerbated by the abuse, specialized services to address the trauma should be provided in addition to the therapy needed for the original problems. Given this complexity, the need for gradual resumption of trust in the helping process, and the need for cooperation with other professionals, client victims of sexual exploitation may require ample therapy hours for their recovery.

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Supervision Strategies to Prevent Sexual Abuse by Therapists and Counselors

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Introduction

A recent review of the literature revealed not a single article on the role of supervision in the prevention of sexual abuse of clients by therapists. This paper will attempt to outline methods of supervision that can be used to prevent many such abuses. In the articles section in this handbook on working with therapist-perpetrators, there is extensive information on supervisory strategies to prevent behaviors which are precursors of abuse from developing into victimization and to convert them into therapeutic practices. Those articles also discuss in detail the supervision of the therapist-perpetrator.

Supervision takes many forms, depending on the setting in which supervisees are practicing. This paper addresses various groups of professionals—psychotherapists, clergy who do pastoral counseling, social workers, chemical dependency counselors, and those who work in battered women's shelters, to name a few. The ideas presented here can be shaped and adapted to meet the needs of practitioners in these diverse kinds of work.

Supervision, in the literature of the counseling and therapeutic professions, has meant many different things. Here it means clinical supervision as opposed to administrative supervision: that is, the supervision that deals specifically with the therapist's work with clients.

Also, for the purpose of this paper, supervision and consultation have been lumped together under the term supervision. Generally, supervision implies that the supervisor has the ability to hold the supervisee accountable as an employee, while consultation implies a relationship in which the supervisee pays the supervisor to provide case consultation. Many therapists and counselors have neither supervision nor consultation—some because their professions do not value or understand the need for it, some because they are unlicensed or unregulated, and some because they have not personally sought it.

Psychotherapy is inherently a vulnerable profession —for clients, therapists, and employing agencies alike. Good supervision protects everyone in the psychotherapy system and enhances the quality of therapy.

Even in those professions requiring supervision, it may not be required after the practitioner is licensed. Looking at supervision from a developmental perspective (Conroe, 1985), one which suggests that students will gain knowledge and skills and be able to handle more complex tasks with greater independence over time, this may be an appropriate guideline. However, using this model has a serious hazard. No longer needing supervision may be equated with being professionally mature. Therefore, therapists may not acknowledge that they need help without feeling immature or risking being perceived as incompetent. Such a framework invites professionals to hide their problems from others and to deny them within themselves. What starts as a relatively minor problem with a client can become a major problem under these circumstances.

But if supervision is viewed from a structural perspective, termination of requirements for supervision upon certification or licensing is grossly inadequate. From a structural perspective, the therapeutic relationship is seen as *inherently* vulnerable and complex. Boundary problems can be expected to arise because of the nature of the relationship, no matter how skilled or knowledgeable the therapist is. Other structural issues include: differential power, the need for the client to be vulnerable to make changes, the therapist's use of self and resulting vulnerability, and the transference and countertransference processes that are built-in aspects of the therapeutic relationship. The therapeutic relationship, in other words, always involves boundary issues. With effective supervision, boundary problems can become part of the healing and growth in the therapeutic relationship (Dujovne, 1983); without it, they can become an occasion for client victimization.

Supervision should be part of therapists' and counselors' ongoing professional development, whether or not it is mandated by professional organizations beyond licensing or certification. Ongoing supervision, whether in the form of peer review, professional

consultation, or traditional clinical supervision, is clearly in the best interests of everyone involved: therapists, clients, and employers. For therapists, supervision decreases isolation and provides a climate of support for learning and growth. For employers, it provides accountability. For clients, it ensures appropriate and effective service.

Sexual abuse by therapists has been compared to incest in the family in its damaging impact on the victim (see preceding article by Luepker), the family system, and the society as a whole.

Growing awareness of the impact of incest has caused practitioners and professional groups to develop more vigorous preventative and therapeutic strategies to deal with incest. It is crucial that the similarly severe damage done by therapists who sexually victimize clients be recognized — damage to victims, professions, and society.

In summary, sexual abuse of clients by therapists strikes at the very heart of the therapeutic endeavor. Helping professionals must take measures to prevent and address this extremely serious violation of the therapeutic relationship. If ineffective measures are taken, the result could be serious damage to the very persons who helping professionals are committed to help. This failure would threaten the integrity and credibility of all the helping professions.

Supervision and the Continuum of Violations in the Therapeutic Relationship

Boundary problems in therapy occur on a continuum, ranging from relatively minor violations of professional ethics and/or boundaries such as asking a favor of a client, on one end, to being involved sexually with a client, on the other. The underlying quality that characterizes all behaviors on the continuum is a betrayal of the client's trust. The betrayal takes place within the context of a relationship system in which the client's trust is an essential ingredient for a successful outcome.

In their work with victims of sexual abuse by therapists, Milgrom and Schoener (see their Article in this Section of the handbook) have found that the central issue is not the sexual activity; rather, the sexual behavior is the final stage in a series of abuses that have been taking place before the sexual abuse and/or at the same time. The client is as injured by other ethical boundary violations as by the therapist's sexual behavior.

In looking at supervision as part of preventing sexual abuse of clients, this entire continuum of behavior must be considered. First, how can supervision make it less likely that serious boundary violations will occur? What are appropriate limits within the therapeutic relationship and how can supervision help to maintain them? Second, how can supervision intervene in cases of less severe violations so that they do not progress to sexual abuse? And third, once a sexual violation has occurred, how can supervision make it less likely that it will be repeated?

Schoener, in his work with over 1,000 cases of client victimization, has found that the therapist's personal problems and character structure make a significant contribution to such events. An article on assessment by Thompson in this section of the handbook offers more information on this relationship. In addition, he has found that some therapist-perpetrators either do not have the knowledge of professional ethics and boundaries, or they do not understand the application of the knowledge they have. In both cases, the therapist may also fail to understand the need for supervision. Supervision will be ineffective in preventing therapists from harming clients when it (1) focuses only on clients, (2) does not include vigorous limit-setting within the supervisory relationship, and/or (3) does not give direct educational information about expectations of therapists in a therapeutic relationship.

This paper will describe one type of supervision which addresses these therapist-centered issues, and in turn makes the therapist more competent in dealing with clients' concerns.

A Model of Supervision

The model of supervision we believe is most likely able to prevent sexual abuse of clients by therapists involves two relationships: the therapist-client relationship, and the supervisor-therapist relationship. The therapist-client relationship is a temporary one which is designed to end once the changes the client wants to make have been accomplished. The purpose of the supervisor-therapist relationship is the professional growth and accountability of the therapist.

To the therapist-client relationship, clients bring their history — with family of origin, therapy and therapists, and other relationships — and the problems that they wish to work on in therapy. To the therapist-client relationship, therapists bring their personal history, professional skills, and professional ethics and values. Awareness of these three factors allows therapists to use themselves as agents of therapy.

In addition to the above, therapists bring to the supervisory relationship their previous experience with supervision, and conscious and unconscious information about particular therapist-client relationships. To the supervisor-therapist relationship, supervisors bring their own history — personal, professional, and supervisory (both as supervisee and supervisor); supervisory responsibility; integrated understanding of therapeutic ethics, roles, and processes; and responsibility to the agency and/or professional organization.

The supervision model proposed here utilizes *mirroring*. The process dynamics in the supervisory relationship mirror those in the therapist-client relationship, so that if the supervisor changes the dynamics of the supervisory relationship, the therapist will be able to change the dynamics in the therapist-client relationship. In turn, the client will be able to change his/her relationships with others. This circular process can be repeated again and again, sometimes working with multiple processes at the same time.

The supervisor's first task in the process of change, then, is to become aware of the process in the therapist-client relationship that is preventing the therapy from being effective. Clues to discover the problematic process come from the process and feelings in the supervisory relationship, and the process and feelings in the therapist-client relationship.

Second, the supervisor must do in the supervisory relationship what the therapist is not doing in the therapeutic relationship. And the supervisor must tell the supervisee what needs to be done at the same time she/he is modeling the desired behavior. An example from group supervision may be of help in making the concept of mirroring clearer.

> A therapist presented a case in which an early adolescent child had repeatedly run away from a single-parent home where the mother set few limits and was preoccupied with her own tumultuous relationships with men. At the mother's initiation, the child was taken to court and the court ordered counseling as one of the terms of probation. The mother repeatedly missed and cancelled appointments, and the therapist brought the case to group supervision because she felt immobilized and hopeless. Initially, the group suggested involving the probation officer in trying to get the mother and daughter to follow through, and there was some discussion about whether that would be effective. There was a general feeling of powerlessness and discouragement about whether the legal system would really do anything to help. The supervisor saw the same process within the parent-child and the therapist-client relationship: abdication of responsibility followed by some form of leaving, followed by feelings of helplessness and discouragement, followed by an appeal to outside authority.
>
> The supervisor intervened and told the therapist that she must call the mother and tell her that she must come to therapy for her own sake and for her daughter's. The supervisor stressed the pain that both mother and daughter were in, their estrangement, and the long history of confusion and disappointment between them. (There were significant recent events involving loss and grief that mother and daughter had not talked about at all). In doing this, the supervisor modeled firm and caring limit-setting behavior that dealt responsibly with problems directly within the relationship, without involving outside authorities except as a last resort. The therapist could be more powerful and affirming in her relationship with the mother. In turn, the mother could be a more powerful, involved, and caring parent.

The learning in this method comes from three sources: the supervisee sees the supervisor *model* the appropriate behavior; the supervisee hears the supervisor *teach* the behavior; and the supervisee learns *experientially* what it is like to be the recipient of that form of therapeutic intervention.

In situations involving prevention or intervention in the area of sexual victimization of clients, the crucial content areas are those involving (1) ethical standards, (2) interpersonal boundaries, (3) appropriate roles, and (4) the power dynamics involved in the therapeutic relationship.

In this context, boundary issues are seen as part of the process of doing psychotherapy, and as grist for the supervisory mill. In the context of supervision, boundary problems that are not serious violations of professional ethics can provide rich opportunities for self-awareness and learning that make the therapy and the therapist more effective. They can become occasions to explore such issues as transference, countertransference, and resistance in the context of both the supervision and the therapy. For a detailed discussion of supervisory methods of approaching boundary violations, the reader is referred to the article on supervision in this section of the handbook by Nielsen, Peterson, Shapiro, and Thompson.

While many of the supervisor's behaviors in this process are the same as therapeutic behaviors, supervision is not therapy. The difference is, as Doehrman (1976) has put it,

> a difference in purpose. The aim of supervision is the teaching of psychotherapeutic skills, whereas the goal of therapy is to alter the patient's characteristic modes of reacting . . . Hence, the problems dealt with [in supervision] are limited to their particular manifestations in the supervisory returns to the teaching of psychotherapeutic skills . . . (p. 79).

The objective of this model of supervision is to use every difficult situation in the therapy and the supervision as an opportunity for supervisees to gain knowledge of themselves — their feelings, resistances, blocks, impasses, vulnerabilities, and impact — so that the therapists' feelings can be tapped and used in the service of the therapy. As Spiegal and Grunebaum (1977) and Doehrman (1976) have pointed out, an increase in creativity, spontaneity, and warmth in therapist-client relationships can result from such supervision.

Characteristics of the Supervisory Relationship

Trust

The first element that must be present in the supervisory relationship is trust. Supervisees must be able to be vulnerable within the relationship, or they will not be able to disclose the information the supervisor needs to help with issues of boundary violations. It is the supervisor's job to establish a climate of safety and trust within which such disclosure can take place.

The process of establishing trust in supervision which is most likely to prevent victimization of clients, however, is different from the approach normally taken in psychotherapy. In areas that involve boundary problems, the supervisor's task is to ask any and all questions necessary to get to the bottom of what has happened. Thus, supervisor and supervisee together can understand the underlying processes that are taking place in the therapist-client system, and the supervisee can develop new competence, not just suppress the behavior or take on a set of rigid rules. The outcome of such a process ultimately is increased trust. There is increased trust within the supervisory system, and supervisees can trust their own competence more.

Supervisor in Charge of Supervisory Relationship

Second, supervisors must be in charge of what takes place within the supervisory relationship, including setting the tone and direction and keeping it a clearly task-oriented relationship. The purpose of supervision is the professional growth of the supervisee, and it is the supervisor's job to provide a process that fosters learning. Supervisors must be willing and able to pursue anything that will be important in getting to the root of supervisees' difficulties with the client. They must be in charge of which clients the supervisees present, to what depth they are presented, and in what direction the supervision goes. This is not to say that supervisors will always direct these aspects of the relationship, but they must have and use the power to direct them when it is essential to the supervision.

In the mirroring process model of supervision, this behavior allows the supervisee to bring the same expectations to the therapist-client relationship, and, in turn, for the clients to take charge in their relationships (e.g. with children) where appropriate.

Supervision—Includes Countertransference

Third, supervision which is effective in preventing and correcting sexual abuse of clients must include the countertransference issues within both supervisory and therapeutic relationships. It should include the therapist's feelings about the client and the therapy, reactions to the supervisory relationship, personal history as it relates to the client's work, and previous experiences with supervision.

Newman (1981), among others, has addressed the need for self-awareness as part of becoming a more competent therapist: "therapists are not really effective until they can uncover and work through the personal issues that

keep them from hearing and responding to the clients in the present," (p. 32). She also stressed the need for the supervisor to "work directly, in the moment, with whatever is blocking [the supervisee's] effectiveness," (p.33).

The supervisor must take the initiative to bring up countertransference issues, and countertransference should be an ongoing part of the supervisory relationship, not just something to be looked at in crisis situations. The supervisee's reactions to clients and to supervision provide a crucial information base from which therapeutic action can be drawn. If the therapist does not become a part of the supervision, the work in supervision will remain superficial or technical, and the therapist may miss information that could lead to more serious problems.

Boundaries of Supervisory Relationships are Clear

The supervisor must insure that the boundaries of the supervisory relationship itself are clear. The supervisor must be clear that her/his relationship with the supervisee is a professional relationship — not a social, collegial, romantic or personal one. The sole purpose of an effective supervisory relationship is the professional development of the supervisee. According to Glaser and Thorpe (1986), sexual relationships between supervisor and supervisee are not rare, and this, of course, is a serious violation of appropriate boundaries.

The supervisor must also be clear that the supervisory relationship does not include therapy and is not aimed at therapeutic change. While the mirroring process model of supervision does involve personal vulnerability on the part of the supervisee and requires willingness to look at the countertransference issues involved, it must always be focused on improving the supervisee's work with the client and never become an end in itself (Peterson, 1984). When such work does not resolve the client-therapist issue, the supervisor may recommend therapy for the supervisee and make a referral to someone else.

Supervisors also fail to maintain appropriate boundaries when they avoid the difficult issues in a supervisee's work or fail to ask the hard, probing questions that must often be asked if the supervisees are to avoid serious boundary problems. Peterson (1984) points out that when the comfort of supervisee and supervisor supersedes learning, the boundaries of the relationship have been violated.

Supervisor's Awareness of Own Countertransference

Supervisors' own feelings and reactions to what is being presented in the supervisory setting give vital information about the process that is occurring between supervisor and supervisee. Awareness of them also enables supervisors to sort out the parts of their own reactions that do not pertain to the case at hand. The awareness of internal experiencing, while it adds one more level of processing in an already complex set of relationships, also provides essential grounding for both supervisor and supervisee by keeping the work focused on the therapeutic issues.

Content and Themes in the Supervisory Relationship

In addition to the process of supervision suggested above, there are specific content aspects of the therapeutic relationship that must be brought continually into focus if harmful abuses are to be avoided.

Limit-Setting

Limit-setting must be a constant focus of both therapy and supervision. The supervisor must set limits with the supervisee wherever necessary and assist the supervisee to become more able to determine when and how to set limits. This may run the gamut from the therapist setting limits about receiving gifts from the client or phone calls between sessions, to setting limits about sexual involvement with the client. The purpose of limits in the therapeutic relationship is to create a safe relationship in which the client can heal or grow. The purpose of limits in the supervisory relationship is to define an accepting interpersonal space in which the supervisee can show mistakes, uncertainties, and lack of knowledge without being personally condemned or shamed. Given this, the supervisee can learn and become professionally more competent. When the limits are violated, supervision is compromised. Allowing limits to be broken in either relationship, without (1) reestablishing appropriate boundaries, and (2) therapeutically processing the violation, sabotages the purpose of the relationship.

A related issue is that of the supervisor being able to make appropriate demands and have expectations of the supervisee. Montgomery (1978) stresses the need for supervisors to model assertive behaviors in their supervisory relationships so that supervisees can in turn be assertive in their work with clients. The model

suggested here adds another layer: clients will be able to be more interpersonally assertive as they learn from their therapists. Ethical concerns are among the most critical aspects of the supervisory relationship. The supervisor must be willing to take clear stands from an ethical point of view and to challenge supervisees to push through their fear and abandon less effective and competent behaviors in favor of more powerful and ethical ones.

As Peterson (1984) has pointed out, such challenges are extremely uncomfortable for both therapist and supervisor. Without them, however, the supervisee is being deprived of experience that would promote ethical development, and give permission to have expectations and make appropriate demands of clients.

The Role and Power of the Therapist and Client

The limits that must be set within the therapeutic relationship flow from a clear understanding of the therapist's role and power. To have effective therapy that does not abuse clients, the therapist needs to assist clients to find their own power to meet their goals for life effectively.

Many therapists who have abused clients, by contrast, view therapy as a dependent relationship in which the therapist takes over segments of the client's life or plays roles that should be played by persons in the client's life outside of therapy, e.g., friend, spouse, lover, or parent. In supervision it is important to stress that therapists have power only over themselves and what they do in the therapy session — NOT over clients or clients' lives outside of therapy. Supervisees will learn this in supervision in many different ways, but probably the most powerful learning takes place from the supervisor's having an appropriate relationship with the supervisee. Again, the idea of a mirroring process suggests that the supervisory relationship provides a model and an experience of respectful, non-abusive relating that the supervisee can carry into therapeutic relationship with clients.

Just as the supervisor is not all things to the supervisee, the supervisee cannot be all things to the client. In their training, many therapists have been taught, sometimes directly and sometimes indirectly, that they are responsible for the outcome of the therapy and for the client's behavior while in therapy. That assumption introduces a fundamentally flawed notion of therapist and client roles which prevents the therapist from setting limits effectively. The particular danger of this distortion is that it inhibits therapists from expecting their clients to be responsible for their own lives. That, in turn, prevents the progressive empowerment of the client that is an outcome of effective therapy.

Some therapists who have sexually exploited their clients have breached the boundaries of the therapeutic relationship in the opposite direction and their clients have become substitutes in those therapist's lives for friends, lovers, mentors, pharmacists, loan officers, real estate agents, lawyers, or even therapists. Supervisees must be educated about meeting their own needs outside the therapy office and must confront any situation in which a therapist is not doing so.

Task Orientation in Therapy

Supervision aimed at helping therapists avoid sexual involvement with clients should stress that both supervision and therapy have a task orientation. The purpose of therapy is to solve the client's presenting problem through growth or change on the client's part. The relationship exists only for that purpose and dissolves when the purpose has been fulfilled. Therapy is not life, or even the main event. It is not a substitute for marriage or friendship, and it is not a place to be soothed or calmed. The supervisor models these basic notions in the supervisory relationship. They, in turn, become issues for examination in the therapist-client relationship. Once the supervisee grasps the fundamental nature of the relationship, it can be a conceptual base from which to set the necessary limits in therapy.

Countertransference Issues

Three particular types of countertransference bear on sexual exploitation of clients by therapists. Continuous and explicit attention by the supervisor to these issues educates the supervisee. Through examining issues of gender, family of origin, and previous therapy or supervision, supervisees learn that (1) they can expect to have countertransference reactions; (2) these issues can be addressed with the supervisor; (3) therapy is enhanced by dealing with them clearly and consciously.

1. Issues of Gender and Sexuality

Supervision aimed at preventing sexual exploitation of clients by therapists should focus on how the therapist relates to clients on issues of gender and sexuality. The questions here are (1) how does the therapist relate to the client as male or female and as a sexual person; (2) how does the client relate to the therapist as male or female and

as a sexual person? The supervisor should take the lead in keeping this issue in the foreground in an ongoing way, so that the supervisee gets the message that there is nothing unique or terrible about gender or sexual issues, and it is irresponsible not to talk about them when they arise. Dujovne (1983) has written an excellent article about sexual feelings in psychotherapy. Schoener (1985), in his work with agencies where a therapist has sexually exploited clients, found that sexual feelings between clients and therapists were not discussed in those agencies until the therapist was exposed. One objective of preventative supervision is to make such discussion a routine part of the work

2. *Issues from Family of Origin*

The therapist's own family of origin provides many different kinds of countertransference material which, if not available consciously, can provide a breeding ground for exploitative therapeutic relationships. Therapists who were victims of incest, battering, or other kinds of verbal or physical abuse are particularly vulnerable to becoming unwitting abusers of their clients because they have been victims of family or other systems in which personal boundaries were breached. For example, therapists may find themselves competing with the client's parents, or trying to fix their own family by fixing the client's family, or trying to give the client what they needed but did not get as children. It bears repeating here that the supervisor's role in providing clear boundaries within the supervisory relationship gives the supervisee the experience needed to learn to set appropriate boundaries within the therapeutic relationship. In turn, this allows the client to relate to others within healthy boundaries.

3. *Issues from Previous Therapy and/or Supervision*

Just as unfinished business from the therapist's family can block work with clients, so boundary violations in previous supervision or personal therapy can have a negative impact on the supervisee's work, both as a therapist and in supervision. Supervision which aims to make therapists less likely to abuse their clients must address these unhealed wounds. This will help to teach the supervisee that he or she is expected to have and to discuss countertransference reactions and that they are valuable material with which to enhance the effectiveness of therapy, once they have become conscious.

Summary

In this paper, we have described a style of supervision which we believe is most likely to prevent sexual abuse of clients by therapists and counselors. The process involved is one in which the supervisory relationship is seen as mirroring the therapist-client relationship, and the supervisor creates change in the supervisory relationship so that the therapist can, in turn, create change in the therapy relationship.

Characteristics of the supervisory relationship which make it most effective were also identified: building trust by intervening, being in charge of the relationship, including countertransference issues, and keeping clear boundaries.

A series of themes in the supervisory relationship which have particular bearing on the issue of victimization was also outlined, including: limit-setting; the role and power of therapist and client; task orientation in therapy; and countertransference issues involving issues of gender, family of origin, and previous therapy and/or supervision.

Another article in this section of the handbook (see Nielsen, Peterson, Shapiro, and Thompson) discusses the occurrence of boundary violations and the use of supervision to promote the accountability of the supervisee so as to prevent more serious violations and enhance the therapeutic process. It also gives suggestions about supervision of therapist-perpetrators.

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Issues in Assisting Clients who have been Sexually Exploited by Therapists and Counselors

Advocacy: The Process of Assisting Sexually Exploited Clients

Jeanette Hofstee Milgrom

Introduction

The term *advocacy* means different things to different people. In this article it means actively assisting a client in formulating, filing, or processing a complaint in the case of unethical or unprofessional conduct by a therapist.

To correct the power imbalance in the therapist-client relationship, advocates assist their sexually exploited clients in restoring the power balance by throwing their weight on the client's side of the scale. The goal of advocacy is to empower the client and to promote the healing process.

This article is addressed to those who provide counseling and/or therapy. All such persons may need to take an advocacy role on occasions when a sexually exploited client comes to their attention. Many counselors and therapists may not be familiar with this role and may initially feel uneasy about assuming it. However, the advocate does not have to go it alone. Assistance, support, and resources can be found along the way.

The Advocacy Role

The advocacy role includes several components for which basic counseling skills are critical: being able to communicate, to empathize, and to establish a working relationship with a client.

Some skills are particularly important. Clinical assessment of the often depressed and sometimes suicidal client is essential. Crisis intervention skills are important, especially when the trauma is recent.

A crucial part of the advocate's role is to state to the client that in cases of sexual exploitation the therapist is *always* responsible, no matter who initiated the sexual part of the relationship. Clients may not be ready to accept this due to their own feelings of guilt and loyalty towards the abusing therapist. However, the absence of a clear statement on the part of the advocate may prolong the client's confusion.

Establishing trust with a client whose faith in counselors or therapists has been badly shaken requires special attention. It is important to accept clients' reluctance to trust and to actually commend them for not blindly trusting subsequent counselors.

Also, clients must be told what will happen with the information which is shared with the advocate— what records will be kept, who has access to the information, and what mandatory reporting, if any, will take place.

Exploited clients need and often want very clear professional boundaries on the part of the advocate and/or subsequent therapist. Having been badly served by the offending therapist— who may have played the roles of friend, counselor, lover, spouse and/or parental figure— the last thing the client needs is a repetition of this confusion.

One other matter to be mindful of is timing— that is, when to encourage the client to take certain steps in the complaint process. Expecting the client to take major action too soon is likely to backfire and have the opposite result, whereas passively going along with the client's postponing any action tends to prolong the client's agony unnecessarily.

The Advocacy Process

The advocacy process consists of a series of steps which may vary from case to case. They are presented in order for clarity.

1. Awareness that victimization may have occurred

Some clients may express their concern or complaint directly. Other clients may give indirect clues, which may include great distrust, physical distance, depression, and low self-esteem. It is important to ask the client about any previous abuse, including the possibility of abuse by a previous counselor. This is no different from asking a client about possible family violence, chemical abuse, or sexual abuse. Questioning won't hurt the client, whereas overlooking the possibility of previous abuse may deprive the client of an opportunity to deal with it and come to a resolution.

When the client initially tells the story of being sexually abused by a previous therapist, one should not assume particular reactions on the part of the client (see the article by Milgrom and Schoener in this section of the handbook). People react differently to experiences of victimization. For

example, sexual intercourse may seem like a more serious abuse of a client than erotic talk or suggestive behavior. However, the client may be more thoroughly confused by the latter. It is important to help clients arrive at *their* definition of the problem.

2. ***Assessment and crisis intervention***

The first task of the advocate is understanding of the client's experience of sexual exploitation and his/her emotional response to it. The experience may range from a relatively minor infraction of ethical boundaries on the part of the former therapist to extremely serious and damaging sexual exploitation.

Whereas some clients may be able to relate their story in chronological order and include specific details, others may be less articulate and/or too embarrassed to share what took place. The advocate should ask any questions necessary for clarification. For example, if the client reports having been abused, the advocate may ask what the previous counselor said or did that made the client feel that way.

The advocate's or subsequent therapist's function is to assess the client's immediate life situation and needs. What else is going on in the client's life? What is the client's family or marital situation? What is the client's job or financial arrangement, health, social support system, and degree of depression? The client may be in crisis, and the advocate's first task may be crisis intervention.

Before further exploration of how to go about filing a complaint can take place, the client may need to get medication, be hospitalized, move out of an abusive situation, or get an unlisted telephone number to prevent contact from the abusive former therapist.

Though there may be isolated instances where this is in question, it is highly likely that the client is telling the truth about what she or he experienced. The client's consistency in telling the same story and truthfulness in other areas can help in the assessment.

When a client is actively psychotic, hallucinating or otherwise out of touch with reality, it may be impossible to assess whether the report of sexual exploitation is factual. Referring the client to a psychiatrist for evaluation and possible medication is in order in this case, with the option that the client pursue the complaint later when she or he is stabilized.

A client may be a habitual liar and may have fabricated the story. Even in this instance the advocate has a responsibility to address the issue, involving appropriate other parties to clarify what happened in the therapeutic relationship, and to work toward a resolution which is in the best interest of the client, as well as anyone else involved.

Another problem may be exaggeration or misunderstanding on the part of the client. A client may report as sexual abuse an incident in which a counselor put a hand on the client's arm or knee. The problem in this case may be a therapist who uses poor judgment and/or is inexperienced and trying too hard to be helpful rather than one who is actually exploitative. While this may not be exploitative behavior, it may still have caused the client distress. More investigation of the situation by the advocate and client is needed to address this issue.

3. ***Exploring the options available for addressing exploitation***

Exploring the options with the client is the next phase (see Wheel of Options on the next page). The question in this stage of advocacy is: which option or combination of options is most likely to accomplish the goals of this particular client as effectively and efficiently as possible, in a manner which is consistent with what the client can tolerate emotionally, financially, and in terms of possible public exposure?

It is the responsibility of the advocate to maintain current information on resources, procedures, etc. Information may be obtained from professional organizations such as the National Association of Social Workers (NASW), the State Psychiatric Society, or the State Psychological Association (see the final section of this article).

The option chosen should closely correspond with what the client basically wants to accomplish. It may be helpful to ask the client what, in fantasy or

imagination, he or she would ideally like to achieve and then to translate it into realistic possibilities. The client's goals generally are a combination of the following:

A) In all cases, taking action provides the clients with the opportunity to stand up for themselves. They can communicate to the former therapist that the sexual exploitation was not okay and that it hurts clients. It is a way for the clients to "take their power back."

B) Clients often are concerned about the likelihood of the exploitative counselor hurting future clients, and they want to minimize that possibility.

C) Clients sometimes want to seek monetary compensation for the damages: refund of fees paid, or reimbursement for the cost of subsequent therapy.

D) The goal of both the client and the advocate in all cases is to arrive at a resolution which permits clients to put the abuse behind them and go on with their lives.

Wheel of Options

Adapted from Walk-In Counseling Center
2421 Chicago Avenue South
Minneapolis, Minnesota 55404

Many sexually exploited clients believe that they brought the abuse on themselves and consequently have no right to complain or take action. Other clients believe they can either do nothing, or sue, with no options between these two extremes. Communicating to the client a range of options and having the client decide which one(s) to pursue is in itself empowering. If the client is considering legal action, contacting an appropriate attorney should be the first step prior to taking any other action.

The crucial guideline is that the client must be the central person in deciding which option(s) to take. If the subsequent counselor or advocate has a strong bias in one direction or another, he or she should inform the client of this bias. However, the advocate's bias must be subservient to the client's choice and best interest (mandatory reporting such as under the Vulnerable Adult Act, of course, takes precedence). However, advocates should keep in mind the vulnerability of exploited clients and their tendency to follow the recommendations made to them without questioning them.

4. *Initiating action*

The next task of the advocate is to help initiate the chosen action. Some clients need more help than others. It may be enough to give some clients a telephone number to contact. In other cases it may be appropriate to take some steps on behalf of the client. In most cases it will be necessary for the client to write down the story of what happened. Clients who have poor writing skills may need help in this process. Clients often express considerable difficulty in writing the story. One should be mindful of the fact that the client often relives the traumatic events in the process. It can be helpful to ask the client to state a time goal, a deadline by which the writing is to be accomplished.

5. *Continuing support*

After the process has been initiated and the complaint has been filed, it may be weeks, months, or years until the time of action. Supportive contact with the client during this period is important, as the client is likely to have ups and downs, and often is not able or not allowed to speak to other people about the situation. It helps if the client has access to the advocate and can touch base periodically.

6. *Preparing the client for the event*

When the date of the "action" (e.g., hearing before an ethics committee or board of examiners; confrontation session with former therapist; civil or criminal suit; etc.) approaches, it is important to prepare the client as well as possible for the event. This includes letting the client know what to expect in terms of proceedings, time frame, people present, and physical layout (as an attorney would do in case of a lawsuit). It can be helpful in lessening the client's anxiety to role-play the anticipated situation with a client, or "walk through it".

In cases when a meeting or a processing or confrontation session is scheduled with the former therapist, it is important to discuss the client's expectations ahead of time. Unrealistic expectations should be pointed out to the client. Included might be expecting an apology from the former therapist, or a promise he or she will never do it again. The client may have no way of evaluating the therapist's sincerity, understand the former therapist, or understand what happened, which may be unrealistic because it may be impossible to make sense out of nonsense.

Often a great deal of energy has been invested in dealing with the victimization and the complaint process. Clients tend to be at a low ebb after it is all over, and it is well to assist the client in planning for the day or night after the session(s), in activating a support system, and in thinking of new activities for the future or reviving old interests.

7. *The advocate's presence at the event*

It may be appropriate for the advocate to be present at the session or hearing. In some situations, such as a confrontation or processing session with the former therapist, it may be imperative for the advocate to be there to lessen the power imbalance between the client and the former therapist (see article by Milgrom and Schoener in this section of the handbook).

In other instances, it may be more appropriate to meet with the client before or after the hearing.

8. Termination and follow-up

Following the hearing or meeting, a short "debriefing" session with the client is likely to be very helpful. At this time the advocate may also want to determine with the client whether this is the last contact, whether there will be follow-up in a few days or weeks, or whether the client should contact the advocate. Clear termination of the role of advocate is necessary, particularly in view of the client's prior ambiguous experience where boundaries between a professional relationship and a social or sexual relationship were vague or nonexistent and client status was ill-defined.

Advocacy and/or Therapy

Some clients need therapy subsequent to the experience of sexual exploitation and some need advocacy. Most clients are best served by a combination of the two, either simultaneously or consecutively.

Advocacy and therapy can go hand-in-hand. Ideally, having two different persons involved, one as the advocate and one as the therapist, is probably the most productive arrangement. The client is less likely to perceive the therapist as omnipotent when several persons are involved in working with him or her. This arrangement can work particularly well if advocate and therapist keep in touch (with the client's permission) and keep each other informed of important developments and concerns in the client's situation. However, it may not always be possible for two different persons to assume these roles. In smaller communities (e.g. rural areas, ethnic minority or gay/lesbian communities) a therapist may also need to function as an advocate and vice-versa if the client is unable or unwilling to go beyond this particular community. In this situation it may be helpful to differentiate for the client when one is functioning as an advocate and when as a therapist.

Problems for the Advocate

Whereas there are definite rewards in functioning as an advocate for and with sexually exploited clients, there are also some potential problems inherent in it. In part, these are just two opposite sides of the coin.

The advocate often experiences dramatic progress on the part of the client. From being a wounded individual, the client may proceed through a stage of great courage to a state of strength and renewed integrity. This is rewarding for the advocate. At this point, the advocate has to terminate with the client. This terminating takes sound professional judgment on the part of the advocate.

Stress and burnout may go hand-in-hand with functioning as an advocate, as it tends to in any work with victims in crisis. The advocate's workload can be erratic, clients need the advocate promptly, and the advocate may need to be immediately responsive and available.

Some counselors and therapists are uncomfortable with the advocacy role either because they don't know how to function in this capacity, or because they choose not to function in a dual therapist/advocate role. Then it is necessary to locate other advocacy resources for the exploited client.

In view of the fact that in cases of sexual exploitation of clients, the perpetrator is another counselor, the temptation may be not to hear the client's story, to overlook the possibility of one's fellow professional's infractions, and to redefine the incident or situation as the client's emotional problem. Although the client may well need counseling or therapy for prior or subsequent problems, one should keep in mind that in cases of sexual exploitation by counselors and therapists, the exploitation *is* the client's primary problem. Other things come later.

Since the advocate is dealing with the client regarding matters of an emotionally and sexually very private nature, the advocate must maintain a balance between being afraid to ask and pressuring the client for unnecessary detail. Both voyeurism and timidity should be avoided.

Even though it is appropriate for the advocate to be appalled by the client's sexual exploitation by another counselor or therapist, the advocate should not, in turn, re-victimize the client by "using" the client to fight the advocate's cause. Although this temptation may arise, the particular individual client's best interest must be of primary importance.

Support and Resources for the Advocate

Support for the advocate can be found or created. Minimally, the advocate should have one other professional (a supervisor, colleague, agency director, or consultant) available both to ventilate to, and to seek consultation about how to proceed. Sharing one's

indignation, frustration, successes, and failures as an advocate with another professional is not only a desirable way to conduct this role, it is actually necessary in order to avoid or deal with the problems described above.

Building a professional network is another way to deal with the problems inherent in advocacy work. Establishing contact with, and consulting other therapists, lawyers, agency administrators, professional organizations such as the National Association of Social Workers (NASW), regulatory agencies (such as the Board of Psychology and the Board of Medical Examiners), or Adult Protective Services, can be very helpful for the advocate.

Additionally, locating and utilizing referral resources for the client can help to serve the client in a comprehensive manner while taking some of the burden off the advocate. These resources may include, but are not limited to, the local or regional mental health center, family service agency, sexual assault center, therapists in private practice, and self-help groups such as Alcoholics Anonymous or Al-Anon.

In conclusion, functioning as an advocate for and with clients who have been sexually exploited by a previous counselor or therapist is often rewarding, sometimes stressful, always interesting and challenging, and different from case to case. In view of the fact that sexual exploitation of clients by counselors and therapists is a widespread phenomenon with often severe, negative effects on the client, serving as an advocate is one significant way in which to contribute to the resolution of the problem.

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Group Treatment for Clients who have been Sexually Involved with their Psychotherapists*

Ellen Thompson Luepker
Carol Retsch-Bogart

In recent years, public attention has been directed at the fact that some psychotherapists and their clients become mutually involved in sexual activity. This unethical conduct occurs despite explicit prohibition by professional mental health organizations and the community's reasonable expectation that therapists will put their clients' needs and interests ahead of their own. Such behavior violates the mandate of the Hippocratic oath, "...at least do no harm," (Stedman, 1982).

Clients who have been sexually involved with therapists suffer a range of negative reactions, yet until recently have been ignored by the therapeutic community. This paper describes group treatment services developed and provided for such clients. It is hoped that this article will stimulate further understanding of the experiences and needs of these clients, as well as present a practical model for treatment.

Psychotherapists involve themselves sexually with their clients more than has been previously acknowledged. Our seeming lack of awareness relates not only to our own inherent tendency to disbelieve the extent of such behaviors, but to the hesitancy of clients to report its occurrence. This parallels our clinical experience with the reporting of incest, in that the client usually suffers alone because of the taboos surrounding the subject.

These clients have a dilemma. On the one hand, their isolation intensifies their confusion, guilt, sense of shame, and feelings of responsibility. They do not know who is to blame nor how responsible they should be to protect their therapist. They may fear retaliation should they report their involvement. Quite likely they are even more needy than before of qualified professional help, but they now distrust it. They experience a profound sense of loss because the problems for which they sought help were not solved, while others were added. On the other hand, telling someone what happened frequently isolates the client further, as family and community respond defensively by denying that such events could have actually happened, or by discounting their importance, or even by blaming the victim for their occurrence.

This paper discusses seven groups for twenty-seven clients offered between April, 1980 and May, 1984 by Minneapolis Family and Children's Service in cooperation with Walk-In Counseling Center (WICC) of Minneapolis.

These time-limited treatment groups used a brief therapy format with the following goals:

1) To provide an opportunity to discuss and clarify in confidence their feelings and reactions associated with their involvement.

2) To provide information regarding the nature of appropriate psychotherapy and its availability.

3) To educate the client in being a more effective mental health services consumer.

4) To assist the client in identifying and utilizing alternative responses to their exploitation.

Areas that will be addressed in this article include responses to the problem, the process of interagency planning and division of therapeutic function, the conduct of intake interviews, group themes, countertransference, the use of the therapeutic relationship, and outcome.

Formation of the Groups

Since 1974, the Walk-In Counseling Center of Minneapolis (WICC) has provided information and individual counseling, as well as assistance in pursuing ethical and licensure complaints to over 1,000 clients, predominantly women, who reported sexual behavior with therapists. In 1976, WICC offered group therapy for women who had been sexually involved with their therapists. To our knowledge, this was the first such therapy group of its kind anywhere. Group treatment proved to be helpful to the participants, but WICC was unable to continue providing this treatment. Accordingly, they turned to Minneapolis Family and Children's Service to continue this service.

* Initial data presented at the Annual Meeting of the American Orthopsychiatric Association, San Francisco, California, March 1982.

The agencies agreed to separate the two functions of group therapy and advocacy. Advocacy (provided either by WICC or other Family and Children's Service staff) would assist clients in pursuing complaints to licensure and ethics boards. Freed from this role, the group leaders could enjoy greater freedom in therapy, objectively helping their clients to discuss their widely ranging feelings without feeling pressured to take any action.

Announcements were placed in several community newspapers throughout the Twin Cities area to inform the public of the upcoming groups and how to arrange for intake interviews. While these announcements did not elicit referrals, they did increase the community's awareness of the problem.

Referral Sources

Clients learned about this group in a variety of ways. About one half of our members were referred from Walk-In Counseling Center. Another 20% were in-house referrals from individual therapists at Family and Children's Service. The final 30% were from outside sources such as other social service agencies, professional licensing boards, and from group members themselves.

Intake Interviews

Both leaders were present for the intake interviews. This established a relationship with both therapists from the beginning. During the intake interview, we obtained information about the client's purpose for seeking help in the group, their current life situation (including their specific problem experience, their support system, and their areas of strength), pertinent family history, their relationship with and their sexual involvement with the therapist, and other treatment history. We provided information about the group's purpose and goals.

The leaders also shared their expectations of group members: that they arrive on time, that the group conclude at the appointed time, and that members attend regularly, except in the case of illness or an unavoidable absence, to be announced to the group in advance. It was stressed that what was said in the group would remain confidential and that contacts with other group members between meetings be shared in the group to facilitate group process. Another important message was that the group members would be encouraged, but not forced, to share their feelings in the group.

In their previous therapy, the clients accepted into the group had experienced some undesirable enmeshment with their therapists, had lacked boundaries, had not known what to expect in treatment, and had felt compelled to secrecy. Thus, we believed that creating a predictable group structure and openness was crucial to establishing a useful therapeutic relationship.

The leaders explained the usefulness of collaboration with Walk-In Counseling staff when the client was active in both agencies and requested permission from the client for this mutual effort. Fees were scheduled on a sliding scale, based upon the client's ability to pay, as is FCS policy. Clients entered into an agreement to pay fees on a regular basis, either weekly or monthly.

Table I
Client Population Characteristics

Age (at time of group)	34 (mean)	22-52 (range)
Age (at time of sexual involvement with previous therapist)	27 (mean)	16-49 (range)
Marital status (at time of group)	Single	10
	Divorced	8
	Married	7
	Separated	2
Education	Less than high school	2
	High School Diploma	1
	Some College	9
	College Diploma	12
	Graduate School	3
Work Status	Clerical (5)/Trade (3)	9
	Professional	10
	Managerial	2
	Unemployed	5
	Student	1

Table II
Therapy Characteristics

Type of Therapists*	
Psychiatrists	7
Psychologists	9
Social Workers	6
Alcohol/Drug Abuse Counselors	4
Lay Analyst	1
Unknown Category	1
Pastoral Counselor	1
Type of Practice Setting	
Private Practice	18 (10 solo; 8 group)
Public Agency/School/ Hospital	11
Duration of Involvement with Therapist	2 years (mean)
	1 year (median)
	2 weeks to 13 years (range)
Time between Termination of Therapy	
Relationship and Group	3 years (mean and median)
	1 year to 13 years (range)

* The reason there are twenty-nine therapists is that two clients were each exploited by two therapists.

Client/Therapy Identifying Information

Tables I and II illustrate client and therapy characteristics and are self-explanatory. The needs for which these clients had originally sought help included vocational counseling, help with marital and family problems, emancipation from family of origin, and help for a spouse's or their own chemical dependency. Two clients were high school students at the time of the sexual involvement with their therapist. All clients stated that they had felt vulnerable and depressed at the time they sought help. All 27 clients were female and the 29 exploitative therapists were male.

Our clients had experienced various levels of sexual involvement with their therapists. While nearly half engaged in sexual intercourse, others participated in fondling, kissing, embracing, and oral sex. Inappropriate behaviors occurred in non-sexual contact as well. For example, one client did her therapist's shopping for his wife. Others served as consultants for the therapist's own personal problems. Some clients anticipated marriage with their therapist in the future, an expectation based on dating between therapist and client, engaged in intimate conversation which included plans for the relationship, and in one instance, the therapist told a client that she was "his salvation". Three clients took vacations with their therapists. One therapist intruded in all areas of his client's life—managing her divorce, talking with attorneys, and dealing with the teachers of his client's children. Another therapist fondled his chemically dependent client in exchange for pills. One therapist and client smoked marijuana together.

Family Histories/Previous Levels of Functioning

Nine of the twenty-seven clients interviewed were victims of childhood sexual abuse. This parallels the prevalence of incest in the general population; researchers estimate that sexual abuse affects 15-34% of all families (Finkelhor, 1979). Nearly all of the clients described "tense" or "difficult" family situations, including such problems as incest, alcoholism, divorce, emotional and/or physical abuse, poor communication, and either extremely passive or domineering parents.

Clients from the more severely disturbed families reported having felt depressed, suicidal, paranoid, and phobic. Six were psychiatrically hospitalized prior to the sexual involvement with therapists.

Five clients required psychiatric hospitalization some time after the onset of sexual activity with their therapist or following termination of therapy. They had not been previously hospitalized.

Although we lack data to make a definite comparison, our own and colleagues' unequivocal impression is that this population's characteristics are representative of our general agency client population. An exception is this population's high percentage (40%) of psychiatric hospitalizations, which seems much greater than that found in the agency's overall client population.

Presenting Problems at Group Treatment Intake

At the time of intake, many of the clients were having trouble getting along with other people and had low self-esteem. The discomfort about their previous therapeutic involvement and the wish to feel better were the primary reasons for which clients came to the groups for help. Nearly all expressed shame and guilt about their relationship with the therapist. They felt responsible for what had happened, believing it had been their fault and that they had seduced the therapist. In the intake interviews, some clients expressed that they were feeling angry, betrayed, and "ripped off." Several were angry because they needed therapy to help them undo or resolve their past experience with therapy. There was anger and sadness over help they never received, and yet most felt they had received something worthwhile from the exploitative therapist. Several women had filed or were considering filing complaints or lawsuits and were afraid of the possibility of retaliation. Some were afraid of hurting the therapist in his personal or professional life. Many of the women who had hoped for an enduring special relationship or marriage with their therapist were filled with feelings of sadness, disappointment, rejection, jealousy, and a wish for renewed contact, even as late as the time of the intake. Many of the clients expressed frustration with themselves for their "poor judgment" and "naivete." They considered themselves "dumb" even though they could see that they had been needy and vulnerable at the time of the previous therapy. Some members reported feeling emotionally "numb." Others had a fear of their feelings resurfacing. Several expressed confusion at not knowing how they really felt.

At the time of intake, nearly every client explicitly expressed an intense need for confidentiality. Their trust in therapy was minimal, which we acknowledged as understandable and adaptive. Most had received little support from family, friends, and peers and reported a sense of isolation. Often, well-meaning people had suggested that they "leave the past to the past" and "sweep this experience under the rug." This had left them with little opportunity to talk out their feelings.

Clients reported other problems which had existed before, but which had been exacerbated by the exploitative therapy, resulting in major interruptions in their developmental growth. All of the clients questioned their reality-testing and lacked a clear sense of what was appropriate in therapy.

Clients' Goals at Intake

Clients had the following goals upon entering the group:

1) To meet other women who had been exploited by therapists and share their experience;

2) To receive support from others in a safe and confidential atmosphere;

3) To talk about the many mixed feelings they experienced;

4) To discuss the various aspects of their own experience, gain some perspective, and work through the experience;

5) To feel less ashamed and guilty and more acceptable as a person;

6) To become more trusting of self, more independent, and more assertive;

7) To learn what is and what is not appropriate behavior in therapy;

8) To acquire support while going through lawsuits or making complaints to ethics boards; and

9) To discuss other areas of life that have been affected by their sexual involvement, including their relationships with men, or with friends, peers, and families; to discuss their sexuality; and to consider their future life directions.

Observations of Therapists' Role at Intake

Clients later revealed that it was crucial at the time of intake for them to feel believed by their new therapists, an issue comparable to the entry phase of work with incest victims. Members also said they found it helpful to be told that clients usually have a wide range of feelings regarding patient-therapist sexual intimacy. The leaders sometimes had intense reactions to the material presented and needed to remain aware that their expression, manner, or behavior might block the clients' ability to fully and freely express their feelings.

Length of Groups

Each of the seven groups was time-limited. They lasted from two to twelve sessions, with three to five members per group. The shorter groups were those with fewer members.

Group length also varied as a function of clients' needs. The weekly group sessions lasted one-and-one-half hours.

Group Themes

Concerns about Confidentiality

All clients felt it imperative that everyone in the group would keep what they said in strict confidence. While this is a need in any treatment group, it was accentuated in these groups due to fears of retaliation by the previous therapist and intense guilt about the involvement with their previous therapist. In one group a member prepared a written contract for everyone to sign, pledging confidentiality. In the other groups, the agreement was verbal.

Initial Cohesion

Group members expressed relief when they realized that they were not the only ones who had experienced this problem and the ensuing feelings of anger, distrust, and sadness. Knowing that when groups are composed of members with similar problems, cohesion develops rapidly, yet provides a false sense of security, the group leaders proceeded cautiously. They informed members that while they were experiencing a sense of closeness and relief in being with others who had had similar experiences, it should not be mistaken for that deeper sense of trust which takes more time to develop.

Countertransference Issues

Countertransference is defined here in the broadest sense, including all of the therapist's feelings towards the client. The countertransference which the leaders experienced initially was the wish to be a "better" therapist than the one with whom the client had encountered problems. They imagined that they would do everything right and that group members would finally see models of truly helpful therapists. Sometimes this countertransference fantasy was promoted by the clients themselves, who wanted us to undo the disaster in the previous therapy. The leaders' fantasies were soon eroded, however, as it became clear that what the group members really wanted was to be able to talk freely and comfortably with a therapist who would not be angry, shaming, or seductive. It was also clear that what group members really wanted was to see the leaders as imperfect at times, and to have the opportunity to point this out. The following example illustrates this need, as well as the therapist's temptation to be over-accommodating and overstep boundaries in a wish to compensate for the client's past pain.

> Anne, thirty-three, arrived at the agency for her intake interview feeling furious at the co-leaders. She had originally sought vocational counseling with Mr. B. Instead of focusing on her vocational concerns, he asked her about her sexual practices and offered specific advice. She felt confused. When she expressed this confusion to him she felt Mr. B. "gave up" on her. She felt abandoned, became depressed, and was subsequently psychiatrically hospitalized. There she felt unable to talk about the preceding events that prompted her admission.
>
> As Anne spoke, she sat angrily in a corner, not looking at the leaders. She stated emphatically that while she was interested in being in the group she refused to pay for further therapy relating to the damage that was caused by the first therapy. Anne was trying to hold the leaders responsible for what previously had happened and to punish her prior therapist through punishing them. The leaders were empathic with Anne's feelings, and were tempted to waive her fee. Nonetheless, they adhered to the agency policy that clients pay what they are able to pay. While they could appreciate her feelings, they could not make up for the hurt she had experienced elsewhere. While Anne was furious with their decision, she did decide to join the group and pay the required fee. Following completion of her group experience, Anne continued in individual therapy.

Another countertransference issue involved the co-therapists' anger and discomfort as they listened to the group members recount their experiences. The leaders' over-identification with these clients sometimes became an obstacle to facilitating further discussion. All group members noted how hard it was to talk about what had happened, but how necessary it was to be able to do so. They directly asked the leaders for more help with this task. The leaders found it helpful to have regular consultation, as well as to talk together after each group session. This minimized the likelihood that their own feelings would inadvertently become obstacles to the group.

Still another countertransference issue that threatened to become a barrier to effective work with these clients was the leaders' own initial fear of harassment or accusations of libel. This fear was useful in understanding the clients' similar fears. It was sobering to learn from WICC staff that some clients had actually been threatened by their therapists when they had pursued complaints to licensure boards.

Grief Work

Each of the group members had experienced a profound loss as a result of sexual exploitation by the previous therapist. In most cases, their therapist had offered the hope that this sexual involvement would help solve their problems. For many, the therapist's sexual advances raised their needs to believe that they indeed were lovable, interesting, and desired. For some, there had been a greater degree of sexual response than in other relationships. Therefore, when the involvement ended, there was not only the loss of hope that therapy would be helpful, but also a loss of enhanced self-esteem and sexual pleasure. In addition, the involvement with the therapist had distracted those clients from establishing and working on satisfying relationships with others. When cut off from their therapists, many realized how isolated they had become.

Because of these losses, grief issues were a common group theme. The clients needed to conclude the old relationship in order to begin a new one with other people. The following case example illustrates one woman's mourning process and how this facilitated a more effective and satisfying relationship with her children:

> Marilyn had been referred for counseling for help with her marital problems. Her husband was an alcoholic. She hoped that her marriage could improve if she obtained information and guidance about problems connected with alcoholism. Her counselor told her that she could be a "better wife, mother, employee, and friend" if she cooperated in some heavy petting with him. She cooperated because she believed him. Accordingly, she became distracted from the problems in her relationship with her husband. When she began to distrust the helpfulness of this approach, questioned the counselor, and finally threatened to speak with others on the staff about their behavior in therapy, he accused her of "playing one of her crazy games."
>
> At first Marilyn appeared to be in an initial stage of mourning. She seemed disbelieving as she described the events surrounding therapy and her subsequent divorce. She wondered if the loss of her marriage was related to the therapy. As she realized the seriousness of her situation she decided to turn to WICC for advocacy services. She wished to make a complaint against the counselor and his agency. Later she decided to file a formal charge of unethical conduct against the counselor and his agency. She also decided to file charges against the counselor with his professional licensing board.
>
> Marilyn decided to join our second group after her first group ended because she was feeling anxious about the upcoming litigation. In this second group, she described feelings of pervasive anxiety and anger. She was tearful as she spoke of feeling responsible for her divorce and her children's loss of their father. She went on to describe her difficulties in setting limits for her teenage children. She related this to her guilt. The group helped Marilyn to express her feelings at her own pace. Gradually she became able to set limits for her children, thereby gaining more control in her relationship with them, which in turn helped her feel more successful.

As part of the grieving, it was as important for group members to talk about their affectionate feelings toward their first therapist as it was to talk about their anger and distrust.

Betrayal by Professionals Associated with the Therapist

All of the women in the groups reported a sense of betrayal by other agency personnel with whom the former therapist was associated and/or betrayal by those who had originally referred them. Several group members wondered why other agency personnel associated with the ex-counselor were not aware of what had gone on and why they had not attempted to stop it. Others who had complained to referring physicians or counselors felt their concerns were discounted. The following is an example:

> Jean was referred to Dr. A. by her female psychotherapist, Ms. N., who believed that a male therapist would be a better choice given Jean's history of incest with her father. Jean expressed her misgivings about this, pointing out that Dr. A. had been placed on probation by the board of examiners two years earlier for improper sexual contact with his patients. She feared that Dr. A. would make sexual advances towards her. Ms. N. reassured Jean that Dr. A. would be helpful to her and that Dr. A. had personally told Ms. N. that he had "once had a problem, but this had resolved itself." When Dr. A. initiated hugging during a therapy session with Jean, she made an appointment with Ms. N. to complain. Ms. N. told Jean, "Dr. A. is the most intrusive therapist I know, but he works miracles." Ms. N. encouraged Jean to return to Dr. A., which

she did. Jean cried as she talked about Ms. N.'s inability to protect her. As a result of therapy in the group, Jean decided to make an appointment with Ms. N. to tell her how she felt about the dismissal of her concerns about Dr. A.

A sense of betrayal by other professionals associated with the therapist can be analogous to the feelings children have about the mother's "not knowing" and not stopping incestuous involvement between father and daughter.

The Group as Mirror for Other Relationships

By examining the group interaction in the "here and now" (Yalom, 1975), clients could see how their difficulties within the group were like those in their families, friendships, and work settings.

The following example illustrates how "here and now" observations helped to highlight conflicts and dilemmas which these group members faced in both past and current relationships:

> Martha spoke elatedly of how much better she was feeling in contrast with last week's meeting when she had shared desperate and suicidal feelings. Her comments in the preceding session had alarmed all the group members. No one believed that she had recovered so quickly, and yet all remained silent. In the subsequent session, Jane expressed anger that the group leaders had not confronted Martha more directly with her unbelievable recovery. She had felt hesitant to express her own disbelief in Martha's sudden change and blamed the group leaders from whom she "took her lead" for her own silence. If they remained mute, so should she. Martha, on the other hand, wondered why no one had challenged her, but instead kept their distance. In fact, she was aware that she had not felt as well as she had claimed.
>
> Jane began to examine her own silence and talked about her family's style of denying serious events. For example, when her sister had returned home from the hospital after a suicide attempt, the parents spoke of her having "had the flu." In her relationship with her former therapist, she had also tried to pretend that his fondling wasn't really happening. The group noted that Jane's feelings and perceptions were accurate and helpful to them. So why should she be reluctant to share them? Jane then shared her "fear of being perceptive" that might lead to abandonment by significant others. She noted that her own family did not like her to be critical or to say what she thought. Awareness of her fear of speaking out resulted in Jane's taking risks to share her perceptions in the group and elsewhere.

Reality-Testing

Jane's example illustrates a dominant theme in all of the groups: a distrust of one's own reality-testing. While most of the women had a sense that "something was wrong" in the relationship with the therapist, they had distrusted their doubts. Some distrusted their decisions not to pursue complaint options available through legal or professional organization channels. A major function of the group, using the "here and now" approach was to encourage sharing of feelings and to support trust in one's feelings and unique judgments.

Guilt

A major need in the groups was to talk about guilt feelings and their responsibility or part in initiating the sexual relationship with their therapist. Several clients had felt attracted to their therapist and believed these feelings had encouraged or caused the sexual involvement. Some had believed that the sexual relationship sidetracked them and the therapist from talking about the problems that they were afraid to face, such as alcohol dependence. Group members asked for help in talking about their guilt feelings, and experienced some relief in knowing that others had felt guilt. A similar sense of guilt and responsibility is experienced by incest victims.

Need for Education

Another major need expressed by all of the group members was to clarify what is appropriate and ethical behavior on the part of counselors and therapists. The leaders were often asked to repeat that it is not appropriate for therapists to act out sexual feelings, even though the therapist as well as the client may have such feelings. It was difficult for these women to comprehend that sexual contact was inappropriate even when invited by the client. Group members referred frequently to an article by Schoener, Milgrom, and Gonsiorek (1983) which spells out the therapists' responsibility, as though needing repeated assurance that it is the therapists' responsibility to set limits for acting on feelings.

Confusion regarding "what is therapy anyway?" was also expressed. Specifically, there was confusion about whether therapy is supposed to be an actual re-enactment of earlier family experience. It was particularly confusing

for the women who had been told by their therapists that the relationship with the therapist would help them "work through" their earlier child-parent relationships. These clients needed to learn that effective therapy cannot literally re-enact earlier relationships, but rather it can clarify and sometimes solve the problems derived through them by expressing in words their important thoughts and feelings. The therapist must provide boundaries so that earlier feelings can be reawakened, identified, and discussed, in order to form more satisfying relationships.

The co-leaders had opportunities to model the use of boundaries within the therapeutic relationship. For example:

> In the final minutes of the last session, Denise spontaneously invited all of the group members to her home for a party, to be held in the near future. All of the group members were interested and pleased by the invitation. The leaders were uncomfortable, feeling that the boundaries of the therapeutic relationship would become blurred in such a social setting.
>
> One of the leaders stated that while she appreciated the invitation, she considered it inappropriate to socialize with clients. She would, however, be pleased to meet with the group members again in the agency should they wish to have another group meeting. The group members were satisfied by this answer and decided to request a follow-up meeting a few months later.

Outcome

As a result of group treatment, clients experienced the following outcomes: relief in having a confidential opportunity to share their experiences with others, relief in discovering some universality in experiences and feelings, benefit from education on how to become an effective mental health services consumer, and the opportunity to mourn. These experiences allowed them to form new and more satisfying relationships. Group members also learned to trust their feelings and use these as tools in relationships with others. Problems for which the clients had originally sought help could once again be addressed. As one client put it, "the problems for which I originally sought help have been 'on hold' all these years. As a result of work in the group, I can now move forward!" This sense of becoming "unstuck" was experienced by nearly all of the participants.

Disposition at Termination of Group Treatment

Many of the group members chose to continue in some kind of group in order to work further on difficulties in forming relationships with others. One member who had been struggling with her sexuality joined an educational discussion group on sexuality. Several felt renewed interest in defining career goals, and arranged to obtain career counseling. One member who had struggled with low self-esteem since childhood, due to a severe learning disability, gained enough confidence to obtain psychological testing and consultation.

Alcohol dependency problems prompted another member to obtain an evaluation and recommendation regarding chemical dependency treatment. Other members continued in A.A. and several joined Al-Anon groups. One woman decided to participate in another group for clients sexually exploited by therapists because her anger toward therapists and anxiety about upcoming litigation became overwhelming. She made effective use of the second group and subsequently felt more in control at work and with family. Several clients were referred back to Walk-In Counseling Center for consultation and support regarding the decision to confront their therapists or to seek legal action.

Conclusions and Recommendations

We have described the development and experiences of seven treatment groups for twenty-seven women who were involved sexually with their twenty-nine psychotherapists. Treatment was offered in addition to advocacy services, provided by WICC, which gave information and assistance in pursuing ethical and licensure complaints.

These brief therapy groups were experienced as a critical stepping-stone in the recovery process of exploited clients. Many of the clients, at the onset of the groups, were angry and distrustful of therapists, and felt cynical about the therapeutic process. The gradual trust-building between leaders and clients, the growing relief from shame and isolation, and the use of clear and respectful boundaries in the group helped to restore members' faith in the possible value of therapy. This corrective experience also helped them to re-identify the problems that had originally led them to seek therapy years before. Many realized that these problems had been "on hold" for years, and became ready to finally move on in their lives.

These clients represent a group which is usually ignored by the professional community. Because of the favorable results with the clients described here, it is recommended that such services be made available elsewhere.

Educational materials which describe appropriate treatment and resources for clients who have concerns about their treatment should be made available to the public as a preventative measure. Also, in the routine course of obtaining past treatment history and understanding the nature of past therapy relationships, psychotherapists can be helpful by being open to material relating to sexual involvement. When a client/patient presents a complaint of sexual intimacies within a therapeutic relationship, psychotherapists can help by listening with respect and believing the client's statements until or unless it becomes absolutely clear that the complaint is unfounded. Therapists need also pay attention to countertransference, which may become an obstacle in listening to the clients' distress about the exploitative relationship. Information regarding options for filing formal complaints should be made available to the client/patient. Referring psychotherapists should seriously consider any complaints brought back to them by a client.

Because of the taboos surrounding sexual intimacies between therapist and client, therapists are frequently hesitant to reveal in supervision their sexual feelings about their patients. All countertransference feelings, including sexual feelings, need to be discussed and worked with as useful tools in the training of the therapist and in the course of supervision.

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Therapeutic Approaches for Clients who have been Sexually Abused by Therapists

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Introduction

Scope and Purpose of This Paper

Clients who have been sexually victimized by therapists have been damaged and come to their next therapist with special fears, concerns, and vulnerabilities. This paper identifies some of the special problems and needs, and the countertransference issues for the therapist who works with them. In each section, approaches to solving these problems are suggested.

The previous article by Luepker and Retsch-Bogart deals more specifically with the early stages of work with a client who discloses sexual abuse by a previous therapist. The present article is focused on the issues it raises for the new therapist. To get a complete picture, the reader is urged to read the articles as a pair.

When a therapist is sexually involved with a client there has been a fundamental distortion of the purpose and dynamics of the therapeutic relationship. The goal of therapy with these clients is to empower them in their lives by providing a place for them to learn empowerment skills, and to experience themselves as trustworthy and active persons on their own behalf. If this is successful, they can apply those skills to other relationships. The therapist must have a clear sense of the boundaries of a professional relationship, the roles and responsibilities of therapist and client, and the appropriate use of power in the therapeutic relationship. More information on these areas is provided in the article on preventative supervision by Thompson, Shapiro, Nielsen, and Peterson in this section of the handbook.

Special Problems Resulting from Previous Victimization

This part of the paper will discuss a number of special problems that clients who have been abused by therapists have when they re-enter therapy. It is important to emphasize that the problems discussed below are a direct result of what these clients have experienced at the hands of an unethical therapist, and not of personal or characterological problems of the client. In addition, these clients bring to subsequent therapists the unresolved problems for which they originally sought therapy. Throughout the therapy, these two sets of issues continue and often intertwine as themes.

Each subsection below will identify a problem, trace its origin in the abusive therapeutic relationship, and suggest some therapeutic approaches to dealing with it.

Client-Victims' Difficulties with Trust in the Therapeutic Relationship

The sexually abusive therapist betrays the essential foundation of the therapeutic relationship: the client's need to trust in order to make changes. The client may have been told by an abusing therapist that his or her problems with trust could be solved by becoming involved in an intimate relationship with the therapist. When faced with a lack of cooperation, an abusive therapist will often instill fear and guilt in the client, telling the client that progress will not be made in therapy unless the client cooperates with what the therapist wants. There may be threats of disclosure to family members or the client's spouse. The sexually exploitative therapist twists the meaning of trust regarding the client-therapist relationship to such an extent that what should be the basis of healing becomes the basis of serious psychological damage.

The result of sexual victimization is that the client has unusually intense ambivalence about therapy. The client needs and wants therapy, but is extremely wary and often suspicious of what will happen if he or she should trust a new therapist. Trust problems are ongoing throughout the course of therapy, often reappearing periodically, and are to be expected with these clients.

* This article was written in the following way: A questionnaire was written by the first author and sent to all the other authors, who individually answered the broad questions it contained. Then an extended meeting was held in which the authors discussed the issues, using as a base their responses to the questions, but also discussing many other areas as they arose. This discussion was organized and written up by the first author in the form of a draft, which was critically reviewed by the other three and revised to produce the present article. This paper specifies where ideas are those of a particular person.

Clients may express their reluctance to trust the new therapist in many different ways — verbal and nonverbal, conscious and unconscious. They may sit huddled up when they first come to therapy. They may not make any eye contact; they may come late or not at all. They may test the therapist by asking for extra time or attention or by cancelling appointments. They may also withhold significant pieces of information for long periods of time. Progress may be followed by regression and distrust. The usual signs of distrust may be exaggerated.

It is crucial for the therapist to expect and accept these repetitive difficulties with trust. At the beginning, it is important to validate the clients' fear of trusting the therapist — to provide assurance that they have no reason to trust a new therapist. The working through of each episode of feelings of fear, rage, guilt, or betrayal is itself much of what is therapeutic.

At times, abused clients will hide their distrust of the new therapist because in the past the abusing therapist has said, "You need to trust me and trust what I'm doing and if you don't, there's something wrong with you!" From this experience, the client has learned that questioning a therapist can result in abuse, further mistrust, and a sense of confusion. By telling the client that immediate trust is not expected, the therapist begins to lay the groundwork for the client to trust and act from an internal sense of judgment about what is helpful.

Given these clients' difficulties with trust, indirect or paradoxical approaches are contraindicated. Such methods may contribute to a sense of confusion about what is really happening in therapy, and they allow for misinterpretation and abuse of power more than other approaches.

Client-Victims' Distorted Understanding of the Nature of the Therapeutic Relationship

In cases of victimization by therapists, many of the boundaries that define a therapeutic relationship have been damaged and/or destroyed. The client-victim is left with a distorted understanding of what should and should not happen in a therapeutic relationship. The appropriate roles of therapist and client have been confused. While each client-therapist relationship is unique, some situations come up frequently, and bear discussion here.

Contracting explicitly with the client about the dimensions of the therapeutic relationship is crucial at the outset, and throughout the course of therapy. This includes clear statements about such issues as physical contact, starting and ending on time, between-session phone calls, extra sessions, and charges for services. In addition, contracting includes telling the client that nothing sexual is going to happen in the relationship, and that the therapist is responsible for insuring that it doesn't.

Another issue relating more subtly to boundaries is the purpose and duration of therapy. Clients who have been victimized by previous therapists have usually been given a message by the therapist that anything the client brings up in therapy becomes a new problem about the client. The client may have been told, for example, that feeling good is a sign that there is something the client is not willing to look at. From this viewpoint, therapy is endless, and life is a therapeutic problem.

The new therapist must help the clients identify their goals and how they will know when they have been reached. In other words, the end of therapy should be built in from the beginning. This message teaches clients the time-limited, task-focused, and goal-directed nature of the therapeutic relationship.

Each of these boundary-setting processes becomes in therapy something that can and probably will be tested as therapy unfolds. The process of making the boundaries clear and then testing them is an essential part of the clients' learning to trust both the therapist and themselves.

Client's Questioning of Own Reality

In most cases of abuse by therapists, clients have had questions about whether what was going on in the therapy was helpful, therapeutic, or morally right. Often when they raise those questions with a therapist-perpetrator they are told that their perceptions are incorrect. Given the authority inherent in the therapist's role, clients are likely to question their own judgment, and whether it is safe to say *no* and set limits with another therapist. Clients must continue to receive the message that the therapist is open to hearing feelings of mistrust and confusion, and wants to support them in learning to trust their own judgment.

In another approach to this issue, Stefanson has suggested that the therapist explore with the client what would have to be true of a therapist who would sexually victimize a client. For example, the therapist might be highly self-centered, naive, lacking in empathy, and/or manipulative. The purpose of such exploration is to

empower the client to trust his or her own judgment by becoming a more astute observer of past and present therapist behavior. This approach might be most helpful later in the course of the therapy, as the client begins to work explicitly on developing and trusting an inner sense of judgment.

In addition, persons who have been abused by previous therapists often have difficulty identifying their feelings. They may have a delayed reaction or be unable to tell the therapist about their reaction to what is happening in therapy. They may feel unable to say no to suggestions from the therapist, or even to say that they are not comfortable with what is being suggested. While it is crucial that the therapist be in charge of the therapy, it is also helpful to ask clients regularly how they are feeling about what the therapist is doing or proposing, and to respect their responses.

Clients with Many Levels of Problems

It is the experience of the authors that many victims of therapist sexual victimization are also victims of some form of childhood abuse — sexual, physical, and/or emotional. Consequently, these individuals are often dealing with layer upon layer of confusion, anger, feelings of betrayal, poor self-esteem, and developmental impasses.

Client-victims may have flashbacks similar to those of incest victims; they may have significant relapses through the course of therapy; they may become very dysfunctional at times. The therapist who works with them must accept and be willing to work with this variable course of therapy. Extreme patience, accompanied by the firm limit-setting and boundaries discussed above, are required of the therapist.

It must be stressed, however, that sexual exploitation can happen to *anyone*. Different individuals are vulnerable to different kinds of therapist abuse and circumstances. The vulnerability of the client that has been exploited by the therapist will always become a focus in the later therapy.

Countertransference Issues for the Therapist

Because these clients have been abused by a previous *therapist*, rather than another person, the new therapist has reactions to the client's victimization from a professional point of view. Working with client-victims inevitably stirs up powerful emotions — including rage, impotence, grief, exhaustion, frustration, guilt, shame, professional embarrassment, fear, uncertainty, anxiety, and paralysis. These countertransference reactions are natural and unavoidable, and must become conscious if they are to be constructive. In working with client victims, therapists face a serious risk of becoming a part of the victimization system, and a stance of relentless self-awareness is necessary to avoid it.

Trying To Be the Perfect Therapist

Therapists who work with client victims often find themselves trying to be the perfect therapist. There can be any of several motivations for this. First, the therapist may want to protect the client from feeling any further pain at the hands of a therapist. While this is basically a compassionate stance, if it is acted out, it actually interferes with the empowerment process that is necessary for the client to recover. The client does not learn to trust by being sheltered, but rather by working through each issue of disappointment and miscommunication as it occurs.

A common struggle of therapists who work with client-victims is the tendency to want to protect the client by not reporting or not encouraging the client to report the abuse. The therapist's fear may be that the client will not continue in therapy, or will be retaliated against by the perpetrator if a report is made. However, the risk of corruptibility on the part of the new therapist is at its height if he or she agrees to collude with the client in keeping the secret about the abuse. Secrecy is one of the core characteristics of the abusive therapeutic relationship. The therapist who joins the client in keeping the secret not only joins the dynamics of the abusive system, but allows it to continue. Doing so is fatal to the therapeutic goal of empowerment of the client.

Another possible motivation for trying to be perfect is to avoid becoming the target of the client's rage at the previous therapist and other victimizers. Since persons who have been victimized by others have the potential for becoming victimizers, the therapist may be fearful and self-protective. However, a crucial part of the healing for victims is working through their rage so that they are no longer controlled by it. One important place they can do this is in a therapeutic relationship. Within the context of a safe, accepting relationship they can repair disappointing or anger-producing situations. The therapist assists in the working through of rage by setting clear limits regarding its expression within the therapeutic relationship. In addition, the therapist works

with the client toward expressing anger respectfully by processing every instance in which the client acts it out in destructive ways. With caring, respectful, and capable processing of such situations by the therapist, they become part of the client's learning and healing in therapy. Without it, the therapist may become part of an abusing system.

Third, the therapist may try to be the perfect therapist to make up to the client for the damage done by the other therapist. In this case, the therapist's primary feeling is guilt. Again, the therapist who acts on these feelings without awareness risks further victimization of the client because of taking responsibility for what the therapist has done and for what the client feels. This is a distortion in the therapist's role and responsibilities. The therapist is responsible only for what happens in the current therapy, not for the client's feelings or the other therapist's behavior.

Fourth, the therapist may be responding to an overt or covert message from the client: "you'd better not hurt me, too!" In this case, the client may be operating from a "good therapist/bad therapist" transference in which the new therapist, by being the good therapist, will undo the bad therapy the therapist-perpetrator has done. The therapist may feel immobilized and confused by this transference. It is crucial that any good therapist/bad therapist dichotomizing in the countertransference be recognized and worked through, rather than acted out, and that the therapist assist the client in repairing this splitting. Benoist suggests that one way to help blur the good/bad dichotomy is to talk with the client about the benefits of the therapy with the perpetrator.

For example, the client may have felt special or cared for by the earlier therapist. Also, there may have been some effective therapy done prior to the victimization. The therapist can help the client see that the previous therapy was neither "all good" nor "all bad!"

Regardless of feelings or motivation, therapists may become perfectionistic about not being perfectionistic! What is needed instead is: (1) awareness on the part of the therapist of paralysis due to unrealistic expectations of avoiding all mistakes; (2) increased self-awareness of feelings and what she/he may be trying to avoid or to accomplish by being perfect; and (3) direct action based on this awareness to remedy the paralysis by changing the therapist's behavior so that it is therapeutically effective. In most cases, the therapist, regardless of experience, will need consultation from others in order to move through this process of clarification and action.

New Therapist's Anger at the Abusing Therapist

Another countertransference issue is the therapist's anger and/or rage at the therapist-perpetrator. While it is a natural reaction to victimization, it must be dealt with responsibly, or it can impede therapy. Anger may be so consuming that it prevents the therapist from giving full attention to what is happening with the client. Also, the client may feel burdened with or responsible for the therapist's feelings. In either case, the lines of responsibility between therapist and client have been blurred.

Various approaches have been taken to deal with the therapist's anger so that the client is not further victimized. For example, some practitioners believe an explicit, non-abusive expression of anger with an explanation of what produces the anger is valuable affirmation and modeling for the client. If this approach is taken, it is important to ask the client how she or he feels about what the therapist has expressed. Such a feedback process allows therapist and client to include angry feelings in the context of a caring relationship. It also gives the therapist information about the client's resiliency which can be used to fine-tune future interventions. Another approach may be taken if the therapist feels so angry that he or she is unable to express the anger within a therapeutic context. In this case it is important to take the time and ask for any consultation needed to work it through. Then it can be brought back to the therapy.

Self-Blame When the Client Relapses or Moves Slowly

Given the challenges that clients who have been victimized by therapists bring to subsequent therapy, the new therapist can expect many setbacks and difficult times. In response, therapists feel at times that they must not be doing a good job — or even more painful, that they are incompetent. They may also feel discouragement, shame, or anger at the client.

Frequent consultation is essential in helping therapists to (1) accept the difficulties in the therapy as part of working with these clients; (2) receive objective feedback about the effectiveness of the therapy; (3) receive ongoing support; and (4) identify alternate approaches to the therapy.

Therapist's Sexual Feelings toward the Client

One of the most disturbing countertransference

reactions for the new therapist of these clients is having sexual thoughts or feelings toward them. It is also a very common experience for therapists. Obviously, to act on such feelings would be to further victimize the client. Even sharing the feelings with abused clients would create the possibility of confusion and mistrust, given their previous experience with a sexually abusive therapist.

Self-awareness and self-responsibility on the part of the therapist are required if sexual feelings are not to obstruct progress in therapy. The therapist must be aware of the feelings, understand their origins, and think through interventions which will make them useful rather than harmful. Consulting others or reading articles in professional journals can be of help. However, at times therapists feel so ashamed of having sexual fantasies or feelings about a client that they are unable to move toward a problem-solving process. In these cases, immediate case consultation is essential.

Resentment of the Client's Needs

A common experience in working with victims of all kinds, and especially with victims of past therapists, is frustration with the number of demands, needs and problems these clients bring to therapy. To some extent, it helps to know in advance that this will be the case, but resentment may still occur. The therapist may still feel burdened, wish the client would not come on a particular day, or dread seeing him or her. In turn, the therapist may feel guilty, ashamed, or lacking in compassion. A possible cause of such feelings is failure to set clear enough limits throughout the therapy and/or to stand by the limits when they are challenged by the client.

Acting out feelings of resentment or discouragement in the therapeutic relationship would put the client at risk of further victimization. Self-awareness on the part of the therapist is the key to successful navigation through these difficult times. The therapist must identify the feelings, uncover how they result from what is happening in the therapy or in the therapist's life, and find options to change the situation. Because these feelings of frustration can be so intense, the therapist will probably need consultation and support from others to continue to deal responsibly with negative feelings.

Special Needs of the Therapist

The therapist who works with victims of other therapists will find this work to be complex, difficult, challenging, and emotionally draining under the best of circumstances. Under less than optimal conditions, therapy may be ineffective or damaging to the client and/or the therapist. Below are some suggestions for optimizing the therapist's well-being and effectiveness.

Ongoing Consultation

The most crucial element in providing successful treatment is the ready availability and frequent use of consultation. In the first few cases of this kind, the therapist may want to make a more formal, one-to-one consultation arrangement with another therapist experienced in working with client victims. In other cases, peer consultation may be what is most appropriate. In either case, the purposes of the consultation are: (1) to avoid impaired judgment due to isolation; (2) to receive the support necessary to stay out of the abusive system that the client has experienced and may still be experiencing; and (3) to receive technical consultation about particular strategies and interventions throughout the course of the therapy. The courage and perceptiveness required to help a client work through sexual victimization by a therapist cannot be overstated; frequent consultation is a must.

Availability of Legal Advice

Second, the therapist must have access to legal advice. Client-victims pose many specialized problems that may involve reporting, confidentiality concerns, court cases, and lawsuits. In particular, the therapist should have access to an attorney who is sophisticated in psychotherapy practice issues and well-versed in the laws relating to them.

Care with Scheduling

Recognizing the unusually demanding nature of work with client victims, therapists should plan their schedules so that they have time between the sessions with each of them. Additional attention must be given to how many of these clients are being seen at any given time, to prevent becoming emotionally drained and ineffective.

Maintenance of Personal Well-Being

One of the common precursors of therapist sexual abuse is the therapist's neglect of his or her own needs. It is common for therapists who work with victims of all kinds to neglect or abuse themselves. To avoid becoming part of the victimizing system, therapists who work with these clients must take special care to maintain a balance between the demands of their work and their own needs. In particular, they must avoid personal and

professional isolation and have rich and satisfying lives outside of work.

Other Concerns in Working with Client Victims

In this section issues will be discussed that arise repeatedly in working with client victims but do not fit neatly under any of the headings above.

Touching Clients

In most helping professions, serious questions are being asked about the role of touch in therapy. Arguments both for and against the therapeutic value of touching clients are advanced vigorously and regularly in both professional writings and discussions. While these discussions are important in forming guidelines for therapist behavior in general, more troubling questions are raised if the client-victim is the subject of discussion.

Client-victims of therapist sexual abuse have been confused and abused by the inappropriate use of physical touching. What may be healing under other circumstances has become damaging. While it may be extreme to rule out touching client-victims at all, the following guidelines can be suggested. First, any touching should be requested by the client rather than initiated by the therapist. The therapist must be clear internally and with the client about what kinds of touching will be permitted in the therapy. Even when the client requests touching, the therapist must respond to any request with respect for her/his own boundaries. Second, the therapist should talk with the client about any request for touch, focusing on its meaning to the client. The meaning of the therapist's touch, if it were given, and the therapist's declining the request, if it were not, should be explored.

Third, the therapist should take responsibility for checking with the client about how any touching that does take place has been experienced and interpreted. Finally, the issue of touching in the therapy should be one that is addressed openly and freely throughout the course of the treatment.

Issues Related to Diagnosis

A significant issue with victims of all kinds, including those who have been exploited by therapists, is that of diagnosis. First, victims of therapist exploitation often appear initially to have a personality disorder, e.g., borderline, histrionic, or avoidant personality disorder, but after some therapy these symptoms may be seen to have been a response to the exploitation rather than a result of preexisting problems. On the other hand, some client-victims may have long-term personality problems, and the result of the victimization may have been to stress their fragile coping resources to the breaking point. It is often difficult to distinguish between these two kinds of clients early in therapy. While there are no simple solutions to these diagnostic problems, it may be suggested that therapists take a longer period of time to make an assessment of client-victims than they might with other clients. In addition, once a diagnosis has been made they should remain open to new information from the client that might suggest that another diagnosis would be more appropriate.

Second, it must be recognized that the diagnosis being used in some way affects both clinicians' choice of treatment approaches and their implicit prognostic assumptions. A diagnosis of a personality disorder suggests a longer course of treatment and a less optimistic prognosis, for example, than a diagnosis of an adjustment disorder. For this reason, it seems important to be as precise as possible in making a diagnosis and to remain open to changing it as the clinical picture changes over time. Therapists might also consider using a diagnostic approach that includes primary and secondary diagnoses, e.g., adjustment disorder and borderline personality, with one primary and the other secondary — where it would be appropriate.

Confidentiality Issues

Working with client victims raises extremely difficult issues around confidentiality. In most cases, there is both a double bind and a moral dilemma for the therapist. The following examples illustrate how complex and troubling they can be.

Because of work with other clients, the new therapist may be aware that the present client is not the only victim of a particular perpetrator. By disclosing that information to the client, he or she is breaching the confidentiality of the other clients and may risk a lawsuit from the perpetrator. If the information is not disclosed, the client may believe he or she is the only victim. It might be helpful therapeutically for the client to know that there were other victims of the same perpetrator. This could break down the illusion that he or she was the "special" one of the abusing therapist or relieve the client of some self-blame.

In another situation, the therapist may consult with colleagues who have clients who see the therapist-perpetrator. Sharing information about victimization may violate ethical standards about confidentiality, or laws about slander or libel. Not disclosing information, however, may allow victimization to occur or continue.

The first requirement of therapists in these situations is to be well-informed about the ethics of their professions and the legal standards that apply in the situation. This allows for responsible assessment of the risks and benefits. Beyond that, therapists must make a moral decision based on their values about the importance of professional ethics, protection of clients, and personal risk. However, therapists must avoid personally judging a therapist-perpetrator by going beyond what is actually known about another therapist's behavior, and unjustly spreading rumor or gossip. Also, identifying information about specific client-victims should not be revealed if the current therapist deems it necessary to share any of the types of information described above.

Concerns About Documentation

Therapists who work with victims of therapist sexual exploitation must face the possibility that they may be required at some point to appear in court or release case records for use in a court proceeding. Since such events are not optional, it can be suggested that those who would not be willing to appear should not work with client-victims.

Given the possibility that records may be requested, it is important that therapists keep careful and complete notes about their work with these clients. In particular, documentation of the initial symptoms and problems of the client is crucial. In some instances, by the time the client's case comes to court, his or her level of functioning may be so much improved that it may be difficult, without documentation of the earlier problems, for the victim to be dealt with fairly. In addition, careful notes should be kept from each session with the client, and all testing data should be included in the file. Such complete records provide the documentation that protect both therapist and client in potential legal proceedings.

Therapist of Same or Other Sex as Perpetrator and/or Client

It is important in working with client victims to confront the issue of the sex of the new therapist *vis-a-vis* the sex of the therapist-perpetrator. On the surface, it may seem simpler than it is. However, the gender of both therapists, their sexual preference, the client's sexual preference, and the heterosexual or homosexual nature of the abusing situation may have a bearing on the client's ability to feel safe and to work toward trusting in therapy. If the client has been sexually abused as a child as well, it will be important to consider whether the abuser was the same sex as the therapist-perpetrator, or the opposite sex.

Whatever the sex of the new therapist, healthy attitudes toward sexual and gender issues are critical. Specifically, the client-victim should not be seen by a therapist who is uncomfortable with or angry at either men or women in general.

Some suggestions may help to guide therapists' thinking around these issues. First, the therapist should gather information from clients on the sexual abuse they have experienced, including whether it was same-sex or opposite-sex, and how the client experienced the sexual involvement. It is important not to make assumptions but to elicit the information from clients. In this conversation, both therapist and client will become clearer about what has been harmful and what would feel most safe.

Second, the therapist should promote open discussion of what the client wants, and why, and encourage the client to share feelings about seeing a new therapist of the same or opposite gender as the perpetrator. The client's wishes about the gender of the new therapist should be respected. If the client has difficulty deciding, the new therapist may want to offer the option of meeting with a colleague of the opposite sex to help clarify feelings at the outset. Though a client may choose to work with a therapist of one gender initially, she/he may want to make a change later in the therapy. In that event, the therapist should help the client to process the meaning of this change and make an appropriate referral, if necessary.

Finally, the new therapist must assess his or her own comfort level about being the same or opposite gender as the therapist-perpetrator and be willing to refer the client if he or she feels unable to work responsibly with the client for any reason. A careful and thorough consideration of all the transference and countertransference issues that would be involved in working with the client should be included in this self-assessment.

Summary

This paper has attempted to outline some of the common challenges encountered in working with victims of therapist sexual abuse. More than other clients, these clients have special difficulties with trust in the therapeutic relationship, including problems in trusting the therapist and trusting their own judgment and perceptions. They have a confused and/or distorted understanding of the roles and responsibilities of therapist and client. They are also more likely than other clients to have many levels of problems.

Countertransference issues which arise in working with client-victims were also discussed, and approaches to them suggested. Therapists may, for many reasons, attempt to be the perfect therapist. They may be angry or rageful at the therapist-perpetrator or blame themselves if the client makes slow progress or relapses. They may be troubled by sexual feelings toward the client or by feelings of resentment.

Some special needs of the therapist were outlined, including ongoing consultation, availability of legal advice, care with scheduling, and maintenance of personal well-being.

Finally, some other concerns in working with these clients were identified: the issues of touch, diagnosis, confidentiality, documentation, and the gender of the new therapist.

It is hoped that this paper will provide a basis for discussion and sharing among professionals who work with victims of therapists.

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Issues in Working with Therapists and Counselors who have Sexually Exploited Clients

Supervision Approaches in Cases of Boundary Violations and Sexual Victimization by Therapists

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Introduction

This article discusses clinical supervision in cases of boundary violations, up to and including sexual exploitation of clients by therapists. It proposes a model of boundary violations based on several assumptions. First, the model assumes that boundary problems are an ongoing part of therapy. Second, boundary problems are seen as being able to progress from less serious to more serious, and supervision is proposed as a way to intervene to stop the progression. Finally, victimization of clients by therapist-perpetrators is seen as being on the same continuum, though at the most harmful end of it, as other boundary violations which are less serious.

A major factor contributing to the problem of client sexual abuse by therapists has been the general reluctance of helping professionals to acknowledge the inherent ethical vulnerabilities in practicing psychotherapy. Conceptualizing therapists as either "good" *or* "bad" reduces boundary problems to an either/or phenomenon; either one violates clients' boundaries, or one doesn't. Thus, "good" therapists may feel they must hide or deny their boundary issues and mistakes so as to avoid being seen as "bad" therapists. Hiding boundary concerns often makes for more severe violations, and may perpetuate victimization of clients. And clients who have been abused may remain confused as to how their therapists, whom they have experienced as "good", could exploit them.

This article stresses the importance of conceptualizing boundary issues as an integral part of the therapeutic and supervisory process. A therapist must be able to recognize and utilize boundary violations to better assist clients in meeting their therapeutic goals. Thus, the whole subject of boundary violations becomes an essential part of any supervision process.

In the first part of this paper, boundary violations are described as being on a continuum. The basic characteristics of boundary violations — double-binds, secrets, crossing of generational lines, and a distorted presumption of ownership — are discussed. The continuum has been broken into five levels, from least to most severe.

In the second part of the paper, supervision of the therapist-perpetrator is specifically addressed, with attention to key practice issues.

The frameworks proposed in this paper are based only on clinical observation and are offered as working models to guide practice and stimulate further observation and discussion in the helping professions.

Characteristics of a Boundary Violation

Delineating a boundary violation requires the extraction of themes. Each situation is unique and complex, and the potential for unproductive detours into detail is strong. Consequently, there are many obstacles to distilling what is significant. In this section, some characteristics that all boundary violations share will be identified.

At its base, a boundary violation is a classic *double-bind.* By definition, a double-bind consists of two sets of messages which, at the same time or at different points in time, contradict each other while they enjoin the receiver of the messages not to notice the incongruity. Usually, the recipient feels paralyzed. There is no way to win. Action does not produce resolution.

Consider the following example:

> Marsha is in a Women's Incest Group. Sally, one of the group leaders, is pregnant and expects to deliver soon. All the members are curious about what it's like to be pregnant. Sally realizes how meaningful it would be for the group to feel the baby kicking and urges the group to feel her stomach.
>
> Marsha is double-bound. To be a "good" group member, she feels obligated to touch Sally's stomach. After all, everyone else sees this as a wonderful opportunity. To do so, however, feels "bad" or "icky" to Marsha. Furthermore, to comment on the invitation and her discomfort

* Some of the ideas in this article originally appeared in an unpublished paper by Marilyn Peterson entitled "Boundary Issues in Psychotherapy".

would ruin the intimate mood in the group. In this situation, there is no action that feels positive and safe.

As is evident in the preceding example, a double-bind constricts people from freely using all of the available options. Hence, a double-bind limits growth.

Also, embedded in every boundary violation is a *secret.* This second distinguishing characteristic contains elements of power and privilege. Who carries the secret? What power is in the content? How can the material be used?

A secret is information that is either withheld or preferentially shared with others. The information belongs to others or is owed to another. In contrast, information that does not belong to others is private. In addition to concealing information, the keeper of a secret is aware that other people don't know, are innocent, and lack information.

One who owns a secret can make important decisions about another person's life. Involvement in a boundary violation often produces *shame and guilt.* These twin appendages of secrets are not linked to content. Rather, secrets inherently conceal. And that which is concealed is dirty, shameful, wrong, or guilt-producing.

Consider the following example:

Valerie, a prominent local writer, has been attending a support group for phobic persons. One of the two leaders has been gathering material for an article, or perhaps even a book, on anxiety reactions and how to treat them. Valerie is discouraged because she has been in the group longer than anyone else. She calls the leader occasionally for some extra encouragement. During their last phone conversation, he suggests that they get together for the purpose of giving her some extra therapeutic help. He also mentions his idea about an article or book and suggests a possible collaboration. Valerie is scared to address openly her discomfort for fear the therapist will feel rejected, get angry, and withhold his assistance.

Valerie now carries the secret of this invitation, while continuing to attend group. She feels "differently" toward the therapist and even more "different" as a group member. Although she has done nothing wrong, she feels shameful and embarrassed.

A third characteristic of a boundary violation is the *crossing of generational lines.* In the therapeutic relationship, the therapist is in the more powerful position by virtue of clinical expertise and responsibility. In its most elementary form, the therapeutic relationship is analogous to a parent-child relationship. The needs of the child/client are primary and define the nature of the interaction. Other professional roles (e.g., teacher, supervisor, advisor, and counselor) involve similar generational boundaries with differential power and responsibility above and below the generational line. In a boundary violation, generational lines may be crossed in two ways:

1. The therapist and client may reverse roles so that the therapist's needs assume priority over the client's; or

2. The therapeutic division between the roles may be ignored so that the therapist and client become peers.

Consider the following example:

Bob has been in counseling for over a year. He has one issue to confront before he is finished. Recently, he received notification that he had used up his insurance benefits. Desperate, he approaches his therapist for assistance. The therapist considers Bob to be extremely responsible and conscientious. He suggests that Bob do some filing and typing for the agency in exchange for his therapy. While the therapist and Bob are still in a therapeutic relationship to one another, Bob's access to the office and to client files makes him a peer with his therapist. Furthermore, it moves him from a peer position to all the other agency clients into a superior position.

In addressing the crossing of generational lines, it is important to distinguish between incest and boundary violations. Incest is one kind of boundary violation. Generational lines are crossed only in one direction: the child is made peer to the adult. The concept of boundary violations allows for the crossing of generational boundaries in any direction. In the previous example, Bob moved from client to peer with his therapist and from peer to superior with the other agency clients.

The impetus to cross generational lines derives from a *belief system about ownership.* This fourth characteristic of boundary violations fuels the entire system. More

specifically, people give themselves permission to "trespass" when they believe they own another. Expressions such as the following are built on a presumption of ownership:

"I know what's best for you";

"I thought you would want to know";

"I know you better than you know yourself";

"You belong to me".

For example:

Millie is a therapist for a residential treatment facility. Several years ago, Millie helped to change some demeaning intake procedures. The impetus for these changes came from the experiences of Betty, a client of another therapist employed by the same facility. Millie meets Betty at a social function, is thrilled to see her and introduces her to friends as a "quasi" client. "We went through all those rough times at that crazy facility together."

Millie and Betty aren't peers. Millie is therapist and Betty is client. Millie's myth that "we went through this together", as well as the belief that advocating for a client implies possession, allows her to violate Betty's boundary as client.

The identified characteristics of boundary violations remain incomplete. As a therapy community, we have only begun this investigation. At present, the known common elements include a double-bind message, a secret which "seals-off" and perpetuates shame and guilt, and the crossing of generational lines in any direction. Added to these is a presumption of ownership that authorizes people to cross generational lines, to deliver and to withhold secrets, and to produce double-binding situations.

A Model of Boundary Violations

The very characteristics of boundary violations make them a difficult subject to verbalize. This is especially true for those violations which do not fall under ethical or legal sanctions. Unfortunately, boundary violations become clearer and easier to identify when they have progressed to the most severe and overt extremes. The following description of levels is offered as a tentative framework to organize and clarify thinking about boundary issues.

The proposed model illustrates therapist-client boundary violations on a continuum, showing the progression in five levels. These levels are not distinct and separate categories. When placed on a continuum, the end of one level is the beginning of the next. In each level, the characteristics described earlier (double-bind, secrets, crossing of generational lines, and question of ownership) are present. It is the degree of severity that may progress.

Not all therapists begin at Level One. Some begin at Level Two or Three due to prior training or their own history of abuse by a therapist. How far a particular therapist moves along the continuum, or how long the process takes is not predictable. However, without supervision it is much more likely that a therapist will remain "stuck" longer in any given boundary problem, or continue to progress along the continuum toward more serious violations. Many therapists never progress from Levels One or Two to more serious levels, while others progress very rapidly.

Level One: Boundary issues may be utilized to improve the therapeutic relationship and to help the client meet goals through positive resolution.

At this level the therapists feel confused or uneasy about some aspect of the therapeutic relationship. They find themselves questioning, evaluating, or even second-guessing themselves. Something is not right, but the therapist is not certain what it is.

Consider the following example:

Mary and her husband had been seeing Nancy for marital counseling. After they were divorced, Mary reentered therapy with Nancy for individual work.

Mary, who had come early for her session, overheard Nancy on the phone talking about her own impending divorce. Mary, totally surprised by this information, continued to listen. Nancy, sounding upset, began to call her husband names to the other person on the line. When Nancy came out of her office fifteen minutes later, Mary pretended she had just come in.

In this situation, the client's boundaries were inadvertently crossed. The client might feel anger about getting information that she really didn't want to have. She might also feel grief because the generational line had been crossed, and the relationship subtly changed as a result.

The depth of this information is appropriate for a peer, not for a client. She would probably also be feeling confusion about the double-bind this puts her in. If she says something to Nancy, Nancy will feel Mary is being too personal and won't want to be her therapist. Mary is quite likely feeling guilt about having continued to listen and about keeping this secret, but is afraid to tell Nancy because she "knows" Nancy will feel embarrassed and angry. Thus, Mary claims ownership in that she knows what's best for Nancy, and in effect emotionally moves Nancy to a subordinate position.

Nancy, who doesn't yet know what has happened, is unsettled after her session with Mary. She is unable to identify what is wrong, but a therapeutic shift seems to have taken place. Both therapist and client in this example had the boundaries of their relationship crossed.

For this situation to continue to be classified in Level One, Nancy would have to recognize that boundaries had been crossed and take steps to redraw them. Even if the client fails to share the information, the therapist can still openly address her own discomfort with the client regarding the therapeutic shift.

One way Nancy can actively address this situation is to notice her own feelings of discomfort and uneasiness. She would then realize a shift had occurred and reflect about what had happened. She could consult with a colleague when she realizes that she and Mary had some parallel issues. Nancy then might choose to discuss her discomfort with the client, open up the process and, regardless of the information she gains from the client, restore appropriate boundaries.

While different therapists use different methods to address boundary issues, one clearly inappropriate response is no response at all. Therapists may choose not to address such situations with clients directly, but they must be aware of their own feelings of discomfort, and have a plan in mind to address the shift in some way if it continues.

Examples of Level One boundary problems include:

- A client asking his or her therapist extremely personal questions and the therapist responding by giving the requested information, rather than by setting appropriate therapeutic boundaries or exploring the meaning of the question to the client;
- A client repeatedly phoning the therapist at home during the night and the therapist failing to set appropriate limits,
- A client attempting to protect and/or nurture the therapist and the therapist allowing it rather than addressing the situation as a therapeutic issue;
- A client verbally abusing the therapist when angry and the therapist failing to set limits about non-abusive expression of anger.

Also included at Level One are those situations in which the therapist realizes that he or she has inadvertently crossed therapeutic boundaries. Examples of these types of situations might include: unknowingly entering into a dual relationship with a client (e.g., the client is in a relationship with a former romantic partner of the therapist) and personal phone calls or conversations in a social situation being overheard by a client. It must be stressed that regardless of how a boundary problem begins, it is the therapist's responsibility to respond appropriately and therapeutically to the situation, not the client's.

At Level One, boundary issues can be effectively utilized to better understand the therapeutic relationship, and to assist the client to improve other relationships through positive boundary restructuring. Level One boundary issues are an ongoing, everyday part of the practice of counseling and psychotherapy. They result from the processes of transference and countertransference, as well as from the interactions of the therapeutic relationship. As such, they have definite therapeutic value when used effectively by the therapist. However, without reflection and action by the therapist, they often progress to Level Two.

Level Two: Boundary issues in effect immobilize the therapist, who is thus unable to utilize them toward therapeutic gain without outside consultation.

As in Level One, therapists feel uneasy and confused, but now they begin to attend to the client in a "special" way. The self-evaluation process has moved to one of obsessing. The second-guessing has progressed to a point where therapists' ability to trust themselves is impaired. In the later stages of this level, therapists lose sight of the client's therapeutic goals.

In the next example, we will follow Nancy and Mary as if there had been no intervention.

Nancy (the therapist) began to dislike her sessions with Mary. She noticed that she felt on guard and was aware of working too hard to please and "fix" Mary. Nancy felt shameful about having worked with Mary and her husband when she had "failed" at her own marriage. She began worrying that Mary and her other clients would learn of her divorce and judge her incompetent to do marital counseling.

Nancy strongly identified with Mary's rage at her ex-husband. She also found she no longer confronted Mary on her hostile behavior in the therapeutic relationship. Due to Nancy's own fears of being found incompetent and her over-identification with Mary, she didn't feel able to explore Mary's hostility towards her husband or herself.

Mary, too, began organizing their relationship around the secret information. She asked in each session how Nancy was doing, and noted how she appeared when she answered Mary's questions regarding her family. Mary's shame increased as she noticed that Nancy appeared to be doing fine when Mary was feeling so miserable about her own divorce.

The original dynamics remain the same, but the boundary violations increase in severity.

Examples of Level Two boundary issues include a therapist:

- "Feeling stuck", unable to make progress in the therapy;
- Having unresolved countertransference issues;
- Failing to attend to a client's crossing of the therapist's boundaries;
- Obsessing about a client; and
- Attending to a client in a "special" way.

Since boundary problems are affecting the therapeutic relationship, effective supervision at this point would be helpful in arresting the progression. Consider the following possible scenario:

In supervision, Nancy talks about her therapeutic relationship with Mary. She receives support to explore the ways in which she is stuck, and the ways she has violated Mary's boundaries. She exposes her fears and becomes able to reframe them. At their next session Nancy opens up the process with Mary and redraws the boundaries by setting limits and giving Mary feedback about her hostile behavior. Mary then can still make a decision for herself regarding her secrets, but Nancy, as the therapist, upholds her responsibility to maintain appropriate boundaries.

The supervisor's job is to assist Nancy to make overt the difficulties which are being experienced, and to add any missing pieces. The supervisor will then follow-up with Nancy after Nancy has met with the client.

Level Three: Boundary violations include behavior on the part of the therapist that is therapeutically harmful to the client.

It is common at this level for therapists to continue feeling confused. The feelings of uneasiness have now progressed to a growing sense of anxiety and alarm. Feelings of shame blanket much of the therapeutic relationship and may have generalized to the therapists' feelings about their competence. Due to these issues and the increased sense of being double-bound, therapists in this level feel even more "stuck" as the need for secrecy increases. The role-confusion intensifies and contributes to therapists' feeling helpless and to some extent "victimized" by the client.

Susan has always felt a special connection with Rob. Even though Rob "came through" chemical dependency treatment (with Susan as his primary counselor), he has never really "seemed" like her client. Now that he is in aftercare, Rob isn't required to schedule appointments with Susan, but continues to schedule weekly. Susan finds their sessions to be a nice break from her other clients, as Rob always seems as interested in her problems and accomplishments as she is in his. Susan knows that in a regular situation these are not appropriate therapeutic boundaries, but Rob isn't "really" a regular client. When Susan thinks about the rules of the agency, and the profession, she feels a sense of panic. She is sure no one will be able to understand the special circumstances of this situation. Susan also feels increasing shame as she is aware of feeling an increasing sexual attraction to Rob.

Susan and Rob have now begun meeting at restaurants for "informal" sessions, even though Susan knows this is strictly against agency rules.

At a staff meeting, the aftercare counselors express concern about Rob's involvement in aftercare. His attendance has been sporadic and he has seemed unwilling to follow the group rules. Staff members suggest a meeting involving Susan, the aftercare counselors, and Rob to present him with both their concerns and consequences if he fails to follow the rules of the program. Susan is able to convince the other staff members to "give Rob another chance" and hold off on the meeting.

Susan realizes that she is in danger of losing her job if Rob tells of their meetings.

In this example, Susan is at Level Three. She now fails to think of Rob's therapeutic needs, and has caused Rob further therapeutic harm by blocking help for him from other sources. Susan is experiencing many double-binds, secrets, and generational boundary violations. She feels a great deal of shame and no longer has a sense of what information belongs where. At this point she is feeling threatened both personally and professionally.

The *double-bind* is as follows: If Susan continues to hold secret meetings or withholds what has been going on, she is going against agency rules. If she stops the meetings, she is in danger of Rob's talking, and hence, of losing her job.

The *secrets* include the overt manifestations of the relationship, but also the covert secret between them, which is that Susan is behaving unethically.

The *generational boundary violations* include all overt and covert manifestations of Susan viewing Rob as a friend, as well as her failing to view Rob as a vulnerable client. They have moved from a therapeutic to a peer relationship.

The *distorted issues of ownership* include Susan's belief that she knows what's best for Rob. He doesn't really need therapy; rather, he needs friendship.

Without intervention, Susan is about to cross the line into Level Four, which is designated for therapist-perpetrators. If Susan were receiving supervision at this point, further progression might be prevented. There would be little that Susan could present to her supervisor or supervision group that wouldn't bring into focus her anxiety and shame. The other staff members would also then address the issues around Susan's seemingly protective behavior.

Level Four: Boundary violations occur in which the therapist overtly exploits the client.

The therapist now has crossed the line of ethical and/or legal standards and become a therapist-perpetrator (supervision of the therapist- perpetrator is covered later in this paper). When therapists have progressed to this level, they have denied, minimized, and rationalized the exploitative behavior and the consequences to the client. Much energy is invested in self-protection. The client is engaged in the process of protecting the therapist as well. The ways therapists protect themselves from exposure at this level are part of the victimization. By this point therapists have crossed so many ethical boundaries that in order to continue these behaviors they must move into Level Five.

To illustrate Level Four we will follow Susan and Rob as if no intervention had occurred.

Susan has convinced Rob that he needs to keep their relationship a secret, although Rob is feeling shameful about breaking his "honesty commitment" in the group. In Susan's estimation, she and Rob are close friends aside from their therapy relationship. She has borrowed money from Rob, but only with a strict repayment schedule, and recently has begun to be sexual with him.

The characteristics of the boundary violations now have become so deeply embedded in Susan's professional life that she may no longer be aware of feeling shame. Susan has convinced herself that she and Rob can be friends, lovers, business partners, *and* have a therapeutic relationship as well.

Rob is being exploited. He trusts Susan's therapeutic decisions, but he feels both confused and flattered that he is special to Susan. He no longer feels like he belongs in his aftercare group, nor does he belong in his AA group as he is now unable to talk about one of the most important events in his sobriety. Rob is also confused because his relationship with Susan "feels" like others that his counselors have labeled incestuous. However, he has no place to clarify his confusion, as he has been sworn to secrecy. Recovery from his chemical addiction is being compromised in order to protect Susan.

Included at this level are any violations of a severe nature. Sexual contact of any kind by the therapist clearly falls into this level. In addition, there are severe violations that are not sexual. Financial ventures with a former or current client are included. Examples of these are borrowing money from a client, making investments or purchasing or selling real estate with a client, or accepting money willed by a client. Accepting political favors, such as job appointments, is also included. In addition, a role reversal in which the client becomes the therapist's therapist is a severe violation.

Level Five: Therapist rationalizes exploitative behavior and organizes his or her life around a delusional system.

When in Level Five, therapists display a massive distortion of reality. They have organized their entire life around the delusion that the exploitative behavior is acceptable and even helpful to the client. This exploitative behavior may be of an emotional, sexual, or financial nature. Therapists at this level may have multiple client victims.

Consider the following example:

> John was considering publishing an article supporting sexual behavior between therapists and their clients. He knew he wouldn't actually do this because it would constitute professional suicide. Yet, John felt frustrated with the therapeutic community for being so unsophisticated and "stuck" in traditionalism. He felt angry about having to expend so much energy hiding what he considered to be appropriate behavior with clients.
>
> John was finding it extremely difficult to continue any of his professional affiliations due to his colleagues' rigid attitudes. That problem was actually extending to his personal affiliations as well.

As is evident in the preceding example, John has become totally immersed in his ethical delusion. It is common in this level for the therapist to change professional affiliation and location of practice to enable the continuation of the abuse.

The Impact of Victimization on Clients

It is important to remind clinicians that the emotional ramifications of boundary violations for clients vary depending on the situation and the client. As Milgrom and Schoener report in their article in this section of the handbook, accurate assumptions as to client responses are impossible.

For one client, a Level Two boundary violation will cause severe emotional discomfort; for another client, the same violation will cause mild discomfort.

The variations in client trauma are important to note for a number of reasons. First, therapists as a profession must address the range of client response to boundary violations that have been labeled "minor" or "unimportant." Some clients report that the emotional violations caused them as much trauma as the sexual violations.

Second, helping professionals must approach clients, not with a standardized set of expectations that they must fit into, but with open minds as to the impact of a particular experience for them. As with a child victimized in a family system, the consequences vary from person to person, even within the same family.

Recognizing and Redrawing the Boundaries through Clinical Supervision

The first part of the section addresses the supervision of therapists and counselors in Levels One, Two, and Three. It is assumed that no sexual contact or other illegal behavior has occurred. The second part of this section addresses the ongoing supervision of offending therapists and counselors in Levels Three (later part), Four, and Five. It is assumed that sexual contact or other illegal behavior has occurred, and that the therapist-perpetrator has received legal or professional consequences.

Recognition of a boundary violation is elusive. The participants feel bound, trapped, and stuck. They can't extricate themselves alone. They can't separate the facts and establish the clarity necessary for resolution. By contrast, the third person, acting in a supervisory capacity, has the objectivity and emotional detachment to extract the relevant information, and to suggest remedial action.

As stated earlier, one of the first signs of a boundary violation is the high degree of obsession experienced by the therapist. The quality of the obsessing is analogous to hunting for a missing puzzle piece — the therapist continues to re-examine the same places hoping for "a fit."

Consider the following example:

A therapist has a client who wants to bring his mother into counseling. When the family session is scheduled, the therapist realizes that he has had a previous association with the client's mother. He recalls that, as fellow students, they had in fact discussed her marital problems. Nonetheless, he proceeds with the session. The therapist is uncomfortable working with the client and his mother. Even though he acknowledges the prior association, he continues to feel bound and confused.

In sharp contrast to the supervisee's fixation, the supervisory group easily reacts to the incongruences. The members of the group, alarmed by the situation and the current or potential consequences, spell out the conflicting agendas. They act as a Greek chorus, as a "supra-conscience" that encourages the supervisee's response to thoughts and feelings often banished from the mind.

The supervisee is then able to progress toward a second level of awareness. A boundary has been violated, secrets have been kept, generation lines have been broken, and people have taken liberties with one another. This recognition produces the pain inherent in a violation. Experiencing the feelings of hurt, anger, disappointment, and betrayal for oneself and others expands awareness, assigns appropriate ownership, and allows the formulation of an action plan.

Articulating the violation lifts the lid on a third layer of awareness that blocks the supervisee's movement. This stratum contains both professional expectations, and shame about inadequacy and failure that blind the supervisee to his or her own rights and responsibilities.

The professional expectations include prescriptions from graduate school, for example:

- "The client's needs come first" does not allow therapists to access realistically their own limitations. In the example, the supervisee does not allow himself to say NO to a family session with the client's mother; and
- "Maintain objectivity" does not allow the supervisee to experience the emotions necessary for boundary violation recognition.

The shame about inadequacy and failure is expressed in the following beliefs:

- "If I were competent, this wouldn't be happening";
- "I'm not good at setting limits";
- "I should have seen it coming";
- "I should be able to do therapy even with these boundary dilemmas"; and
- "This isn't happening to any of the rest of you (supervision group), so I must be the one who's crazy."

Expressing the internalized rules and personal humiliation exposes the professional dilemmas and invites corrective input from the supervision group or supervisor. Priorities are reset, and the supervisee is freed to take appropriate action to redraw the boundaries.

The reliance on ethics to guide and inform decisions and behaviors is paramount. Ethics direct supervisees to logically, rationally, and critically make moral decisions in their practices, based on an underlying philosophy that is consistent with their beliefs and congruent with societal, institutional, and professional policies. Ethics of conscience and ethics of social responsibility become guideposts, both for exploring boundary violations, and for a reckoning process which corrects the ethical violation.

Customarily, the exploration of a boundary violation (as previously described) suggests the necessary corrective plan. Its specifications are determined by ethical considerations (standards of conduct in relation to others) and by the context of each situation. In the next section we will turn from supervisory interventions to a consideration of the risks and vulnerabilities of various practice settings in relation to boundary violations.

Special Vulnerabilities in Therapeutic Settings

The therapeutic environment requires attention in this discussion of supervision. Each treatment or therapeutic setting has inherent boundary problems which must be considered in providing supervision. For example, private practice often has fewer formalized and structured

methods of overt accountability than does agency practice. Court-ordered clients may be less likely to question staff behavior than would more autonomous clients whose future is less dependent on staff opinion and report. Therapists, supervisors, and administrators must honestly assess their own particular setting to be better able to prevent and/or address boundary violations. The following is a discussion of five types of therapeutic situations and a tentative assessment of the particular boundary vulnerabilities each presents.

Agency, Out-Patient Services

The structure of an agency presents some specific vulnerabilities to boundary violations. Almost every counselor or therapist who has worked within an agency structure has felt torn from time to time between what is required by the agency and what is best for the client. Every system pressures its members to conform to a certain philosophy and set of procedures. Some of these expectations may interfere with maintaining appropriate boundaries with clients. For example, staff members may be told to keep census up at all costs. Such a practice may result in exhaustion or burnout, which makes therapists more vulnerable to boundary violations. Or they may be expected to "fix" clients regardless of the situation. Such an expectation blurs the appropriate role responsibilities of therapist and client.

Agencies may not provide adequate clinical supervision and may not allow staff to obtain outside supervision. When this is the case, there are usually no vehicles to express concern about oneself or other staff members who may be acting unethically toward clients. If the system is dysfunctional, staff are usually rendered impotent to effect any change.

An agency may also have a policy of not releasing any negative information on ex-staff (even if the staff person was fired) due to concern about lawsuits from the exposed former staff member. A staff person fired for unethical practice, or one forced to resign, can then be rehired elsewhere with little chance of exposure of past behavior. Preventive strategies to deal with this particular problem have been suggested in the first article in the Administrative Issues section of this handbook. In addition, a recently passed Minnesota civil statute requires disclosure under some circumstances. (See Appendix A.)

Residential or In-Patient Hospital

A situation in which clients live in the therapeutic setting presents an additional set of circumstances which render staff and clients more vulnerable to boundary problems. The clients themselves are more vulnerable due to their live-in status. The staff have more intimate and often more intense contact with the clients.

During evening and night hours clients have a great deal of contact with minimally-trained staff such as drug unit assistants, psychiatric technicians, and overnight house-parents. Evening staff also tend to have the least clinical, administrative, or informal supervision. Working evening and night hours makes it difficult for staff members to maintain other areas of their lives to meet their own emotional, sexual, and professional needs. This may put their clients at an even greater risk of "role confusion" boundary violations. In-patient units and residential programs can also become "closed systems" due to physical isolation.

Private Practice

The very nature of private practice may include more privacy than do other settings. Professionals who are not part of a structured peer supervision network or do not have supervision are truly isolated. Some private practitioners may not even have access to informal peer consultation. Since most private practice therapists are not legally or professionally required to have supervision, no one other than the therapist and the client may have access to the therapy in any way. There is less required accountability to other professionals and much less exposure of cases. As professionals run their own practices, they have a great deal of freedom to make their own rules. This allows more room for personal boundary issues to become professional violations.

The income of private practice professionals is often based on direct service client hours. If therapists' or counselors' sole income is from direct client service, a number of risks arise. At any given time they may base client selection or termination on their own financial status, rather than on strictly therapeutic considerations. Or they may fail to take vacation time, sick days, or holidays. They may also feel financial pressure to see more clients than they can treat effectively, putting both themselves and their clients at risk.

"Alternative" Programs and Philosophies: In-Patient, Out-Patient, or Private Practice

This category could be applied to any setting where the philosophical position is in its developmental phase. Such settings usually incorporate philosophies that depart from a traditional knowledge base and often call the traditional framework into question. The early theory and practice of feminist therapy, chemical

dependency, family therapy, and battered women's movement and shelters all fall into this category. Each year an increasing number of organizations is created with these kinds of frameworks and the special vulnerabilities that accompany them. Building an organization is an exciting event calling for a vast amount of energy, passion, and commitment. However, there are also special vulnerabilities.

For example, when the field of chemical dependency was created, practitioners were trying to develop a new model of treatment to address the problems of addiction. They were scorned by the therapeutic community, partially for departing from and attacking traditional theories and methods. Practitioners were also labeled as unprofessional due to their lack of academic training. During this developmental phase, certain practices were sanctioned that are now being recognized as unethical. Abusive confrontation was used as a means of "breaking through denial." Clients and counselors alike were trained to verbally attack a group member who was unwilling to display emotions in the "correct" format. Counselors were often former clients whose major training was their own addiction and recovery. Clients were then expected to make role shifts that were unhealthy for them to make (e.g., becoming co-therapists with persons who were originally their personal therapists). Much of the role confusion present in chemically dependent families was also present in chemical dependency treatment programs. Nevertheless, this field was also responsible for developing an important theoretical base and a number of highly effective treatment models.

Another example can be found in some of the early family therapists who turned away from traditional individual psychotherapy and developed the concept of "the family system." In doing so, they were ostracized from the traditional therapy community. In almost every alternative philosophical movement, there is a closing of the system from within in response to its own philosophy and to pressures from the outside.

Clients and therapists in alternative programs often find themselves sharing the same ideology which usually includes addressing problems of the entire society or problems that traditional programs have either ignored or dealt with inadequately. This may help to create an "us versus them" stance. This stance can narrow the organization or therapist to the point where they can perceive no other agency or therapist as competent. This stance impairs both clients and therapists because they are unable to trust any other professionals.

In these situations there are few role models or "blueprints" for practice. Programming and ideology are always changing. Staff often feel a lack of accountability to other professionals or standards of ethical behavior because they are the "only real experts". Often the staff's passion and commitment to a particular ideology are the only requirements for hiring. Therapists and counselors are then left feeling inadequate and overwhelmed, due to a general lack of knowledge and training. The program's very philosophy may invite boundary violations. Viewing clients as equal in power to therapists is one example of this. It isolates the staff and fosters incestuousness. In this situation, loyalty to a given ideology may supersede loyalty to one's clients.

Practice in Small Communities

There are special boundary vulnerabilities for those who practice in small communities. For example, gay and lesbian, Black, Native American, Hispanic, disabled, and feminist therapists practice in a relatively small "community within a community." Those who practice in rural or small-town settings are faced with similar boundary problems.

The boundary problems under these circumstances result from the many kinds of contact that occur outside the immediate therapeutic setting. In small towns, the client may also be the therapist's grocer or pharmacist. Clients' children often go to the same schools as the therapists' children. Often clients have access to personal information about the therapist just by living in the same area. In minority groups, there may be social contacts between therapists and clients, as well as common involvement in political activities on behalf of the group. Clients may be acquainted socially with therapists' spouses, partners, children, or other relatives, or may have previously seen their therapists' friends for therapy.

These contacts violate the ethical standards regarding dual relationships between therapist and client, and make it difficult to protect clients from information about therapists that may complicate their therapy. They also make it difficult for therapists to maintain a social network that is not somehow client-related. Clients may feel as a result that the privacy of their therapy is compromised. Therapists may be unable to meet their own needs outside of therapy without compromising ethical standards. At the very least, this kind of practice setting requires ongoing, rigorous attention to boundary concerns on the part of therapists and supervisors.

As in some of the practice settings outlined above, there are no simple answers to the boundary issues raised by practicing in a small community. The keys to ethical practice and the prevention of client victimization, however, are awareness of the implications of any given practice setting and willingness to confront responsibly any boundary problems they present.

Supervision is an essential part of the ongoing process of clarifying boundaries and setting appropriate limits with clients. It also assists therapists and counselors to fulfill commitments to confront and/or to report unethical behavior by colleagues within the same community as well as outside of it.

Supervision of the Therapist-Perpetrator

Supervision of the therapist-perpetrator (latter part of Level Three and Levels Four and Five) must be distinctly different in some ways from the supervision of therapists in the preceding levels. A sexual violation or other illegal behavior has occurred, legal and/or professional sanctions have been implemented, and an independent assessment as to the clinician's ability to resume practice has been completed. It is important to restate that sexual transgressions come at the end of a long line of client boundary violations. The lack of effective clinical supervision increases the likelihood of more serious infractions.

Special Requirements of the Supervisor

Supervision of a therapist-perpetrator is a complicated and emotionally taxing process. Supervisors need clarity of purpose that allows them to remain focused in light of pressures to compromise their position. The temptation to minimize the seriousness of the victimization is powerful. The implicit cultural support of perpetrators is strong, and the response by the perpetrator, and frequently by the profession, may be, "Why are you making such a big deal out of this?"

Given these conditions, the supervisor must seek ongoing consultation. Support which alleviates the supervisor's isolation and sharpens the supervisor's clarity reduces the temptation to overlook what is important. In that it is conceivable that the supervisor is a perpetrator, the use of a supervision group or supervisory consultant allows a forum for addressing violations. The supervisor's willingness to confront and challenge unethical behavior rests on a commitment to the clients' welfare and to the principles that guide professional conduct.

At times, the supervisor has to use methods with the therapist-perpetrator that contradict professional training. For example, the supervisor has probably been taught to be accepting, and to help the supervisee learn from mistakes. When a sexual violation has occurred, the supervisor must instead state in definitive terms that what has happened is ethically wrong, harmful to clients, and should not have happened.

The supervisor has also probably been taught to follow the timing of clients. When a sexual violation has occurred, the supervisor instead must become highly directive, often asking the therapist-perpetrator to engage in high-risk behaviors long before the therapist-perpetrator is "ready." For example, the supervisor may insist that the perpetrator make a report to a licensing or protective agency immediately, and it is unlikely that he or she would feel "ready" to do so.

Finally, the supervisor has usually been taught to bring clients out of a crisis, and to help them feel better. When a sexual violation has occurred, the supervisor instead may need to provoke and encourage the crisis. Feeling bad can become a motivator for action. The supervisor's ability to remain focused and to apply non-traditional methods will model the courage necessary for the therapist-perpetrator to confront his or her own victimizing behavior.

Assessment by the Supervisor

The supervisor must determine whether she or he is willing to supervise the individual. This is in addition to the assessment, performed by someone other than the supervisor, to determine whether the therapist-perpetrator can resume practice (see the article in this section of the handbook on assessment of therapist-perpetrators). This decision should grow out of a review of all of the potential supervisees' cases, which identifies the critical practice issues, and evaluates the therapist's openness to learning. The question to be answered in the assessment is how feasible it will be to supervise this individual therapist-perpetrator.

As a first step in this assessment process, the supervisor should review the entire caseload with the therapist-perpetrator, including all current clients, and possibly also including former clients. This procedure will allow the supervisor to discover patterns of client and therapist vulnerability, to discern attitudes and beliefs that permit transgressions to occur, and to

determine the advisability of the therapist-perpetrator's continued practice. As enumerated earlier in this paper, it is important to assess the following: the possible exploitation of other clients, the degree of distortion in the therapist-perpetrator's thinking, and the degree to which denial and rationalization prevent exploration of the therapist-perpetrator's problems.

Detailed questioning of the therapist-perpetrator regarding the caseload should involve far more than a cursory review. For each case, the supervisor must ask the therapist-perpetrator a number of questions:

- "Why is this client coming to you?"
- "What are this client's specific goals?"
- "What have you been doing in your therapy or counseling sessions toward those goals?"
- "Describe your relationship in detail."
- "How do you feel about this client?"
- "How do you think the client feels toward you and how do you know that?"
- "How long have you been seeing this client?"
- "What happens between sessions?"

Besides simply posing these and many other questions to obtain an in-depth picture of the therapist-perpetrator's caseload, the supervisor must pay special attention to how the therapist-perpetrator responds to the questions. How concerned is the therapist-perpetrator? How does he or she explain behavior with clients? How does the therapist-perpetrator present himself or herself to the supervisor?

By reviewing the caseload thoroughly with these questions as a framework, the supervisor can create a picture of the practice issues that may have resulted in the victimization of clients. In the next section, some common issues are discussed.

Identification of Practice Issues

The supervision of a therapist-perpetrator requires attention to particular issues. Case review must include a thorough description of the relationship between the therapist and his or her clients, in order to ascertain thematic patterns. The themes discussed below commonly arise in supervising therapist-perpetrators. Addressing them in supervision will help to prevent the recurrence of serious boundary violations. The list reflects, in more specific terms, the content and themes already discussed in the article on preventive supervision included in this section of the handbook.

First, the therapist-perpetrator who misunderstands the appropriate role for a therapist often allows confusion as to who is in charge or who has the power. Frequently, the therapist-perpetrator feels helpless in relation to the client. Unable to say "no" to unusual or inordinate demands, intimidated by the client's behavior, bewildered as to the client's needs, the therapist-perpetrator does not feel in charge of the therapy, and therefore reverses roles with clients. The therapist ends up feeling victimized by the client, while behaving as the abuser.

Second, the therapist-perpetrator who practices in isolation from colleagues is removed from a natural check and balance system. Divorced from feedback that corrects distortions, the intensity and intimacy inherent in the therapeutic relationship are magnified, and realistic perceptions are impaired. Another instance of isolation occurs when work becomes the source of all his or her need satisfaction. The refusal to depend on others outside of the therapeutic process for meeting emotional requirements pivots both the therapist and his/her clients into vulnerable positions.

Third, the therapist-perpetrator's misuse of power is particularly evident in the theme of grandiosity, reflected, for example, in the following:

- "I have the answer for you";
- "I am the only one who can help you"; or
- "No one else is capable of understanding our work together or our relationship."

Such mistaken beliefs place the therapist in an unchallengeable position of inappropriate power over the client.

Fourth, the supervisor must be alert to the therapist-perpetrator's tendency to idealize particular client situations, to fantasize rescue operations, or to be mystified by what they perceive as the client's "evilness," "manipulations," "attractiveness," or "psychopathology." These distortions must be challenged and corrected.

Creating an aura that a client is special draws the therapist-perpetrator into gross misperceptions of reality. More important, it invites the therapist-perpetrator to misappropriate power so that the client is perceived as omnipotent, while the therapist's potency is diminished. The therapist-perpetrator's profile for seduction may be related to the financial, emotional, intellectual, spiritual, physical, and/or sexual attributes of the client, the client's situation, or the client-therapist relationship. The supervisor must challenge the distortions and the therapist-perpetrator's professed helplessness relative to the client's strength.

Fifth, the supervisor must be particularly watchful for instances in which therapist-perpetrators may make their own rules. Any sign of a belief on the part of a therapist-perpetrator that he or she has the right to a separate set of procedures, developed and maintained independent of others, should serve as a valuable learning sign. The supervisor must challenge the therapist-perpetrator regarding the client's goals, the therapist's ethical stance, and how the intended direction of therapy allows for meeting the client's goals. The question "if what you want for the client is empowerment, then how will doing it this way get you there?" calls on the therapist-perpetrator to examine the situation. Such a question keeps the issues focused and allows the supervisor to avoid a power struggle with the therapist-perpetrator. If the therapist-perpetrator persistently reacts with anger when challenged, then the supervisor must reconsider seriously the initial decision regarding the individual's potential for rehabilitation.

Finally, the supervisor should attend to that part of the therapist-perpetrator's history, which may have modeled boundary violations as appropriate. A review of the therapist-perpetrator's personal therapy, supervisory and employment history, and student-teacher or clergy relationships often reveals instances of exploitation that influence the therapist-perpetrator's behavior toward clients or others in subordinate positions.

While this list of possible practice issues is not meant to be exhaustive, it does illustrate some of the common misunderstandings of such critical concepts that therapist-perpetrators may have, such as boundaries, roles, and power in psychotherapy.

Identification of Interventions

Having decided to provide ongoing supervision, a supervisor assumes multiple responsibilities. Supervision must include the redrawing of boundaries in all applicable client situations. As in Levels One, Two, and Three, attention to ethical considerations should be continuous. In addition, the supervisor must attend carefully to the therapist-perpetrator's language and nonverbal expressions as indicators of potential danger. The supervisor must continually assess the potential for new violations. In tandem with such judgments, the therapist-perpetrator must be encouraged to share all material that allows for correction and new knowledge. The supervisor must be prepared to take other actions that may be necessary — e.g., transferring a client to another therapist, reporting to a superior in the therapist-perpetrator's work hierarchy, or to an ethics review panel (the client's name should not be included in such reports unless he or she has given written permission). This model allows the therapist-perpetrator to experience limit-setting as creating a safety net, rather than as producing punishment.

Group Supervision

It is our belief and experience that the kind of supervision described above works best in a group setting. The supervision group requires a strong and experienced supervisor who is comfortable with assuming leadership, directing the group focus, asserting ethical stances, and providing the safety necessary for supervisees to take risks with one another.

In this environment, the therapist-perpetrator receives support to address all the critical issues in the client victimization, as well as in the areas listed above. Help for the therapist-perpetrator, in terms of holding him or her accountable, is shared by the group. Group members can confront and challenge as peers and they can reward change with respect and admiration. The supervisor and the group learn how and where the therapist-perpetrator is vulnerable to becoming exploitative of clients. Consequently, what one pair of eyes misses, another catches, and the group can frequently anticipate the implications of a client situation, and move to warn the therapist-perpetrator of the dangers ahead.

The group experience not only provides therapist-perpetrators with a "supervisory community" to help them practice in a professionally responsible manner, but also assists the supervisor significantly in avoiding being inadvertently drawn into the exploitative system.

Group supervision can produce two major results.

First, the amount and quality of attention may mitigate the shame which therapist-perpetrators frequently experience. The group gives a consistent message: "We hold you accountable for your actions, but you don't have to do the changing alone!' Second, therapist-perpetrators often become phobic about their new-found areas of vulnerability. The group can temporarily "parent" or perform the role of conscience until the therapist-perpetrator can internalize new standards. In some situations, the group process can be enhanced by the therapist-perpetrator's involvement in individual supervision as well.

Individual Supervision

Individual supervision can induce a similar process to what has been described in group supervision. The individual supervisor confronts and challenges, assisting the therapist-perpetrator to explore the implications of his or her therapeutic directions. The supervisor consciously provokes anxiety as a means to motivate the therapist-perpetrator to use help appropriately. The supervisor uses the supervisory relationship itself as a model for new or corrective learning.

Just as therapists are vulnerable when isolated, so supervisors need checks and balances on their perceptions and direction. If group supervision is not available to the supervisors, they should establish either a consultation group, or individual supervision, in order to guard against their own corruptibility. Such resources also provide critical support to enable the supervisor to take stands, to challenge and confront, and to keep clear on ethical concerns and dilemmas. The practice of ethics that must permeate all levels of supervision, and the provisions of therapy services, must involve the modeling of openness, the permission to receive ongoing help, the freedom not to have all the answers, and the support to voice doubts and fears.

Conclusion

This paper has presented a five-level model of boundary problems, ranging from everyday therapeutic challenges involving limit-setting and transference, to outright sexual abuse by therapists. The characteristics of a boundary violation were identified, and included double-binds, secrecy, shame, and guilt, the crossing of generational lines, and presumption of ownership. The use of clinical supervision to correct boundary problems was discussed. Special boundary problems in various treatment settings were also identified.

In addressing the supervision of the therapist-perpetrator, the special requirements of the supervisor were discussed. In addition, a series of steps in supervision were suggested, including assessment, identification of practice issues, and identification of possible interventions.

It is our belief that supervision is an essential part of treatment for therapist-perpetrators who show promise for rehabilitation. In addition, supervision must be promoted as a necessary component of responsible practice, rather than regarded as punishment, or limited to graduate school training. The courage required of supervisors to take necessary stands should be buttressed and supported by agencies and professional groups, as well as licensing bodies. In this way, all clients stand the best chance of being helped, and the least chance of being sexually exploited.

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Working with Therapist-Perpetrators: An Introduction

Therapeutic Issues Work Group of the Minnesota Task Force on Sexual Exploitation by Counselors and Therapists*

Levels of Assessment

With greater awareness of sexual exploitation by therapists on the part of legal and administrative agencies, various procedures have been developed to deal with the legal and administrative issues raised by a variety of new laws and regulations. The result has been an often confusing and inconsistent process of dealing with therapist-perpetrators. This section outlines a conceptualization that could clarify some of the dilemmas involved, and allow for more effective protection of the public. It must be noted that not all experts in the field agree with this conceptualization, and it is offered tentatively as a working model.

For purposes of discussion, the therapist-perpetrator who is licensed (or in some cases, registered) may be thought of as being assessed in three different ways. In general, the evaluations will take place in the order described below. They can be differentiated and described as follows:

1. *Legal and Administrative Review*

   First, therapist-perpetrators will come to the attention of licensing boards. They may also be subject to actions of criminal and/or civil legal authorities if charges or suits are filed against them under new laws such as those in Minnesota. The purpose of assessment at this point is to determine whether any legal or administrative action will be taken against the therapist-perpetrators by those in authority. The evaluators at this stage are the responsible persons in the respective groups (e.g., the Attorney General's Office or the Board of Psychology). The main concern, at this level, is punishment or consequences for unacceptable behavior.

2. *Clinical Evaluation Regarding Continuation or Termination of Practice*

   This evaluation becomes necessary if legal charges are filed or action is taken by professional bodies. The purpose of assessment here is to determine whether or not the individual can be rehabilitated to the point of being able to resume the practice of psychotherapy. The evaluation is performed by a psychotherapist with assessment skills. The client is the therapist-perpetrator, who is usually requesting the evaluation. An analogous process, and one with which readers may be more familiar, is used in employee assistance programs.

   The employer is asking an outside professional to give an opinion as to how and to what extent the employee's work-related problems can be solved. While the client is the employee, the recommendations of the evaluator may be used by the employer in making decisions.

   Assessing professionals should obtain written releases at the beginning of the evaluation for the following purposes: (1) to permit contacting of appropriate professional boards, ethics committees, and/or enforcement bodies (e.g., Child or Adult Protection Services) in cases where evaluators believe the therapist-perpetrator's clients may be at risk of further exploitation; (2) to respond to requests for information from regulatory bodies such as those mentioned above; and (3) to provide an evaluation summary and recommendations to appropriate licensing bodies. In addition, the client should be informed of the evaluator's mandated reporting responsibilities at the beginning of the assessment process.

3. *Clinical Assessment For Possible Therapy and/or Supervision*

   If it is determined in the second level of assessment that the therapist-perpetrator can be rehabilitated, certain conditions will be probably be attached to reinstatement. Often they include supervision and psychotherapy. The purpose of supervision is accountability; that of therapy is healing. If the therapist-perpetrator accepts the conditions set for resumed practice, a third level of assessment will take place. The purpose of this evaluation is to allow the therapist or supervisor to determine whether he or she can provide effective services in terms of rehabilitation. In this case, the therapist-perpetrator is the client. The therapist or supervisor retains the

* Members of this work group are listed in the beginning of this handbook.

freedom, of course, to disagree with the previous assessment. In such cases, he or she may choose either to discuss this with the licensing body or employing agency, or decide not to work with the individual.

The supervisor or therapist of the therapist-perpetrator must get releases from the therapist-perpetrator at the outset to permit immediate reporting to licensing boards in cases where he or she believes the therapist-perpetrator may be engaging in exploitative or potentially exploitative behavior with clients.

Because sexual exploitation involves a poor understanding of interpersonal and role boundaries on the part of the perpetrator, it is important that professionals working with therapist-perpetrators be conscious and consistent in their awareness of who their client is, and to whom they have loyalties. In addition, they must always be working toward the particular goal of the kind of assessment they have been hired to do.

Acting as the assessing professional in regard to continued practice is, in most cases, inconsistent with later becoming the therapist-perpetrator's psychotherapist or supervisor. Persons filling both roles for the same individual will inevitably have divided loyalties. As evaluators, they are charged to determine the future of the therapist-perpetrator as a psychotherapist. They must be objective, probing, and thorough in their data-gathering. Their ultimate responsibility is to protect the public from exploitation. If they believe or hope that the therapist-perpetrator will eventually become their client or supervisee, they run the risk of being less rigorous in their questioning. In addition, they may have already begun to assume that he or she can be rehabilitated. For these reasons, it is strongly recommended that the levels of evaluation mentioned above be kept separate, and done by different individuals in sequence. Under unusual circumstances, such as in small town or rural practice, the same person may have to serve in more than one role. In such cases, there should be ongoing clarification to the client regarding what role is being performed at any given time.

To avoid role conflict, it is also suggested that professionals wait for the decision about continued practice before they accept therapist-perpetrators for therapy or supervision aimed at rehabilitation.

The process of assessment suggested here allows a clear separation of punishment from rehabilitation. The purpose of punishment is to give consequences for unacceptable behavior and to set an example for other professionals; the purpose of rehabilitation, where it is possible, is to enable the professional to resume the practice of psychotherapy. Where possible, assessing professionals should avoid becoming involved in decisions that involve punishment and provide input only as to whether or not practice can be resumed, and whether they themselves can provide effective services.

Unlicensed Therapist-Perpetrators

In most states, many therapist-perpetrators are neither licensed nor affiliated with professional groups. Some are not credentialed at all. When this is the case, the second level of evaluation identified above cannot take place. In states without criminal or civil statutes prohibiting sexual exploitation by therapists, the first level may also be impossible.

In these cases, the therapist-perpetrator often comes to a mental health professional for therapy or supervision because of crises that are a result of the victimization. For example, the therapist-perpetrator's spouse may have learned of the sexual relationship with a client and be threatening divorce. Or the victim may have told someone of the relationship and the therapist-perpetrator may be the object of criticism, threats, or emotional blackmail in the community. It is important that professionals in these situations follow a systematic process which has as its first priority stopping the exploitation of clients.

The first step in such a process is to gather extensive information on the victimization and on the individual's professional status to be sure that there is no authority to whom the therapist-perpetrator may be reported. Releases permitting reporting should be secured immediately by the treating therapist, and should be a condition of treatment. If there is a possibility of reporting, it should be done immediately. If not, the professional should insist that the therapist-perpetrator's practice of psychotherapy be suspended until a complete evaluation can be made. This procedure protects other vulnerable clients, and allows the distance necessary to investigate the situation thoroughly. The process of persuading the unlicensed therapist-perpetrator to suspend practice is a very delicate one since there is no authority to call upon, should the individual refuse. The therapist must affirm the therapist-perpetrator's courage

in disclosing the information, while making it clear that the individual must begin to assume responsibility for his or her behavior.

The assessment professional in these cases has the same problem as the person initially contacted: there are no consequences to the therapist-perpetrator for disregarding the recommendations of the evaluator. If the assessment professional decides that the therapist-perpetrator should not resume practice, he or she has a responsibility to assist the individual to leave the field. Where possible, the assessment professional must not abandon the therapist-perpetrator, because to do so would leave the therapist- perpetrator alone to accept his or her limitations, and to define leaving the counseling field as a responsible choice, to avoid damaging clients. The area of vocational counseling is discussed in more detail in the paper on assessment by Thompson in this section of the handbook.

If the assessment professional's recommendation is that the therapist-perpetrator can work toward resumed practice, it is preferable that the individual be referred to others for therapy and/or supervision. Extensive discussion of these areas can be found in the following four articles.

Skills Required to Work with Therapist-Perpetrators

Working with therapist-perpetrators is difficult. At the same time that they are building relationships with therapist-perpetrators, evaluators, therapists, and supervisors may find themselves having strong negative reactions to the exploitative behavior. Because of the problem that brought them to treatment, therapist-perpetrators may be difficult to trust and may manipulate professionals. On the other hand, therapist-perpetrators may elicit such sympathy, because of the crises they face, that professionals may inadvertently minimize or deny the severity of the damage done to clients.

At this time, there is almost no guidance available in the professional literature as to how to conduct assessment, therapy, or supervision with therapist-perpetrators. In this vacuum, treating professionals must make decisions which place them at risk of inadvertently colluding with the therapist-perpetrator. For this reason, it is essential that those who work with therapist-perpetrators have frequent consultation with others, especially those experienced in working with therapist-perpetrators.

In addition, it is recommended that persons who work with therapist-perpetrators be experienced in the specific area in which they are working. For example, those who assess therapist-perpetrators should be experienced in doing psychological assessments, especially of those who have victimized others. Those who supervise should not only be experienced therapists, but should have specific expertise in supervision.

In working with the therapist-perpetrator, there will be challenges to the treating professional's ethical beliefs, and there will be situations which require clear and prompt response if the treating professional is not to be inadvertently drawn into the victimizing system. In addition, persons who work with therapist-perpetrators must have a highly-developed and well-integrated sense of professional ethics, and must be able and willing to take strong stands from an ethical point of view.

Finally, treating professionals must have the ability to work with individuals whose behavior is abhorrent to them without becoming overtly or subtly abusive themselves. They must be able to set limits, express their negative feelings non-abusively, and make appropriate demands for different behavior on the part of the therapist-perpetrator.

Assessment of the Counselor or Therapist who has become Sexually Involved with a Client

Peg Thompson*

Introduction

Scope and Purpose of This Paper

This article focuses on assessment of the therapist-perpetrator—the therapist or counselor who has become sexually involved with one or more clients. For purposes of clarity, assessment has been separated from both therapy and supervision. Further, this article is restricted to the assessment process itself. It does not address the issues of punishment. While licensing boards, ethics committees, and employing organizations may need to take actions to punish a therapist-perpetrator and to send a message to others under their authority, punishment is not the province of assessment.

The central issue in all victimization of clients is the abuse of the power inherent in the professional role of the therapist. Clients, who must trust in order to be helped therapeutically, are betrayed when they do trust. The central focus of any intervention plan which aims at the return of the therapist to practice must be remedial action, to correct the distortion in the power between therapist and client, and to place responsibility for the therapy and the victimization squarely upon the therapist. It must be emphasized, at every step of the process, that the therapist is responsible for the damage that has been done to the client or clients who have been victimized. Unless the therapist can take responsibility for the abusive conduct *and* for the damage it has done to the client, it is difficult to see how rehabilitation can take place.

In order to plan an effective intervention, all the background issues that contributed to the abuse must be explored and evaluated. But it must be clear that none of the factors is an excuse for what has happened. Otherwise, the client-victim may be subtly or directly held to blame for the abuse.

Goal of Assessment of the Therapist-Perpetrator

The goal of the assessment process is to create a plan for intervention that will prevent the therapist, as much as possible, from repeating victimizing behaviors or outright sexual victimization of clients. The intervention is generated from an extensive data-gathering process which will be outlined below. The data gathered should permit the evaluator to get a clear picture of the extent of the problem, its severity, and its duration. Such an investigation involves not only the assessment of the therapist-perpetrator, but an assessment of the entire situation. This, in turn, allows for whatever changes in the therapy delivery system may be necessary to protect current and potential clients. The intervention may include any or all of the following elements: supervision, psychotherapy, vocational counseling, and organizational change. It must be noted at the outset that not all therapists can be rehabilitated so that they can function in a psychotherapeutic role. In these cases, vocational counseling and/or organizational change will be the only interventions needed. Part of the task of the assessment process is to make a judgment in each case about whether the individual can be rehabilitated.

Skills Needed for Assessment

Assessment of therapist-perpetrators is a complex process involving a high level of skill and experience in the practice of psychotherapy, and in psychological assessment. It also requires the ability to think objectively and to deal appropriately with a wide range of individuals who are under severe stress, and who may have characterological problems. This paper is intended to help those who are skilled in these ways to apply their skills to this particular area; it is not intended as a "how-to" manual for less experienced practitioners.

Even beyond the appropriate clinical skills, the assessing professional must have a strongly developed sense of professional ethics, and the ability to take a strong ethical stance against which all statements and behaviors of the therapist-perpetrator can be measured. The greatest risk in working with therapist-perpetrators is one's own corruptibility — the risk of becoming involved inadvertently in the victimization. Like incest, sexual victimization of clients is often denied, minimized, and rationalized by both the perpetrator and those who have been involved with him or her as therapists, colleagues, supervisors, friends, family, and even clients.

* This paper is the result of the combined effort of many people. Gary Schoener, in his presentation to the Therapeutic Issues Work Group of the Task Force on Sexual Exploitation by Therapists and Counselors, provided a framework for assessment. This framework was presented at the Sixth Annual Conference of the National Clearinghouse on Licensure, Enforcement and Regulation in Denver in September, 1986. It is available from the Walk-In Counseling Center (WICC) in Minneapolis in a monograph entitled "Assessment and Development of Rehabilitation Plans for the Counselor or Psychotherapist Who Has Sexually Exploited Clients" (see Appendix C for information on how to order WICC publications). The Therapeutic Issues Work Group itself had several lively discussions which generated large parts of the content of this paper. The final task of combining all of these contributions fell to Peg Thompson.

At any stage in the data-gathering process, the assessing professional may meet with these defenses, or even more subtle "explanations" which shift the responsibility for the abuse to the client and away from the perpetrator. Without an integrated and strongly held ethical sense, assessing professionals may find themselves tangled in the abusive system.

It is important to emphasize that the primary focus of assessment of therapist-perpetrators is the protection of the public. Most persons who do assessment will come from training and backgrounds which emphasize such activities and goals as treatment, growth, and healing. The actions required in evaluation of therapist-perpetrators involve accountability, fact-finding, the making of judgments, and the setting of limits. In the assessment phase, the professional is doing neither supervision nor psychotherapy, but is conducting an investigation to determine if, and/or how, supervision, therapy, or other interventions might be used. While the clinical skills required are the same as in court-ordered assessments, most helping professionals will find assessment of therapist-perpetrators more difficult and stressful because of their membership in the same profession. This work should not be done in isolation, but with both technical consultation and emotional support for the assessing professional.

One of the questions practitioners must ask themselves at the outset of working with this kind of case is what skill they have for the process and how they may need to involve others with specialized expertise from the beginning. For effective intervention and the protection of the assessing professional and the alleged perpetrator, all parts of the data-gathering process should be carried out by experienced practitioners.

Responsibility to Report the Abuse

The assessment professional has a responsibility to ensure that the appropriate reports are made. The alleged perpetrator should be informed at the outset of the assessment of the evaluator's responsibility to report the victimization to appropriate authorities, and should be required to give releases for such reporting before the assessment begins. Assessment professionals who are mandated reporters must report immediately, regardless of who else may have reported. Even in cases where reporting is not mandated, if there is an agency to which the abuse can be reported, a report should be made before assessment begins. The filing of an immediate report ensures that the assessing professional does not become a part of the secrecy of the victimizing system, and does not become ethically compromised. It also provides data about the perpetrator's willingness to face the consequences of his or her behavior. Finally, it sends a message to everyone involved that sexual victimization is never to be condoned.

The alleged perpetrator should also be informed at the outset that anything he or she discloses to the evaluator may be used as part of the final report to a licensing board or other sanctioning body.

Laws and professional review processes that mandate reporting of colleagues for sexual exploitation vary from state to state. It is the responsibility of the assessing person to understand and use the appropriate mechanisms. It is expected that legal standards in the area of client sexual exploitation will be changing rapidly over the next few years and all mental health professionals should keep informed on current requirements for reporting. The therapist-perpetrator should be informed at the outset of any legal mandate to report which obligates the assessing person.

Data Needed for Assessment

In this section the data needed to make a complete assessment will be outlined, with some suggestions for the most effective data-gathering processes. In most cases, the assessment professional will need to get releases from the therapist-perpetrator in order to gather this information. Data will be collected on the therapist-perpetrator as a person and as a professional. The personal data is important because psychotherapy involves the use of the person so extensively.

First, data must be gathered on *all alleges misconduct*, whether it is on the legal record or not. It may be obtained from legal depositions, in the form of either transcripts or videotapes, or from written complaints filed with ethics committees or review boards. This data gives the evaluator a sense of the nature, extent, and severity of the abuse, and makes her or him less likely to minimize or deny the seriousness of the problem. It also provides the basis for all further inquiry with the perpetrator and other professionals.

Second, the assessment must include the *results of any past psychological testing* done on the therapist-perpetrator. The purpose of this information is to assess the psychological functioning of the individual over time. It may give the assessing professional a sense of how long-standing or characterological the perpetrator's problems are.

Third, *information from past and present supervisors and colleagues* who are familiar with the work of the therapist should be gathered. Such information can serve several purposes. It may provide details of the therapist's behavior; it may provide a sense of the therapist-perpetrator's understanding of therapeutic roles, boundaries, responsibilities, and power; and it may also give the assessment person information about organizational interventions that may be available or required.

Fourth, *information from past and current therapists* who have worked with the therapist-perpetrator as a client should be gathered. This information is vital for the assessment of the perpetrator's psychological status and the possibility of rehabilitation. Unfortunately, it may also provide information about the therapist's failure to face the perpetrator's victimizing behavior. In the latter case, a different therapist might be suggested in the intervention plan.

Fifth, *current psychological testing,* sufficient to arrive at a diagnostic picture, should be done. This should include both objective tests, such as the MMPI, and projective tests, such as the Rorschach and TAT. Testing can be done by someone other than the primary assessment professional, but each test should be administered and interpreted by a person who is highly skilled in using that particular test.

For perpetrators sophisticated in the administration and interpretation of the tests used in the assessment process, special problems arise. Because of their sophistication, these individuals may invalidate or distort the results. However, even with professionals trained in all of the tests to be used, testing may still be useful. Many cannot fake psychological tests, and many do not attempt to do so. Test results must be evaluated against other sources of data and can never be used to rule out pathology or disorder. It should also be noted that sometimes a particular test result is just a "miss"; even without faking, it may not fit the situation. Finally, a practitioner may not only try to fake "good" to look healthy but may fake "bad" in order to show false distress. This may be an attempt on the part of the perpetrator to look more upset about the victimization than he or she is and thus to elicit greater sympathy and less rigorous recommendations than might otherwise be given. Or, in the case of a sociopath, the intention may be to look neurotic rather than characterologically disordered.

Finally, extensive *interview data from the therapist-perpetrator* should be collected. It should include the following information: the therapist's professional practice history, including training and supervision; the therapist's explanation of why the victimization occurred; data relevant to assessing psychological adjustment; and a careful review of all the therapist's cases. In this process the confidentiality of victims and other clients must be maintained. (Names and other identifying information should not be used unless releases are obtained from clients or court orders exist to the contrary).

Mental health professionals can sometimes be very sophisticated in defensiveness, masterfully minimizing or explaining their behavior. It is easiest to question them having already studied accounts by the victim(s), background material provided by past supervisors, therapists, and others (e.g., practice partners).

In the process of interviewing the perpetrator, assessing professionals may gain information about other victims which has not been previously disclosed. In such cases, the assessing professional should follow mandated reporting requirements. All information received and reports made should be carefully documented for the protection of the assessing professional.

In the process of interviewing the therapist-perpetrator, the assessing person should act from a broadly based ethical point of view, challenging statements of the therapist-perpetrator which show a flawed understanding of appropriate therapeutic behavior, or which minimize, rationalize, excuse, or deny the victimization. The purpose of these challenges is not to change the person's behavior, but to provide more information for the assessment. From each challenge and response, the assessing person gains information about the perpetrator's willingness to risk, to allow greater self-awareness, to feel guilt or remorse, or to examine past behavior critically.

Key Areas to be Addressed in Assessment Summary

Once data is collected from all sources, the assessment professional should prepare an inclusive summary. This summary information provides the basis and rationale for the recommendations that will be made about whether and how the therapist can be rehabilitated.

Issue 1: Psychological Adjustment of the Therapist

Based on interviews with the therapist-perpetrator and past therapists, supervisors, and/or co-workers, and on past and current psychological testing, a reasonable picture of the therapist's psychological adjustment should be determined.

Schoener proposes the classification system below for use in assessing therapist-perpetrators. It is based on his experience with over 1,000 cases.

0. *Persons Who Have Little or No Knowledge of Professional Standards.* These are persons who have not been trained or whose training did not provide them with thorough grounding in ethical standards or other related topics. They may be paraprofessionals, or persons who have no credentials.

1. *Healthy or Mildly Neurotic.* With these individuals, the sexual exploitation is isolated and related to situational variables. The therapist exhibits awareness of the wrongness of his or her behavior, as well as genuine remorse.

2. *Neurotic/Isolated.* These therapists have long-standing, significant emotional difficulties and their lives are dominated by their work. They become overly involved with their clients and mix their social and emotional needs with doing therapy. While they may not set out to have sex with clients, it develops as a by-product of the other activities.

3. *Compulsive Character Disorders.* These individuals are characterized by the compulsive pursuit of others for sex. They often sexually harass colleagues, and may show other signs of a character disorder. They engage in repetitive, compulsive sexual acting out. Some of them are simply compulsive sex offenders.

4. *Sociopaths and Narcissistic Character Disorders.* These individuals are characterized by self-centered exploitation of others with no true guilt or remorse. More narcissistic perpetrators may be grandiose and think that they know what is best for people, despite blatant evidence to the contrary. Perpetrators with more sociopathic tendencies may exploit their clients financially, as well as sexually.

5. *Psychotic or Borderline Personalities.* These offenders suffer from a long-term, serious emotional disturbance. Included here are both individuals with some loose thinking and poor social judgment, and those who are actively psychotic. The psychosis may be either acute or chronic.

In considering the potential for rehabilitation, one must always err on the side of protecting the public. Psychotherapists in Categories 3, 4, and 5 above can rarely be rehabilitated. In category 2 the prognosis is variable, depending often on the duration of victimization. While every case is different, in general, involvement with multiple clients (which may mean extremely poor boundaries with dozens of clients, but sex with only one for those in Category 2) bodes ill for any rehabilitation. The same is true, in general, for any long-term involvement with one or more clients.

By contrast, those in Category 1 typically have a single sexual involvement without evidence of general boundary problems with clients. Also, in Category 1 are therapists who lose control during a single session with a client. They regain control and may be the party who calls in a consultant or outside help. In some situations, the Category 1 therapist is more upset about the incident than even the client is.

Issue 2: Problematic Behaviors with Clients

The specifics of every case of client sexual victimization are unique. In this section, some common behaviors with clients will be outlined. However, assessment persons are encouraged to follow any hunches they may have in getting a clear picture of what went wrong in the therapist-perpetrator's practice of psychotherapy, including and beyond the specific case at hand. More extensive information on the characteristics of healthy and unhealthy therapeutic relationships is included in the two articles about supervision in this section of the handbook.

Some questions to be addressed in assessing problematic behaviors with clients are:

1. To what degree does the therapist maintain proper boundaries, or even understand boundaries conceptually? Some practitioners seem unable to distinguish social relationships

from professional ones, and others concoct rationalizations to justify breaching clients' boundaries.

2. Does the therapist use self-disclosure in non-therapeutic ways? How much of the client's time in therapy is spent hearing about the therapist's life or dealing with the therapist's problems?

3. Does the therapist touch clients indiscriminately and/or in non-therapeutic ways?

4. Does the therapist act, dress, or talk seductively?

5. Is there a clear therapeutic contract? Does the therapist understand the role, power, and responsibility of client and therapist?

6. Does the therapy aim at fostering independence and empowerment of the client, or is it set up to be very long-term, even lifelong?

Issue 3: Problems in Practice Setting

In this section, the goal of assessment is to see how the setting in which the therapist-perpetrator practices contributed to the victimization of the client. The list below is not exhaustive but is intended to help the reader think of some of the variables that may be involved. Much more extensive information about the role of organizations in preventing and addressing sexual abuse of clients by therapists can be found in the Administrative Issues section of this handbook.

1. What written policies are there in the agency or practice setting concerning boundaries about sexual and social contact with clients?

2. What are the ethical standards of the agency, practice partners, and co-workers?

3. What information is given to clients about these issues? Are there complaint mechanisms?

4. How have any past complaints against the therapist, or others in the practice or agency, been handled?

5. What sort of supervision or consultation is available to the therapist, and to what degree and in what way did she/he make use of it? (Both administrative and clinical supervision should be examined.)

Therapists in solo private practice can be much more difficult to assess in this regard. If they have become isolated, there may be few people who can give any data on their practice.

Issue 4: Problems with Therapist Self-Awareness

In this section, what is being assessed is the therapist's awareness of his or her own issues that affect work with clients. Broadly speaking, this is the area of countertransference in therapy. At issue here are the therapist's blind spots and vulnerabilities. It is most important to examine how the therapist-perpetrator failed to take responsibility for his or her weak points, and for addressing them constructively. Again, extended discussion of this topic is presented in the two articles on supervision in this section of the handbook. The reader is encouraged to read them as part of the preparation for this part of the assessment.

Review of Assessment by Others

At the end of this process, the assessing professional may want to share the report with others who provided data for it. Two purposes could be served by this. First, based on the feedback, the assessing person can sharpen up or add to the report; and second, he or she can get a sense of how helpful the readers may be as participants in the intervention plan. Releases are required, however, to permit such feedback. It is suggested that they be obtained from the therapist-perpetrator at the same time as the original releases to gather data are given.

Recommendations

Once a comprehensive picture of the therapist-perpetrator's psychological and professional functioning has been created, the task of the assessing professional is to make recommendations about continued practice. Again, the goal of the assessment is to identify a process which ensures to the greatest possible degree that the therapist will not victimize clients in the future.

Supervision, psychotherapy, and organizational consulting in cases of client victimization have been discussed extensively in other sections of this handbook. Consequently, this section is restricted to outlining the treatment options available, and briefly discussing when they might be used appropriately.

Decision about Continued or Resumed Practice

The first decision in making recommendations about rehabilitation is whether the individual can be rehabilitated enough to resume the practice of psychotherapy. The following types of therapists may be considered such poor candidates for rehabilitation that return to practice should not be permitted:

- Sociopaths or other characterologically impaired individuals who are chronic exploiters;
- Therapists who will not face the damage their behavior has caused, and/or do not believe that the behavior was unethical or wrong;
- Therapists who are psychologically unstable or emotionally impaired enough that they are unlikely to be able to handle the stresses of psychotherapy as a profession;
- Therapists who are unable to comprehend appropriate professional boundaries;
- Individuals who are incapable of being honest about their behavior and its effects;
- Therapists who, while they may appear initially cooperative, are unwilling to participate in a course of treatment, and/or to limit their practices as prescribed by the assessing professional.

The second decision that must be made is whether some non-therapeutic professional roles may still be possible, or whether the individual should not be working in any area related to psychotherapy. For example, the individual might be able to do intake work, psychological testing, or evaluations.

If the judgment of the assessing professional is that a therapist cannot resume practice, the recommendations should include vocational counseling. If the judgment of the assessment professional points toward resumed practice, clear recommendations should be made as to exactly how the rehabilitation is to take place. Clear guidelines for assessing readiness to resume practice must also be spelled out.

In cases where it is recommended that the therapist-perpetrator not resume the practice of psychotherapy, the assessing person should assist the individual in being responsible enough to leave the field or to find a non-therapeutic role within it. This recognizes the therapist-perpetrator as a person aside from the illegal or unethical behavior, and allows the unethical behaviors to become an opportunity for positive action.

The goal, in other words, is not punishment, but protection of clients; at this stage, it is crucial to involve the therapist in devising a future profession that does not put clients at risk. Without such assistance, the perpetrator may simply practice in another state or under another title, thus perpetuating the abuse to clients.

One common practice limitation placed on therapist-perpetrators is to limit their practice to male clients. This procedure is erroneous because it is based on a faulty assumption: that the therapist-perpetrator is heterosexual, usually male, and won't do to men what he did to women. Because exploitative behavior is the basis of the therapist-perpetrator's conduct, there is the possibility for violations in same-sex relationships as well as in heterosexual relationships. The procedure is also erroneous because it assumes that male clients are safe from the influence of the therapist-perpetrator. In fact, the therapist-perpetrator may deny, or worse, condone a male client's abusive behavior and/or may join with the male client in perceiving himself as victimized by the victim. This practice limitation neglects the strong possibility that the therapist-perpetrator may be blind to male perpetrators, or may indirectly sanction exploitation.

Supervision

In making a recommendation that the therapist-perpetrator participate in supervision and/or therapy, it is important to distinguish between the two in terms of their objectives. The objective of supervision is to hold therapist-perpetrators accountable for their professional behavior by providing supervisory experiences which allow them to become responsible, respectful practitioners. The supervisor's first concern is the welfare of the therapist-perpetrator's clients. Therapy, on the other hand, focuses on the healing and growth of the therapist-perpetrator as a person, and the treating therapist is in the role of helping the therapist-perpetrator.

Supervision is necessary and essential if the therapist-perpetrator is to return to the practice of psychotherapy. The supervisor should have access (by releases signed by the supervisee) to all the data gathered in the assessment process. Extensive information on supervision is available in two other articles in this section of the handbook.

Psychotherapy

Whether or not the therapist-perpetrator is to work toward resumed practice, psychotherapy may be recommended. In either case, it is important to define the goals of the therapy. At the outset of therapy, the therapist should have the therapist-perpetrator sign releases allowing immediate notification of the appropriate review or ethics panel, or legal authorities, should she or he at any time believe that the practitioner constitutes a danger to clients. The psychotherapist must also be willing to assume the responsibility for making such reports should they be necessary. An extended discussion of therapy with perpetrators comprises the other five articles at the end of this section of the handbook.

Vocational Counseling

If the perpetrator can no longer do psychotherapy, vocational counseling may be of assistance. The goals of such counseling would be to identify professional or other vocational roles that do not include intense personal contact. However, in any vocational counseling it is important to consider the potential for other kinds of abuse.

Organizational Consulting

If the therapist-perpetrator has been practicing with others in private practice or an agency, the organization may need help, both to provide a different level of supervision to the individual, and to provide a healthier climate within which therapy can take place. Again, this has been discussed at length in the Administrative Issues section of this handbook.

Plan for Follow-Up

The last part of the assessment recommendations is a plan to follow up on the results of implementing the recommendations. This should include a specific time at which the assessing professional will reevaluate the situation by gathering information from all of the other professionals who may be involved as therapists, supervisors, or counselors, as well as from the therapist-perpetrator. Again, it is important at the outset of the assessment process to obtain the necessary releases to permit this consultation.

In addition, the assessment person should be available as a coordinator, a referral source, or a consultant, to the other professionals involved and/or the therapist-perpetrator.

Summary

This paper has addressed the assessment of the therapist-perpetrator, including sources of information for the assessment, issues to be considered and addressed, recommendations, and possible treatment strategies. Other articles in this handbook contain extensive information on methods of carrying out the particular strategies selected.

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Working Therapeutically with Therapists who have become Sexually Involved with Clients

John C. Gonsiorek

Introduction

This paper describes a number of considerations and issues in providing psychotherapy for psychotherapists who have become sexually involved with their clients. It is important to note that material in this paper applies only to a subset of such therapists. Utilizing the descriptions of therapist types suggested by Schoener (1987) and Gonsiorek (1987) and in the preceding paper in this volume by Thompson, virtually all of the therapist-perpetrators whose treatment this paper describes fall into the neurotic categories. This includes individuals in the "mildly neurotic" category (isolated exploitation, related to situational variables, true remorse of perpetrator) and the "neurotic/isolated" category (overly involved in work and clients, long-standing emotional problems, personally isolated outside of work setting). While some mention will be made of other therapist-perpetrator types in some sections of this paper, these are primarily to illustrate certain issues, and not to suggest that this model has any necessary applicability beyond neurotic therapist-perpetrator types. Treatment length of the model described here varied from about 10 to about 30 months.

Another caution involves the tentative nature of all information about this subject at the current time. The material in this paper is based on the treatment of about a dozen cases, and should be viewed as a set of initial working hypotheses and not as final recommendations. It is my hope that the work here will serve to encourage and structure further efforts in this area, and to encourage a questioning, critical attitude.

Punishment Versus Rehabilitation

Treatment of therapist-perpetrators does not go on in a vacuum. The responses of law enforcement and professional bodies, such as licensing boards and professional ethics committees, can serve to assist or hinder successful treatment. For example, such bodies can prescribe treatment in such detail that the treating therapist is unable to individually tailor the treatment plan. On the other hand, they sometimes allow the therapist-perpetrator too much leeway in determining his or her own treatment. A set of suggested responses by these professional bodies and the rationale for them is outlined below.

The issues of rehabilitation and punishment ought to be clearly differentiated in the response to sexually exploitative therapists. Specifically, I would recommend that there be two sets of consequences for sexual activity with clients. The first is in the domain of criminal law, and involves criminal sanctions for sexual activity with clients. The second is the in the area of administrative law, involving the actions of licensing boards or certifying bodies in the form of temporary or permanent suspensions of the licenses, registrations, or certifications of perpetrating therapists (or a court order prohibiting practice for those individuals who are unlicensed). Further, I would suggest that the terms of suspension of the licenses be based solely on the severity of the offending behaviors. Issues of rehabilitation should not enter into these determinations.

In other words, using the levels of assessment described in "Working With Therapist-Perpetrators: An Introduction" in this section of the handbook, this administrative law response would be entirely a Level 1 procedure (i.e., a *legal* and *administrative* review to take action against the therapist-perpetrator, and give consequences for unacceptable behavior), and should occur prior to any information derived from a Level 2 evaluation (i.e., a *clinical* evaluation to determine whether the therapist-perpetrator is psychologically capable of resuming practice and under what conditions). Within this model then, there will be situations where the therapist-perpetrator's behavior is such that the license may be permanently revoked, based solely on the offending acts of that therapist, with no opportunity for re-licensure.

I would recommend further that these administrative responses by licensing boards be uniform, and determined by a formula. For example, the boards might have three or four different levels of temporary or permanent suspension, based on the nature of the offending behaviors.

Finally, it is recommended that this formula be consistent across all licensing boards in a given state. Level 2 decisions about prognosis and treatability would

be made after this administrative law determination, and only for those individuals who receive a *temporary* suspension of their licenses. Individuals whose licenses are permanently revoked may seek psychotherapy for their own understanding and personal resolution of issues, but a Level 2 evaluation regarding possible continuation of practice becomes an irrelevant consideration for these individuals.

The rationale for this is as follows: if sexual exploitation of clients by therapists is to be taken seriously by the mental health professions and the public, it is important to establish that certain kinds of exploitation are serious matters, warranting a serious response, regardless of the motives or psychological status of the perpetrating therapist. This is the case regarding other serious transgressions against society, such as rape and incest. The development of a formula for licensing board responses is suggested to insure consistency of outcome for all parties, and justice for the therapist-perpetrator.

My observation is that there is often an unacceptable level of variability in the responses of licensing boards, stemming from sources other than the behavior of the therapist-perpetrator. Such alternative sources include the current composition of a board, publicity about a board's handling of other recent cases, whether the client is the same or opposite sex as the therapist-perpetrator, etc.

The evaluating or treating therapist must assiduously avoid requests from licensing bodies to help determine what punishment is appropriate in a given case. This places the evaluating or treating therapist in an untenable dual relationship with the therapist-perpetrator which not only compromises the work which that therapist may do with a therapist- perpetrator, but which also raises serious ethical issues in its own right. It is also unjust to the therapist-perpetrator, who is judged, not by the offending behavior, but on considerably more vague, psychological grounds.

On the other hand, there are some appropriate roles for the evaluating and treating therapists with regard to licensing bodies. The evaluating therapist can often assist a licensing body in determining the appropriate treatment plan for individuals for whom they have already prescribed a temporary suspension. It is important for the evaluating therapist never to guarantee therapeutic outcome, since there is inadequate information to make prognostic statements in this area.

Toward the end of therapy, the treating therapist can also serve a valuable function by helping the board determine under what circumstances the therapist-perpetrator can reenter the profession. While prognostic statements are not appropriate, it is reasonable for the treating therapist to give some indication as to limitations and vulnerabilities of the therapist-perpetrator, what sort of work has been done in these areas, and what reentry structure might maximize the chances of a successful readjustment for the therapist-perpetrator and minimize the chances of any further exploitation of clients.

The intent of these recommendations is to clarify the distinction between punishment and rehabilitation, as well as to provide greater justice for all parties by reducing the likelihood of unpredictable or arbitrary decisions by licensing boards. Finally, I would like to suggest that a licensing board's decision to suspend a license on a temporary basis should not be viewed as a guarantee that the license will be reinstated. The evaluating therapist, as part of the Level 2 evaluation, has the option to recommend against reinstatement; the treating therapist has the option of recommending against reinstatement as a result of the treatment experience; and the boards have the obligation to weigh the interests of the public versus those of the licensee as they integrate information from these diverse sources.

Assessment

The details of what to assess are fully described in the preceding article, but a number of points concerning assessment deserve emphasis in the context of this paper.

My own belief is that there is no inherent problem in the evaluating therapist's becoming the treating therapist if that is agreeable to all involved. While this recommendation differs from that expressed in "Working With Therapist-Perpetrators: An Introduction" in this section, I believe there is considerable agreement about the concerns raised in doing this, as described in that article. Our difference, then, is primarily in the resolution, and not in the articulation of these concerns.

The evaluating therapist must make it very clear at the outset that evaluation and treatment recommendations are completely separate from the treatment process, in that both individuals have the option of discontinuing

the relationship after the evaluation is complete. The therapist-perpetrator may not like the result of the evaluation and therefore may not want to be treated by the evaluator. The evaluating therapist may not wish to treat a specific individual based on his or her reaction to that person.

The ability to be simultaneously respectful, yet detached, with regard to final outcome and recommendations is an essential quality in the evaluating therapist. The evaluating therapist must give the therapist-perpetrator two clear and consistent messages: that the therapist-perpetrator will be afforded the respect due any client, and that the unethical behavior is wrong, regardless of whatever extenuating circumstances the therapist-perpetrator may have experienced. Evaluating therapists must make no guarantees about what they might ultimately recommend, or about how their recommendations may be received by the licensing board.

The core issue is that the therapist-perpetrator has treated a client abusively. Some evaluating therapists have become overtly or covertly verbally abusive to the therapist-perpetrator in a misguided attempt to show how improper the unethical behavior was. If the evaluating therapist treats the therapist-perpetrator abusively, the situation becomes hopelessly compromised.

Maintaining a consistently respectful stance assists in the evaluation. It is not unusual for therapist-perpetrators who are character disordered (rather than neurotic) to view a respectful stance as an opening for manipulation. They may begin to play out their sociopathic scheme in an increasingly transparent manner. In this way, the evaluating therapist can more accurately understand how this particular therapist-perpetrator might best be categorized.

By not imposing judgment on the therapist-perpetrator, the evaluating therapist maintains maximum flexibility and objectivity. Further, this respectful, yet firm stance also sets the stage for certain kinds of reactions with neurotic therapist-perpetrators which are helpful in later stages of their therapy that will be discussed below (see middle phase).

It is recommended that the evaluating therapist suspend judgment in initial contacts and avoid drawing conclusions about the therapist-perpetrator until the evaluation is complete. It is not unusual for some neurotic therapist-perpetrators to appear to be suspicious, evasive, and defensive because of advice from their attorneys, distrust of the legal system, or fear. More character disordered therapist- perpetrators may present themselves in a similar fashion. The maintenance of a firm ethical stance by the evaluating therapist can be very important in such situations. Character disordered therapist-perpetrators will often terminate the evaluation once they understand that the evaluating therapist will not attenuate his or her ethical stand, whereas this is less likely with neurotic therapist-perpetrators. Professionals who are personally uncomfortable with the prolonged period of ambiguity that this sort of evaluation requires should probably not serve as evaluators of therapist-perpetrators.

Once the evaluation is complete, it is important for the evaluating therapist to go over it in detail with the therapist-perpetrator, and ask the therapist-perpetrator to carefully consider the recommendations. It may take more than one session for the therapist-perpetrator to absorb the information. Frequently, the therapist-perpetrator may be panicked or under legal pressure to follow through on the recommendations and may attempt to do so without giving them sufficient consideration. Commonly, therapist-perpetrators will be desperately seeking some sense of direction, and may acquiesce to any clearly formulated treatment plan without considering whether they actually agree with it. In these situations, it is useful to introduce a time delay of a few weeks to permit the therapist-perpetrator to fully consider the evaluation.

Agreement to the Treatment Plan

After the assessment, treatment cannot occur unless there is basic agreement about the treatment plan. If there is no basic agreement that unethical behaviors did occur, and that they constitute a serious problem, there is no rationale for initiating treatment, and it would be hard to imagine what the therapist-perpetrator's investment in the therapy might be. Further, without such agreement, the treating therapist may be cast in the role of police detective in ascertaining what did and did not occur. This represents a dual relationship for the treating therapist that seriously compromises the therapy; however, agreement about the unethical behaviors need not be complete.

For example, if a therapist admits to engaging in some unethical behavior reported by a client, but not to all of the behaviors alleged by the client, this is sufficient,

provided the therapist-perpetrator does not deny that some of what he or she did was unethical and a serious violation. If further revelations of unethical conduct occur, it is important that the therapist-perpetrator acknowledge their seriousness as well. It is important for the treating therapist to recognize that while therapist-perpetrators may not be entirely truthful at this phase, neither can the treating therapist make determinations about facts or events which are currently obscure. Such determinations are not necessary for the treatment to begin.

It is ideal if the licensing board has acted upon the recommendations of the Level 2 evaluation before treatment actually begins. However, given the backlog of cases which many licensing boards have experienced, this is not always possible. If the therapist-perpetrator appears highly motivated to initiate the treatment, and has a good understanding of, and agreement with, the treatment plan, or is in considerable psychological crisis, it may not be desirable to delay treatment until licensing board action occurs. In these cases, the treating therapist ought to make it clear that the treatment plan may require substantial alteration at a later date to fit in with the requirements of the licensing board.

Early Phase of Treatment

This phase of treatment is typically chaotic. Frequently, therapist- perpetrators will be in the midst of complex legal proceedings. They may be facing hearings designed to fire them from their jobs. They may be awaiting hearings at licensing boards or ethics committees. There may be public attention in the media, or in the form of discussions in their community about their behavior. There may be civil action initiated by their clients, as well as criminal charges in some states. The therapist-perpetrator may be thrown into a period of crisis, as a series of complex and often unpredictable legal situations develop. Most therapists are naive about the legal system and, in particular, have a difficult time making distinctions between criminal, civil, and administrative law, any of which may impinge upon them in these situations. Further, many therapists do not understand the adversarial nature of the legal system, and thus personalize these procedures.

It is important for the treating therapist to be genuinely supportive of the realistic stresses endured by the therapist-perpetrator during this period, and to direct the therapist-perpetrator to the appropriate resources, so that he or she may have fair legal representation. In response to these stresses, therapist-perpetrators may attempt to deny, minimize, or rationalize their unethical behavior and begin to take back early admissions of the innate unethical nature of this behavior.

The crucial task of the treating therapist in this phase is to maintain a clear stance that the unethical behaviors of the therapist-perpetrator were, in fact, unethical, while at the same time being understanding of the stressful nature of these events, and being respectful of the right to legal representation. This situation presents the first, and in some ways most important, opportunity for the treating therapist to model appropriate professional boundaries under difficult circumstances. If the treating therapist seriously violates professional boundaries, the therapy is likely lost. However, this is not to say that the treating therapist must maintain perfect behavior and judgement at all times. There have been a number of occasions when I have temporarily erred in either direction (i.e., being insensitive to the stresses, or being tolerant of denial or minimization), but then caught myself, explained my perceptions to the therapist-perpetrator, and then corrected my stance. Through this process, the therapist-perpetrator observes the treating therapist struggling to maintain an ethical posture and sort through complex psychological and legal issues. Needless to say, this will be a harrowing task for treating therapists who believe they must be in control at all times. Such therapists probably ought not to do this work.

Typically, this early phase of treatment will settle down when there has been either some legal resolution, or the therapist-perpetrator comes to understand better the vicissitudes of the legal system, and is less anxious about them. This latter outcome is more likely, as legal resolution can frequently take years. If new legal situations arise during the course of therapy, as they well may, the therapist-perpetrator may be thrown back into the emotional turmoil of this phase.

Given the crisis nature of the treatment in this early phase, the difficulties of proceeding with treatment before the licensing board has made an official response to the Level 2 evaluation are somewhat, but not totally, alleviated. Much of the work in this phase involves stabilizing the therapist-perpetrator, and preparing him or her for further therapeutic work. The middle phase of therapy, as described in the next section, is where the bulk of treatment actually occurs. Therefore, it is strongly recommended that a response from the licensing

board be available before the end of this early phase of treatment and initiation of the middle phase. It may well be unfair to the therapist-perpetrator to proceed into the middle phase of a therapy which may not be satisfactory to the licensing board.

Middle Phase of Therapy

After the therapist-perpetrator has made some adjustment to legal turmoil, and tolerates the ensuing anxiety better, the therapy often enters a more intensely exploratory phase, in which the primary goals of the treatment are addressed. It is recommended that these goals minimally include a detailed understanding of 1) the recent and any previous unethical behavior; 2) the impact of this unethical behavior upon the client; 3) the personal history of the therapist-perpetrator; and 4) how these fit together.

While there is probably no universal "psychology of the therapist-perpetrator", there are some common themes which can be suggested. First, there is typically something in the therapist-perpetrator's history which has led to boundary problems. These can be overt situations where the therapist-perpetrator's own boundaries were violated, such as physical or sexual abuse. These can also be situations where their boundaries did not fully develop, as in severe emotional deprivation, or a cold and emotionally unexpressive family background. In this latter situation, the therapist-perpetrator may have viewed this aspect of his/her history as a problem, and has made an attempt to become more emotionally expressive. Often, however, there is no accompanying development of boundaries. Some sort of history of boundary violations or excessively rigid boundaries is common.

A second theme is insensitivity to power dynamics, which is often accompanied by self-esteem problems. The therapist strives to compensate for feelings of personal inadequacy, but is insensitive to how powerful he or she has become. In particular, therapist-perpetrators are often insensitive to their own power as therapists. They may then underestimate the impact of initially minor boundary violations upon the client, and may rationalize the early stages of romantic behavior with the client by believing that they have equalized the relationship with the client through self-disclosure. In fact, such therapists remain very powerful in the eyes of the client.

There may be any number of other personality characteristics or historical circumstances that are involved in the offending behavior. As a therapist-perpetrator develops an understanding about how his or her specific history is related to the unethical behavior, it is also important in this phase of the therapy for the therapist-perpetrator to understand the immediate life circumstances which led to the expression of his or her vulnerability. The therapy may become very broad in this phase, as exploration takes place in a variety of areas. While this diffuse focus may be very fruitful, it is important for the treating therapist to make certain that the therapeutic goals, as noted above, are clearly addressed.

In particular, it is a crucial therapeutic task during this phase for the therapist-perpetrator to understand the impact that his or her unethical behavior had upon the clients. Is is not unusual for therapist-perpetrators to be obtuse about this during the early phase of therapy, as they may be involved in adversarial legal proceedings with their former clients. However, if this lack of sensitivity and empathy prevails and remains entrenched during this middle phase, this should serve as a warning indicator to the treating therapist.

The treating therapist may want to review the assessment because such insensitivity may indicate that the diagnosis was not accurate and that this particular therapist-perpetrator is more narcissistic than neurotic in personality structure, and may, therefore, be unable to clearly perceive the impact of his or her behavior on others. The treatment plan may require revision as a result. In addition, the ability of the therapist-perpetrator to understand his or her impact on clients is a crucial consideration in recommending whether this individual should ever have a license reinstated.

A good indicator as to whether therapy is going well at this point is if the therapist-perpetrator begins to spontaneously bring up examples about boundary problems, insensitivity to power, other examples of negative impact upon clients, and other issues particular

to his or her history which have not been previously discussed. These may be other circumstances where they have acted in abusive or unethical ways. Typically, they begin to apply what they have learned in the therapy to other relationships in their lives and other situations. They may begin to see that the problems which have led them into unethical behavior have had other manifestations, in relationships with a spouse or significant other, with children, or with work colleagues.

This phase of therapy is anything but smooth. Rather, it is a typically "two steps forward—one step backward" situation where the therapist-perpetrator may deny the damaging impact of his/her behavior upon others. The treating therapist will again have to correct this. There is an ongoing interplay between denial and distortion, on one hand, and a realistic appraisal of one's impact on others, on the other.

During this phase, interviews with a spouse or significant other may be very useful in understanding the manifestations of the therapist-perpetrator's problems in other areas. In addition, adjunctive group therapy may elucidate problems in the interpersonal style of the therapist-perpetrator. This can be especially helpful for the therapist-perpetrator who remains insensitive to his/her own power or is lacking in understanding and empathy for the impact of his/her behavior upon others.

It is crucial during this period to explore the therapist-perpetrator's cognitive understanding of therapeutic work. Frequently, therapist-perpetrators have developed distortions with regard to their theoretical orientation in therapy. These often ultimately stem from their own personal problems, but are often packaged with plausible-sounding intellectual justifications. For example, therapists with personal histories of poor boundaries often gravitate towards highly intrusive and confrontational therapy styles. When questioned about their choice of therapy styles, such therapists may offer a justification which sounds very reasonable, but on further exploration may be more based on an attempt to work through their own history.

In addition, therapist-perpetrators often distort their cognitive and theoretical understanding about their chosen therapy style, which then serves to justify their unethical behavior. For example, a therapist utilizing an intrusive or confrontational form of therapy might minimize or "forget" the contraindication and limitations of the technique. The tasks of this phase of therapy are not complete until this area is fully explored.

The Boundary between the Treating Therapist and the Therapist-Perpetrator

It is important for a number of reasons that the treating therapist examine the boundary between himself or herself and the therapist-perpetrator. Attention to this boundary can serve a role-modeling function for the therapist-perpetrator. In addition, there are often more directly therapeutic reasons for its exploration. Frequently, the therapist-perpetrators have been very lonely much of their lives, and have covered up this loneliness with intellectualized defenses. As mentioned above, they often have self-esteem problems. The therapist-perpetrator's ethical violations and subsequent treatment may present a situation where they allow themselves to be more vulnerable to another person than they have ever been. If the treating therapist has done a good job of maintaining the firm and respectful stance described above, he or she is likely to assume a very powerful position vis-a-vis the perpetrator. Frequently, there may be some idealization of the treating therapist by the therapist-perpetrator. The danger this presents is that the therapist-perpetrator may not fully integrate the changes made, if part of the motivation for doing so is to please the idealized treating therapist. An important goal, then, is to make certain that the integration of changes is relatively independent of the therapist-perpetrator's view of the treating therapist. In doing so, the treating therapist often assists the therapist-perpetrator in developing a more differentiated level of functioning.

One method of accomplishing this is to focus on the boundary between the therapist-perpetrator and the treating therapist by precipitating a disappointment in the idealization. Often, by this point in the therapy the treating therapist will have some understanding of some area of disagreement he or she has with the therapist-perpetrator. These disagreements may involve different perceptions of situations or events, theoretical disagreements, or other kinds of differences. By focusing on this area of disagreement, the therapist-perpetrator can be helped to integrate the possibility that an individual such as the treating therapist can be positively disposed, helpful, and valuable to the therapist-perpetrator, but at the same time be different from them and perhaps in disagreement with them. It is important not to focus on this disagreement in an artificial manner, but to find an area which is unobtrusive, which flows

from the therapy material and which is not violating or disrespectful of the therapist-perpetrator.

The disappointment stemming from this end to the idealization can be acute and may create a period of disruption in the therapy. The intent is to elicit any residual self-esteem issues and distortion in boundaries that the therapist-perpetrator may still have. The therapist-perpetrator's ambivalence about the treatment plan and admissions about the seriousness of ethical misconduct may also be elicited. The goal is to help the therapist-perpetrator understand what he or she has done without distortion or denial, and independently of the support of the therapy relationship.

The disappointment of this idealization may at times cause a regression to a level of denial or minimizing which may not have been seen since the earliest phases of treatment. The treating therapist must maintain the ethically firm, and yet personally respectful stance described above, and must also not create this disappointment in a manipulative, heavy-handed, or "gamey" manner. If the therapist-perpetrator does experience some regression during this process, it is important that the treating therapist not be punitive, but patiently assist the therapist-perpetrator in resolving the disappointment and the issues raised.

Resolution Phase of Therapy

It is important to spend some time with therapist-perpetrators before the termination of therapy in planning the next phase of their career. If they have been serious about therapy and supervision requirements that may have been stipulated for regaining their licenses, there will typically be some opportunity for the therapist-perpetrators to do some sort of mental health work. The individuals discussed in this paper are less likely to have a permanent revocation of their licenses. It is important to help them understand their personal vulnerabilities and limitations and begin to make concrete plans for reentry into their profession in a way that minimizes the possibility that their vulnerabilities and limitations will again express themselves in exploiting clients. It is also important for therapist-perpetrators to consider the option that mental health work of any sort may not be appropriate for them, and to think through clearly what they want to do, and why.

At this time, therapist-perpetrators frequently have to come to terms with some painful realities. For example, even though they may have admitted unethical behavior, accepted the punishment, and have undergone treatment and supervision, they may never be able to return to the community of their former practice. It is important to work through the resulting loss and grief, as well as to realistically assess the probability of their being successful and accepted in their chosen reentry path.

Follow-up

It is desirable to have extended periods (i.e., 6-12 months) for follow-up appointments. The bulk of the therapy has been done at this point, but the follow-up appointments can serve a number of important purposes. They allow the therapist-perpetrator to work through any remaining issues, or to address new situations that may illustrate some of the themes brought up in therapy. If the therapist-perpetrator has made a shift in career focus, new situations may arise which present different dilemmas for which discussion with the treating therapist may be of value.

Strains on the Treating Therapist

There are numbers of ways in which this therapy is a strain on the treating therapist. There is much back-and-forth motion on the part of the therapist-perpetrators during their therapy, as they move in and out of denial about the impact of their behavior. This, in itself, can create stress for the treating therapist. Throughout therapy, the treating therapist may feel, realistically or unrealistically, that the outcome of this case is more public than most others, and so may cherish the progress of the therapist-perpetrator more than that of other clients. If treating therapists do not examine these attitudes in themselves, they may avoid confronting the denial, disappointing the idealization (as described above), or in other ways avoid taking appropriate risks in the therapy. They may want too much for the therapist-perpetrator to succeed, and be unwilling to test this out in ways that might be temporarily disruptive to the therapy.

Another kind of strain on the treating therapist can occur. As therapist-perpetrators begin to receive legal consequences for their unethical behavior, the response of the legal system may not be consistent. Even with the clearest procedures, some aspects of the legal system may remain unpredictable. Justice may not always be done, or at least not done to the satisfaction of the treating

therapist. The treating therapist must then be careful not to collude with the denial and minimization of the therapist-perpetrator, even if the treating therapist and the therapist-perpetrator both feel that the therapist-perpetrator was treated unfairly. In other words, if the legal system responds unfairly to the therapist-perpetrator, this does not change the fact that the therapist-perpetrator did unethical and damaging things to his or her client(s).

During treatment, information which may substantially change the treating therapist's understanding of the therapist-perpetrator and the treatment plan may arise. I would like to emphasize that not all new information about further abuse will necessarily change the treatment. For example, if a therapist-perpetrator admits to sexual involvement with six clients with whom he has had major sexual contact, and in the course of therapy admits to making passes which did not result in sexual contact with two more clients, this may not drastically change the treatment plan.

It is important that the treating therapist not be compromised by being the only person who knows of serious information which pertains to the therapist-perpetrator's behavior. If the treating therapist uncovers new information of a serious nature, he or she should follow whatever mandated reporting requirements are in effect. However, as these requirements are currently in flux, they may not be adequate to respond to the situation. The treating therapist may request that the therapist-perpetrator report him or herself to the appropriate licensing board or other authority. If the therapist-perpetrator does not comply, the treating therapist has the option to decide that the original treatment plan is no longer viable in light of the new information. If, after stating that the therapy cannot move forward until a therapist-perpetrator makes such a report, the therapist-perpetrator still refuses, the treating therapist then has the option of terminating therapy. While this situation of change in the data base about the therapist-perpetrator is manageable, it is also stressful.

It is strongly recommended that treating and evaluating therapists develop a support system of peers working in this area for consultation and support. Further, treating and evaluating therapists should be thoughtful and deliberate in deciding how many of these cases they wish to take. Careful monitoring of one's stress level and countertransference reactions are also crucial.

Administrative Issues

As a general policy, I recommend giving copies of correspondence with licensing boards, administrative agencies, attorneys, and similar bodies concerning the therapist-perpetrator to the therapist-perpetrator directly. This is consistent with data privacy laws, and also helps maintain a clear boundary with the therapist-perpetrator by spelling out what role the treating therapist is playing with regard to these various agencies.

It is recommended that therapist-perpetrators sign an informed consent document at the beginning of treatment, agreeing to the nature and course of the therapy offered. At a minimum, this informed consent document should indicate that the therapy is likely to be anxiety-provoking, of long duration, and may result in recommendations which effectively make it impossible for the therapist-perpetrator to ever practice again. It may also be wise to include in this document how the treating therapist will respond to information which substantially changes the initial treatment plan.

When Not to Treat

There are numbers of situations in which the treatment described here is contraindicated or at least should be viewed with considerable caution. Because it is an exploratory and anxiety-provoking therapy, it is not likely to be appropriate for therapist-perpetrators who are psychotic or borderline.

This therapy model is probably not appropriate for therapist-perpetrators who are primarily character disordered. Many of these individuals will self-select out of therapy during the assessment or early stages. These individuals will often not admit their unethical actions, or will consistently minimize the impact of their actions upon clients. If this is the case, then treatment should not proceed because there is insufficient agreement for a therapeutic contract.

There may be situations where there is virtually no agreement between what the client alleges and what the therapist-perpetrator admits. Consequently, it is unclear to the treating therapist whether the therapist-perpetrator is lying. In these cases, it is advisable not to treat, because there is no basis for a therapeutic contract.

In my opinion, severely character disordered therapist-perpetrators are not treatable to the extent that they can

can resume practice; therefore, the response to them should be legal, not therapeutic. The licensing board should make it clear that resumption of practice will never be a possibility, although they may pursue treatment for personal reasons.

Who can Function as Evaluating and Treating Therapists

The combination of a firm ethical stance and respect towards the client has been emphasized throughout this paper. There are numbers of additional qualities that are important for evaluating and treating therapists. Such therapists should have a fairly high tolerance for ambiguity, as these cases may remain uncomfortably vague for long periods of time.

At the same time, such therapists ought to be able to maintain a goal-directed focus to minimize ambiguity, and to make certain that the therapist-perpetrator does resolve issues and accomplish goals directly related to their unethical behavior, regardless of what other personal problems may emerge.

Therapists who have strong and overriding political viewpoints on this issue are likely to err in the direction of being either disrespectful, or not firm enough about ethical matters. Therapists working in this area ought to have a fairly high tolerance for interaction with the legal system and its unpredictability, and should be adept at rendering testimony. Further, they should be comfortable in working within a "legal mind-set" (i.e., assuming anything they say or do may be challenged in a legal arena).

Therapists working in this area can expect to endure both overt criticism and covert undermining from colleagues who may be ignorant or insensitive about the exploitative nature of sexual contact with clients, or who may be aligned with certain therapist-perpetrators. Therapists who are highly vulnerable to political pressure from allies of therapist-perpetrators because of the nature of the setting in which they work are probably not in a position to do this sort of work.

A therapist working in this area must be able to resist the temptation of media attention. It is my opinion that no matter how sensational or important the case, or how much the therapist-perpetrator client may want it, the evaluating or treating therapist should avoid public statements, unless there is a clear therapeutic purpose, as well as a properly constituted release of information. As the evaluation and treatment of therapist-perpetrators are very much in a fledgling stage, treating and evaluating therapists have an obligation to be cautious and circumspect in their general comments about such work to the media, and not use their work in this area as a route to self-aggrandizement.

Finally, it is my observation that therapists who have a dynamic of under-control vs. over-control in their own personality structures have a difficult time serving as evaluators or therapists for therapist-perpetrators. They are often too trusting when they should be more skeptical, and too angry and vengeful when they should be more patient in working with therapist-perpetrators.

Final Comments

I would like to emphasize again that the model described here is for treatment of therapist-perpetrators who are more or less neurotic. It is probably not applicable to other types of therapist-perpetrators. I would also caution the reader against taking the division of the therapy into phases too literally.

The concept of phases in this context is more a convenient vehicle for discussing various phenomena that occur in treatment rather than an accurate description of the progress of such treatment. There is very much a "back-and-forth" aspect of the treatment described here, as has been mentioned at numerous points in the paper.

The ideas presented here are based on a small number of cases, and should be viewed as initial hypotheses about treatment with a subset of therapist-perpetrators, and by no means as the final word. It is my hope that the contents of this paper will stimulate thought and discussion as opposed to directing practice rigidly.

Finally, I would like to remind readers of the overall context in which sexual exploitation of clients by therapists occurs. Until very recently there were few systems of accountability for perpetrating therapists and little recourse for client-victims. The most common outcome was that clients would be discouraged from complaining by most institutions, including those set up to protect clients, and that if a complaint was made, little or no action would be taken. In recent years, as knowledge about this victimization has developed, there

has been greater sensitivity and receptivity to complaints on the part of licensing boards and ethics committees of professional associations. There have been legal changes, including criminalization of sexual exploitation of clients by therapists, changes in the civil law, and strengthening of administrative procedures designed to give complaining clients greater recourse. While it remains to be seen whether these measures will prove as effective as they are intended to be, there has been a general movement for clients to have greater recourse, and for greater accountability for therapists.

What this may mean in terms of the context is that, in the past, it would have been a very rare occurrence for a client to file false complaints against the therapist. The entire system was so weighted to vindicate the therapist, that such a client would have had to have severe reality-testing problems to make a false complaint and in fact, it has been typical for the clients who make false complaints to be psychotic or borderline psychotic. As the system becomes more equitable, however, this predictable pattern *may* break down, and it is conceivable that the future may hold an increase in false or exaggerated complaints against therapists. Another, and perhaps more cynical, way of saying this is that in the past it was highly unlikely that character disordered clients would file false complaints because there was no gain to be had; whereas, it was highly likely that character disordered therapists would be exploitative because there were few consequences to be had. If this balance shifts as a result of the recent changes to assure accountability and equitable outcome, the process of investigating complaints by clients about therapists is likely to become significantly more difficult and complex.

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Countertransference Issues for Therapists Working with Sexually Exploitative Therapists*

Ann Stefanson

As I began to think about and work on this presentation, I was struck by the fact that this is such a new area for us as therapists that there are no experts with any history. There are at least as many questions as there are answers — if not more.

Countertransference is a process is which the personal issues of the therapist interfere with her/his ability to see the client clearly and objectively as a separate person. The therapist may have no awareness of this process. Such interference not only clouds the therapist's picture of the client; it also prevents the therapist from offering any objective help to the client. In such circumstances, the therapist will be likely to work out their own needs and issues, rather than those of the clients.

I'm going to talk about what I believe are some of the countertransference issues that arise as personal issues or conflicts for us as therapists when we deal with therapist-perpetrators who have sexually exploited clients. These dilemmas may vary, depending on whether we are acting as evaluators or as treating therapists. Also, male and female therapists may face some different countertransference issues that may vary with the gender of the therapist-perpetrator.

Countertransference Issues In Assessment

Consider the therapist who is doing the assessment or evaluation in which the goals are: 1) to create a plan for intervention that will prevent the therapist-perpetrator from repeating victimization of clients, and 2) to determine whether the individual can be rehabilitated to the point of being able to resume practice. There can be some very important and blinding countertransference issues for the evaluating therapist. For example, if I'm the evaluator, I, too, am a therapist, have gone through training similar to that of the therapist-perpetrator, and make my living doing therapy. Because I identify with the therapist-perpetrator, it may be difficult to make a strong recommendation that will deprive this therapist of his or her livelihood. Further, since I'm a therapist, I want to believe in people's ability to change, so I might be far more comfortable in recommending suspension with a period of therapy, supervision, and restricted practice, rather than permanent loss of the right to practice.

At the time of the assessment, the therapist-perpetrator is under great stress, and may be very frightened. He or she may be minimizing the impact of the abuse *or* may be appearing terribly remorseful. Again, as therapists, we might over-identify with the therapist-perpetrator, and remember times of stress for us, and times when we have been sexually attracted to clients. So, instead of seeing the full extent of the pathology, we may only see hope in the remorse — hope for change. The greatest risk in working with exploitative therapists is our own corruptibility, the potential loss of our objectivity and separateness, due to our own personal issues or our own values.

Therapist-perpetrators often see themselves as victims of seductive clients. Some have gone so far as to say that the victims wouldn't have been able to take rejection of their sexual advances and needed the therapist to participate in order to have an ego-enhancing experience. If the evaluating therapist begins to lose sight of the inherent power imbalance in all psychotherapeutic relationships, he or she cannot be helpful. Most of us have felt helpless with a client at some point, but that is a part of our own countertransference reaction. In reality, the therapeutic relationship is unequal, and the therapist is the powerful helper, no matter how helpless he or she may feel. What happens in the session is always our responsibility.

I believe that recommendations for restricted practice often come out of our wish not to deprive other therapists of their livelihoods, and that our proposed restrictions and their implications for future clients are not very well thought out. In the case of a male therapist who has sexually exploited a female client, how do I justify recommending that his work be restricted to work with male clients? One time when this issue was being

* This article was first presented at "IT'S NEVER OK: THE FIRST NATIONAL CONFERENCE ON SEXUAL EXPLOITATION BY COUNSELORS AND THERAPISTS."

discussed in a group of therapists and lay people, one of the men, a physician who was currently in therapy, said, "I don't want to see a male therapist who has victimized women. Some of my issues concern my attitude about women and my wife, and how's he going to help me with them? Don't dump that on me; it's disrespectful and unfair, and I wouldn't even know who I had chosen as a therapist." One of the women present asked how others would feel if they knew that the man their daughter was about to marry was in therapy with a man who had sexually abused women. In making recommendations for restricting the practice of sexually exploitative therapists, we must consider who is exposed to the attitudes and issues of that therapist, not just whom he or she may overtly victimize.

This is not to say that all therapist-perpetrators should never practice again. An extensive diagnostic process is essential to determine recommendations concerning the continued practice of sexually exploitative therapists. The prognosis may be positive for a therapist who has committed a one-time, stress-related offense, because such individuals are usually very amenable to corrective therapy and supervision. On the other hand, I believe that perpetrators who are diagnosed as sociopathic should no longer be allowed to provide the service of therapy. This whole question of who should be allowed to continue to practice and under what conditions is currently the subject of much debate, and there is not total agreement among those of us who have been struggling with this issue.

Addressing Countertransference Issues

What do we do to avoid countertransference issues during the assessment or evaluation period? We don't avoid them — we deal with them. The actions required in doing an evaluation include: interviewing the therapist, psychological testing, fact-finding, and setting limits — all in an atmosphere of accountability. A crucial safeguard to our own countertransference issues and corruptibility is consultation with one or more colleagues who have worked with exploitative therapists. By consultation, I don't just mean talking about the data, I mean that the assessors need to talk about their own struggles and feelings about the therapist-perpetrators, and about the recommendations that they will make based upon their evaluations.

Also, there would be less chance of corruptibility if the evaluator was not also a possible candidate to be the treating therapist for the perpetrator. It might be difficult to evaluate therapist-perpetrators without beginning to look at how you as a therapist could help them. I believe this puts a double strain on the therapist-evaluator and it may double the impact of the wish to believe that everyone can change. Or, if the evaluator had a particularly negative personal reaction to the therapist-perpetrator, he or she might make a more severe recommendation than was warranted. This is another point where there is disagreement.

Countertransference Issues in Doing Psychotherapy with Therapist-Perpetrators

The treating therapist also has to face some very challenging, ongoing countertransference issues. I'm going to tell you some of what I struggled with as a treating therapist the first time I was faced with a sexually exploitative therapist. I'm going to disguise the case, but to the extent that I am aware, I won't disguise myself. A male client that I had been seeing for about a month told me toward the end of a session that he had had sexual intercourse with two clients and that one was currently available anytime he called. Since one of them was now an ex-client, was willing, and was sometimes the initiator of the sexual encounters, he didn't think it was harmful to her. My first internal reaction was, "I don't want to hear this". My second reaction was a feeling of disgust for what he was doing. I cannot believe that those internal reactions didn't affect my work in the final moments of that session.

My next move was to go for consultation concerning (1) my own feelings about working with a male perpetrator who abused female clients; (2) my feelings about identifying with a therapist who might lose his livelihood; and (3) my feelings about the unequal power inherent in the therapy relationship and how he had abused this power with clients who had trusted him. Since I had also been the client of a male therapist, I had a powerful identification with the two victims. I needed consultation to determine whether I *wanted* to be helpful to this exploitative therapist, let alone whether I was *able* to do it.

In retrospect, I believe that this therapist-perpetrator should have had a second, more objective therapeutic evaluation in terms of therapy issues and a treatment plan. I was already biased by having worked with him for a period of time before the abuse was acknowledged.

As treating therapists, we are continually challenged by the therapist- perpetrator's tendency to minimize the harm done to victims *or* to feign remorse. It is often difficult to determine whether the therapist- perpetrator

is actually feeling remorseful or is only pretending to be remorseful in order to manipulate the treating therapist. The difference becomes evident over time. If it is feigned remorse, the therapist-perpetrator will be inconsistent in some way. This often involves blaming the victim.

As therapists, we are forever looking into a client's background and attempting to understand why a client feels and acts the way she/he does. I will often say to a client, "You have very good reason for feeling the way you do." However, there is an ever present danger when working with therapist-perpetrators of this understanding being seen as an excuse for the abusive behavior. I believe that we must hold the therapist- perpetrator accountable for his or her actions. I may understand why, from a perpetrator's background of sexual abuse, he or she may feel like abusing clients; but, it does not justify the abuse in this situation where the victimizer should have been the responsible party. This is not a relationship of equals and we must not lose sight of that, as much as the exploitative therapist may like us to do so.

Special Issues for Female Therapists

The female therapist may face some special countertransference issues, depending on the gender of the perpetrator and that of the victim. In the case of a male perpetrator and a female victim, the female treating therapist may feel fear, revulsion, and uncertainty in the presence of the male therapist-perpetrator. She may feel angry at him and want to deprive him of his livelihood, no matter what his diagnosis is. Many therapists have been clients themselves and know how dependent they felt on their therapists and how much they trusted them to help, rather than hurt them. If the male therapist-perpetrator expresses deep remorse, the treating female therapist may inaccurately interpret it as genuine remorse and a sign of recovery. In these times when we American women are looking for sensitive men who can cry, we are sometimes too willing to accept what looks like sensitivity in men without evaluating the facts objectively.

In working with female therapist-perpetrators who have male victims, the female treating therapist may feel protective of the woman. Also, female treating therapists may so solidly believe that in this society men have the power that they may have difficulty seeing an adult male as an actual victim of a female therapist.

Special Issues for Male Therapists

A male treating therapist in a situation with a male therapist-perpetrator and female victims may have difficulty with his own feelings about the fact that he and the perpetrator are both men. One such treating therapist that I talked to said that he felt ashamed and guilty when he thought of the female victims *and* felt angry at the therapist-perpetrator for giving male therapists such a negative image.

On the other hand, the male treating therapist may wish to deny or minimize the male therapist-perpetrator's deeds because he doesn't want to believe the behavior was that destructive. He may think, "There but for some additional stress go I." That's a frightening, humbling thought. It is difficult not to over-identify.

Other Special Countertransference Issues

Treating therapists, female or male, who have been sexually abused themselves may have a particularly hard time with exploitative therapists. They may be especially vulnerable to getting tangled in the therapist-perpetrator's power issues. Treating therapists who have been abused may be threatened by the victimizer and feel so helpless and vulnerable that they back down from being helpful and setting limits. Or, they may go to the other extreme and be very angry and punitive. Either way, the therapist-perpetrator may not get a fair and objective evaluation or therapy.

If the evaluating or treating therapist and the therapist-perpetrator are both members of any oppressed minority community, then the therapist may feel very ambivalent if he or she is faced with exposing the misconduct and possibly bringing down more stereotyping or other forms of oppression on the community. This is true for racial minorities, the gay and lesbian communities, and other beleaguered groups. Because there is an element of truth in this fear, expert consultation to sort out the social reality and the countertransference issues in order to make appropriate decisions is crucial.

Conclusion

There are, of course, many more countertransference issues — as many as there are different therapists with different backgrounds and cultural expectations. The main point I want to get across is *the need for consultation for therapists* working in this area which requires so much objectivity and skill, and has so much potential for arousing our countertransference issues.

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Sexual Exploitation by Psychotherapists: Some Observations on Male Victims and on Sexual Orientation Concerns

John C. Gonsiorek

Introduction

This paper presents some initial observations on men who have been exploited by their psychotherapists and on sexual exploitation situations in which both therapist and client are of the same sex. The ideas presented here are observations based on a limited number of cases in which I functioned either as a consultant to one of the parties involved, or as a follow-up psychotherapist to the male client who had been sexually exploited by his male therapist. The ideas presented here are highly tentative, and it is unclear to what extent they may be representative of these phenomena in general.

Schoener, Milgrom, and Gonsiorek (1984), in describing the sample of initial cases of sexual exploitation by psychotherapists handled by Walk-In Counseling Center of Minneapolis, reported that of 250 cases, 208 represented situations with male psychotherapists and female clients, 30 cases involved female psychotherapists with female clients, 8 cases involved male psychotherapists with male clients, and 4 cases involved female psychotherapists with male clients. While it is clear that "typical" sexual exploitation by a therapist involves a male therapist and a female client, it is also clear that it is more true that the "typical" client-victim is female more than that the "typical" perpetrator is male. The fact that there were 30 female-female cases is somewhat surprising, given that the base rate for female homosexuality in the general population would suggest a figure half as large, or less. It is unclear how accurate the data on male victims are, because there are some characteristics of male victims that make it less likely that they will report sexual abuse by psychotherapists.

Characteristics of Male Victims

The impact of sexual exploitation by psychotherapists upon the victims has been described by Luepker and Retsch-Bogart and by Milgrom and Schoener in this section of the handbook and includes guilt, shame, grief, anger, depression, loss of self-esteem, ambivalence, confusion, fear, and distrust. It is my observation that male victims as well as female victims display these characteristics, but there also appears to be some unique aspects of the experience of male victims.

Male victims tend to have a difficult time perceiving that they have been victimized. My hypothesis is that this difficulty is related to male sex role socialization. It is congruent for a woman socialized in this society to view herself as having been victimized; however, it is highly incongruent for a male socialized in this society to perceive himself as having been victimized. Another way of saying this might be that males tend to assume that any power dynamic operates in their favor. They tend to have a high level of denial that this may not be the case, and that they are powerless and have been victimized. Further, the psychological aftermath experienced by victims of sexual exploitation by psychotherapists described above appears to be egodystonic (i.e., not viewed as a part of themselves) for many male victims. There is, therefore, an initial barrier of denial that the victimization occurred, and then a second barrier of denial as to what the effects of that victimization have been with male victims.

In a similar vein, many men tend to view sexual expression as a male prerogative. Men often have a tendency to view any sexual experience as something they have chosen or created rather than as something in which they may have been manipulated, tricked, or forced to participate. It is striking how many male victims, even in the face of much corroborating evidence that their exploiting psychotherapist was manipulative, retain the belief that the sexual interaction was freely chosen by them and was their prerogative.

This is especially true when the psychotherapist is female and the client is a heterosexual male. Gay male victims of male psychotherapists tend to fall in between female victims and male victims of female psychotherapists in their responses. It is my hypothesis that during their own coming out processes some gay male clients have experienced sexual manipulation at the hands of other males, and so can perhaps more readily identify it and react against it.

Finally, there are a number of client reactions that appear to be particular to same-sex involvements which will be described below.

Impact upon the Client of Same-Sex Exploitation by Psychotherapists

The sexual orientation of clients may have an impact on how sexual exploitation by therapists will affect them.

Clients whose orientation is firmly heterosexual are apt to view the experience of sexual contact with a therapist of the same sex as highly egodystonic. It appears that this can create two very different effects. On the one hand, some of these individuals may more easily see the exploitation as victimization, precisely because it is egodystonic for them. On the other hand, other clients seem to feel extremely ashamed and confused, and have a great deal of difficulty making sense of the experience.

In some of these individuals, the exploitation can precipitate a crisis about sexual identity which appears to have little or no basis in their own history, but stems directly from the exploitation.

I have a very tentative impression that heterosexual males more easily view sexual contact with a therapist of the same sex as exploitative than heterosexual females, who have a tendency to be somewhat more confused and disoriented by sexual exploitation by a female therapist. Although certainly both sexes present the full range of phenomena, this may be due to the fact that heterosexual males tend as a group to be more intolerant of homosexuality. They view it as more alien to them, and distance themselves from it more strenuously.

Clients whose sexual orientation is homosexual often present some different issues. They may have a difficult time complaining about a therapist of the same sex who has exploited them for fear of being disloyal to their community. In other words, their perception that the exploitative therapist is a member of their oppressed minority group makes for a greater ambivalence about filing a complaint. Client-victims who are homosexual may often have realistic fears, that in the process of taking action against the exploitative therapist, their own sexual orientation may become public, and they may become victimized as a result of this by larger forces in society. While this may at times stem to some degree from internalized homophobias (i.e., self-hatred for being gay; see Malyon, 1982) in the client, it is important to note that the process of complaining realistically represents a much greater risk for homosexual clients. If their sexual orientation becomes public, they may well experience discrimination.

The experience of being exploited by an individual of the same sex may increase the internalized homophobia of a homosexual client because it may contribute to a belief that same-sex relationships are untrustworthy, damaging, and improper. I have the impression that there are also some sex differences in this situation. Some gay males will have a hard time perceiving sexual exploitation by a male therapist as victimization to the extent that they view sexual contact with a variety of males as part of their gay life-style. There is a segment of the gay male community which in some ways is "super male" with regard to viewing sexual behavior as their prerogative. This intensification and crystallization of male attitudes may make it difficult for this subset of individuals to see that they have been used. On the other hand, there are some other gay men who may have had the experience of being sexually manipulated by other men during their coming out process, have worked this through, and have developed the assertiveness skills to avoid being sexually exploited by other men. Paradoxically, this other group of gay men may very quickly label sexual contact with their therapist as exploitative, with minimal denial, and a clear understanding of the abuse involved.

Lesbian clients, particularly if they are strongly feminist-identified, may be deeply ambivalent about complaining about a female psychotherapist who has sexually exploited them, especially if that female psychotherapist is also lesbian and/or feminist-identified. The strong sense of cohesion in many lesbian communities may set up expectations that women, especially lesbian women, must never betray other women.

Again, paradoxically, those lesbian clients who are assertive and clear about the nature of exploitation may have an easier time viewing the situation as exploitative. However, the pressures towards cohesion in the lesbian community do appear to be stronger than in the gay male community. Further, some feminist therapists hold a personal and political belief that therapists and clients should be equal. This belief may make it easier to rationalize or deny the beginnings of boundary violations.

Those clients who are confused about their sexual orientation are often thrown into a deeper stage of confusion when they are sexually exploited by their psychotherapists. Often these individuals display intense ambivalence about filing a complaint, as well as intense ambivalence about their own sexuality. Some clients who

are confused about their sexual orientation are exceptionally vulnerable to prolonged and highly negative effects of being sexually exploited by their psychotherapists, regardless of the sex of that therapist.

Description of Therapist-Perpetrators in Same-Sex Exploitation by Psychotherapists

The description below is not meant to be a substitute for the therapist types described by Schoener (1987), Gonsiorek (1987), and by Thompson in this handbook, but is meant to be an addition to that typology. There appears to be some variation among the therapists who sexually exploit clients of the same sex.

One situation in which psychotherapists appear to be vulnerable to sexually exploiting clients of the same sex occurs when the psychotherapist is in the process of working out his or her own coming out issues. It is important to note that such individuals represent a risk to clients who are gay or lesbian or confused about their sexual orientation, independent of any direct sexual exploitation per se. As such, psychotherapists go through their own denial, ambivalence, and internalized homophobia, and this may often be projected, acted out, or in other ways foisted upon clients. Such psychotherapists may be consciously or unconsciously seductive to clients, particularly if the psychotherapist is fearful of taking risks in disclosing his or her sexual orientation to others. They may unconsciously encourage clients to take poorly planned risks or no risks at all.

Another risky situation occurs when the therapist, whose sexual orientation is more or less stable as gay or lesbian, is socially isolated. This may be a result of poor social skills, depression, a series of stresses or setbacks in their personal life, or other factors which may be characterological or situational. These psychotherapists may tend to view their gay or lesbian clients or clients who are confused about their sexual orientation as peers, or as their support system.

If these psychotherapists perceive themselves to be powerless, or are fearful or unsuccessful in social situations with other gay or lesbian individuals, they may begin to socialize with their gay or lesbian clients because this is an environment in which they can feel respected, successful, and powerful. The situation may then lead to sexual involvement with clients. This is a situation where the sexual exploitation may be the tip of the iceberg if the therapist is using the client for social and personal needs (whether or not any sexual contact occurs). While these problems are certainly not unique to gay and lesbian psychotherapists, they may realistically have less opportunities to reduce isolation.

A final situation which I have observed appears to be the most damaging, exploitative, and perhaps bizarre. These involve psychotherapists who are deeply ambivalent and profoundly conflicted about their same-sex feelings. They are intensely homophobic, and their same-sex feelings are fragmented, at times split off and not integrated into their emotional life. These individuals may act out sexually with clients of the same sex as they feel that they can keep the situation as a "dirty little secret". They often project their intense ambivalence and self-hatred onto clients, and may overtly or covertly blame clients for the sexual interactions. They may give clients messages that they are sick and perverted for being involved in same-sex situations, and that the involvements are all their fault. These psychotherapists frequently are highly disparaging towards other gay or lesbian individuals, may actively discourage a client from forming a support system in the gay or lesbian communities, and give the client the message that gay/lesbian individuals are pathological.

There may even be denial that the sexual contact between the client and therapist represents a homosexual experience. Instead, it may be couched in terms of a "special friendship," or similar situation. I do have a tentative impression that this kind of exploitative psychotherapist tends to be represented somewhat more among clergy or pastoral counselors. The effects of this situation upon the client are often profoundly damaging.

Special Problems Presented by Same-Sex Exploitation by Psychotherapists

There are some unique problem areas presented by situations in which the exploitative therapist and the client-victim are of the same sex.

Particularly if the exploitative psychotherapist is heterosexually married or alleges to be heterosexual, the client may not be believed. For those clients who are gay or lesbian, their sexual orientation may be pathologized and used as "evidence" against them. The purportedly heterosexual therapist who may be a "pillar of the community," but who sexually acts out with clients of the same sex, is the most extreme example of this.

Homosexual clients, especially those who are lesbian, are likely to be highly conflicted about loyalty issues to their minority community in the process of filing

complaints. There is often a realistic component to this ambivalence. It is my impression that psychotherapists who sexually exploit clients of the same sex, or who are believed to be gay, lesbian, or bisexual, are, in fact, often treated more harshly by licensing bodies, ethics committees, the media, and the public. Gay/lesbian clients may be faced with the untenable choice either to not complain and not stand up for themselves, or to set in motion a process which may result in yet another example of discrimination against gay or lesbian individuals.

Finally, gay and lesbian psychotherapists are often challenged to an unusual degree with situations presenting potential boundary problems. This has been described in a few sources (Anthony, 1982; Brown, 1984; Gonsiorek, 1982) as comparable to being a psychotherapist in a small town. A gay/lesbian psychotherapist is much more likely to operate in a social sphere in which clients or ex-clients may also operate. Gay or lesbian psychotherapists who work with gay or lesbian clients must make regular and challenging determinations about appropriate boundaries with clients and ex-clients. Such choices are relatively rare occurrences for heterosexual psychotherapists, except for those who may work in small towns or who may be psychotherapists who are members of other minority groups and are working in their own minority communities. Readers are referred to the sources noted above for further detail.

Recommendations

1. While protection of the complaining client is an important issue in many situations, it is especially important when the complaining client is gay or lesbian, or has been involved in a same-sex situation with their psychotherapist. It is recommended that licensing boards, ethics committees, and other agencies do whatever possible to guarantee anonymity for such clients, when needed.

2. Psychotherapists who are confused about their sexual orientation, or are in the process of coming out should not work with gay or lesbian clients, or with clients who are confused about their sexual identity, until their own issues are clearly resolved.

3. Gay and lesbian psychotherapists need to develop systems of consultation and support to handle the particularly intense and frequent boundary decisions which they face. This is to make certain that they do not work out any residual coming out issues or internalized homophobia with their clients, and that they do not use their clients as their support systems, particularly in times of stress. Developing a dialogue with peers about the "small-town" pressures of being a minority psychotherapist is highly encouraged.

4. Licensing boards and ethics committees should standardize their responses, in both investigation and disposition of complaints. This position is advocated for general reasons of fairness and equitable response, but particularly in this context, as a way to prevent homophobic responses to gay and lesbian psychotherapists who have been accused of ethical violations.

5. Again, I wish to caution the reader that the material contained in this paper is highly impressionistic and should be viewed as a vehicle for stimulating thought and discussion.

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Issues for Institutions that Train Counselors and Therapists

Issues for Institutions that Train Counselors and Therapists

Barbara E. Sanderson

Introduction

As gatekeepers for the mental health professions, colleges and universities that train counselors and therapists have a special role to play in the prevention of sexual exploitation of clients. Such institutions screen applicants for training programs, provide basic information on the process and ethics of providing counseling and therapy services, and monitor the clinical progress of their students.

Part of the professional credentials of graduates are the reputations of the institutions where they trained. Conferring a degree, in effect, places the seal of approval of a given institution on the graduate. Many clients expect the graduates of trusted institutions to conduct themselves in a competent, ethical manner. In other words, the degree granted by the college or university is one of the factors which create the inherent power imbalance between the counselor or therapist and the client. The institution has acknowledged the professional expertise of this practitioner by granting the degree. When these counselors and therapists subsequently exploit clients sexually, the institutions that conferred their degrees may deserve to be indicted along with the actual perpetrators.

Of course, no matter how responsible a training institution has been in regard to sexual exploitation issues, graduates may still be sexually exploitative. This section of the handbook addresses itself to some of the things college and university programs can do to maximize the probability of turning out competent, ethical counselors and therapists.

In many ways, the policies and procedures that make sense for training institutions to implement are similar to those for agencies that provide therapeutic services (see Administrative Issues section of this handbook). At a minimum, the following items need to be accounted for as training institutions seek to fulfill their responsibilities in this area: 1) policies prohibiting sexual exploitation of clients and sexual harassment of students; 2) comprehensive education on sexual exploitation and sexual harassment for faculty and clinical supervisors (including practicum site supervisors); 3) as complete a screening process for prospective students as the state of the art allows; 4) comprehensive, required coursework for students on the myriad of complex issues related to sexual exploitation; 5) clinical supervision of the work of students which continually raises and examines the issues related to sexual exploitation of clients; 6) clearly written and readily available mechanisms for clients and students to file complaints of sexual exploitation and sexual harassment; 7) procedures for investigating such complaints and a range of consequences for substantiated misconduct; and 8) an atmosphere in which ethical conduct on the part of faculty and students is nurtured and the educational institution embraces self-examination and renewal.

The first article in this section, "Course Curriculum for Training Institutions on Ethical Issues in the Development of Therapeutic Relationships" by Thomas, Cohen, Fontaine, Groesbeck, and Nelson outlines a model curriculum which training institutions may adapt for their use. Included in the curriculum is information on: the dynamics of the therapeutic relationship and their relationship to sexual exploitation; laws and ethical standards that relate to sexual exploitation; the setting and maintaining of appropriate therapeutic boundaries with clients; and therapeutic issues in dealing with clients who have been victimized and therapists who have been sexually exploitative. A resource bibliography concludes the article.

The second article, "Similarities between Counselor/Client Sexual Contact and Professor/Student Sexual Contact" by Sanderson, elucidates what is known about the relationship between these two problem areas. It examines current research and theory and raises ethical considerations for the mental health field. The article concludes with recommendations and suggestions for future research.

The final article, "Clinical Supervision of Counseling/Therapy Students As A Model for Non-Exploitive Professional Relationships: An Overview and Suggested Guidelines" by Conroe, Brandstetter, Brown, De Marinis, Loeffler, and Sanderson provides a discussion of how a clinical supervisor can assist students in developing helpful, ethical relationships with clients. Much of the paper is focused on dealing with the problem of sexual contact between supervisors and supervisees, including the ramifications for the supervisees' work with clients. The relevant professional literature is reviewed and guidelines are proposed at the professional, academic, and clinical levels.

The articles in this section begin to address the role of training institutions in addressing the complex issues related to sexual exploitation. These articles are by no means exhaustive and are offered in the hope that they will ignite discussion of these issues and will spur training institutions to act on them.

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Course Curriculum for Training Institutions on Ethical Issues in the Development of Therapeutic Relationships

Janet Thomas
Connie Cohen
Dominic Fontaine
Pat Groesbeck
Randolph Nelson

In recent years, clients who have been sexually exploited by therapists and counselors have become the focus of much public and professional concern. As more victims come forward and speak about their experiences, helping professionals are being forced to confront the issue in legal, therapeutic, and interpersonal arenas. Although the problem of sexual exploitation can and must be addressed by professionals at all levels of management and service, institutions of higher learning have a unique opportunity and a responsibility to educate future providers and to protect consumers of mental health services. Early intervention with students in human service fields could be accomplished with a course curriculum designed not only to increase awareness, but also to allow integration and application of concepts. Such a curriculum should be broad enough to identify the different ways that sexual exploitation impacts various groups within our society (e.g. students, people of color, those who have physical disabilities, those who are gay or lesbian, etc.).

As with any area of coursework, a curriculum that covers the multitude of issues related to sexual exploitation could take a wide variety of formats and the content could also vary. This paper presents one flexible model that could be used in training counselors and therapists. Training institutions are encouraged to be creative in implementing coursework in this area and to keep abreast with this rapidly changing field. To be most effective, all of this information must be applied in supervised work with clients.

The learning objectives of this curriculum include, but are not limited to the following:

A. To raise the consciousness level of students about the ways in which our culture devalues and denies worth to people/groups of people who differ in some way from the dominant culture (e.g. racism, classism, homophobia, sexism, etc.).

B. To inform students about the laws, ethical standards, and institutional policies which address sexual exploitation and to explore implications for helping professionals.

C. To provide a conceptual/theoretical framework for understanding the dynamics of counselor/client relationships and to teach the skills necessary for establishing clear professional boundaries with clients.

D. To discuss the dynamics of sexual abuse and sexual exploitation, to describe the effects on the psychological and emotional health of clients and to explore the implications for treatment.

E. To identify personal and professional strategies which can be used to maintain non-exploitative therapeutic relationships.

The following outline includes a series of training modules. The structure is intended to allow for maximal flexibility in implementation. The content of each module can be expanded or limited. Each could be taught separately in a seminar or workshop, or as a portion of a course. Additionally, these modules could be taught in succession as a complete course. A brief bibliography of recommended readings is included to supplement each module. This list is not intended to be exhaustive as there are many other excellent resources in this area.

I. Human Relations

A. The dynamics of racism, classism, homophobia, sexism, antisemitism, and other oppression issues and how they are related to counseling and therapy.

B. The use of power in the counseling/therapy relationship.

1. The power imbalance between counselor and client and the dynamics of therapy

2. Sources of power for the counselor/therapist

3. Parallels with abuses of power in the education and supervision of counseling/therapy students

C. The dynamics of victimization.

1. The psychological and relational effects of sexual exploitation on clients

2. The incidence of sexual exploitation

3. The underlying continuum of psychological problems of therapist-perpetrators

4. The inherent corruptibility of all therapists

II. Laws, Ethical Standards, Institutional Policies

A. College/university policies prohibiting the sexual harassment of students by educators and practicum supervisors.

B. Ethical standards (focus on specific profession).

C. Overview of the sexual exploitation laws in various states; focus on laws of home state.

1. Criminal laws

2. Civil liability of therapist-perpetrators and their employers

3. Administrative laws

a. Individual professional licensure or registration

b. Licensure of agencies and institutions

4. Other legal protections for clients (e.g., in Minnesota, the Vulnerable Adults Act)

D. Common sexual exploitation policies in mental health agencies and institutions.

E. Reporting of colleagues; legal and ethical considerations.

F. Politics of regulation of mental health professionals.

G. The role of professional organizations in policing the professional conduct of their members.

H. The complex nature of these issues and the potential for conflicts of interest in responding to ethical dilemmas.

III. Structure of Personal Boundaries in Counseling and Therapy Settings

A. Theoretical overview.

1. Family systems theory

2. Transference and countertransference

a. Identifying and addressing client's emotional and/or sexual attraction to a therapist (transference)

b. Identifying and handling countertransference issues (e.g., sexual/emotional attraction to a client, feeling responsible for a client's improvement, measuring professional success by client's success, etc.)

B. Values clarification.

1. List statements or present cases which exemplify the nature and characteristics of a therapeutic relationship and ask students to express their thoughts and feelings about each (e.g., "A therapist should refrain from dating former clients.").

C. Skills for clarifying boundaries/setting limits in a therapeutic relationship.

1. Assertiveness training

a. Concepts and skills for use in verbal communication

b. Applications for therapeutic relationships

i. Business issues, (e.g., payment for services, duration of sessions, phone counseling, calls after hours, etc.)

ii. Interpersonal issues, (e.g., accepting gifts from clients, responding to invitations to events, etc.)

2. Nonverbal communication and limit-setting

a. Impact of nonverbal behavior in therapeutic settings, including, but not limited to:

i. Body motion, gestures, facial expressions, eye movements, posture, voice tone and pitch, silent pauses, use of personal and social space, room size, seating arrangements, and distance between counselor and client.

b. Extensive exploration of the use of touch in therapy, including a framework for students to use in determining what is appropriate touch with individual clients.

c. Nonverbal dimensions of exploitative behavior

IV. Therapeutic Issues

A. Client vulnerability as a function of role.

B. Other issues related to client recovery (e.g., history of sexual abuse, presence of transference issues, social isolation, etc.).

C. Issues in recovery from sexual exploitation by a mental health professional.

D. The treating therapist as advocate for the exploited client.

E. Available treatment modalities for some categories of therapist-perpetrators.

V. Non-Exploitative Therapeutic Relationships: Issues In Prevention

A. Using clinical supervision during and after formal education, including case management, peer consultation, systematic performance evaluations.

B. Recognizing "red flags" signaling the need for consultation (e.g., excessive self-disclosure, feeling responsible for a client's progress).

C. Making ongoing efforts to address personal issues (e.g., through individual therapy, support groups, etc.).

D. Participating in continuing education to insure familiarity with issues related to exploitation.

E. Facilitating open versus closed organizational systems in agencies and institutions that offer counseling and therapy services.

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Similarities Between Counselor/Client Sexual Contact And Professor/Student Sexual Contact in Counselor Training Programs

Barbara E. Sanderson

In the 1970's, researchers began to examine sexual contact between counselors and clients and between professors and students. Until the last eight years, these have appeared to be two independent and seemingly unrelated endeavors. In 1979 Pope, Levenson, and Schover connected the two issues by examining sexual contact between professors and students in psychology training programs.

In the profession of psychology, both types of sexual contact are viewed as unethical conduct on the part of the counselor or the professor by the American Psychological Association (APA, 1981). As Edelwich and Brodsky (1982) put it,

> Although some doctors have been sleeping with their patients since the days of Hippocrates (and some teachers with their students since the days of Socrates), a consensus has developed within the profession that there is no place for sex or other forms of personal intimacy in a professional helping relationship with a vulnerable person.

Bouhoutsos (1984) suggests that modeling of professor/student sexual contact in psychology training programs affects future counselor/client sexual behavior.

If this relationship can be confirmed, the implications for counseling and the training of counselors will be far-reaching. This paper will attempt to take a first step in determining the relationship between these two important areas. The existing research and theory on professor/student sexual contact and counselor/client sexual contact will be examined for similarities between clients and students and between counselors and professors. Then, the similarities in the power dynamics between the two kinds of relationships will be explored. Ethical considerations will be noted and possible implications for the field of mental health will be drawn, including suggestions for future research.

Similarities Between Clients and Students

The similarities between clients and students who have sexual contact with their counselors or professors will be examined in terms of incidence, personal characteristics, vulnerability, transference, harmful consequences of the sexual involvement, and payment for services.

In order to obtain incidence results from research that are generalizable to the wider population, the research population must be drawn as a random sample of the population. While it is relatively easy to determine a random sample among students, the population of therapy clients is much less available for sampling, due to the restraints of confidentiality.

Consequently, there are no random samples of clients available to compare with the several randomly drawn samples of students. One such study of students (Wilson and Kraus, 1983) studied 334 students at East Carolina University in a survey with a 61% return rate. Physical assault, overt demands for sexual activity, subtle pressure for sexual activity, or unwanted touching were experienced once (or more times) by 10.7% of the students sampled.

Findings on personal characteristics of the student and client victims are interesting, but do not permit much comparison. Wilson and Kraus (1983) attempted to discover differences between those students who were most satisfied with their friendships and dating relationships, had the most friendly interaction styles, had the most positive relationships with faculty, or who scored most masculine on the Bem Sex Role Inventory were most likely to be the recipients of the unwanted sexual attention listed above from faculty members. Feminist orientation, physical attractiveness, and grade point average did not make a significant difference.

Luepker and Retsch-Bogart (see article in Therapeutic Issues section of this handbook) studied 27 women who sought therapy to recover from their sexual involvement with former therapists. They report,

> Although we lack data to make a definite comparison, our own and colleagues' unequivocal impression is that this population's characteristics are representative of our general agency client population. An exception is this population's high percentage (40%) of psychiatric hospitalizations, which seems much greater than that found in the agency's overall client population.

Students and clients are both vulnerable, but in different ways. Edelwich and Brodsky note,

> A client in therapy is a client by virtue of some acknowledged difficulty in coping; a student is a student by virtue of being less knowledgeable in the area under consideration.

Hare-Mustin (1979) further highlights the vulnerability of the client when she says that,

> Persons entering therapy do so in a help-seeking posture, not a self-protective one . . . The therapy situation is a novel one for most clients. They do not know what role to assume, and they do not know their rights... Some clients entering psychotherapy may not be capable of protecting their rights.

Kardener (1974) claims that the transference of a client's feelings about his/her parents to the therapist is so powerful that it makes the prohibition of sex in therapy akin to the incest taboo. Indeed, much of the therapy since Freud has centered around building and using the transference relationship.

The question arises as to whether the concept of transference may be applied to the student/professor relationship. In testimony taken during a Sexual Harassment Board hearing at the University of Minnesota (Beal vs. Oden, 1984), Pearl Rosenberg, clinical psychologist, asserted that a transference relationship may develop between a student and a professor. She explained that it is most likely to happen in classes that become support groups where students are encouraged to disclose personal information or when the student goes to the professor with his/her personal problems. This would be especially true in classes training counselors or therapists. Skeen and Nielsen (1984) attempted to determine whether transference was at work in the relationships of 25 sexually involved students and faculty (not randomly selected) they interviewed by asking them if their sexual partner reminded them of anyone. Only five of the subjects responded affirmatively. It is doubtful that this question adequately assessed the presence of transference because it is usually considered to be an unconscious and far more complex process.

A number of researchers have attempted to assess the harmful consequences of sexual involvement for clients and students. Adams, Kattke, and Padgitt (1983) randomly sampled 372 students at Iowa State University.

> Of the students responding, 13% of the females and 3% of the males said they had avoided taking a class from or working with a faculty member who was known or rumored to have made sexual advances to students... A substantial number of female students (composed of similar percentages of graduate and undergraduate women) are deprived of academic opportunities simply because they wish to avoid situations in which they believe they might be subjected to sexual advances from faculty members.

Another random sample study was conducted at the University of California at Berkeley (Benson and Thomson, 1982). Seven percent of the 269 women surveyed "experienced self-doubt and loss of confidence in their academic ability after harassment. This occurred when students were unable to avoid their instructor."

In trying to assess the damage done to clients by sexual interaction with a therapist, Bouhoutsos, Holroyd, Lerman, Forer, and Greenberg (1983) sent letters to all of the licensed psychologists in California. Seven hundred and four (16%) replied, giving information on 559 clients who had been abused by former therapists. While the low response rate makes generalization difficult, the damage that the reporting psychologists perceived to be the result of the former therapist/client sexual relationship was considerable. In 34% of the cases the client's personality was adversely affected through "increased depression, loss of motivation, impaired social adjustment, significant emotional disturbance, suicidal feelings or behavior, and increased drug or alcohol use." Sexual, marital, or intimate relationships worsened in 26% of the cases. Forty-eight percent had problems forming a new therapeutic relationship and were suspicious and mistrustful of therapists.

In working with over 1,000 victims of client/therapist sexual exploitation, Milgrom and Schoener (see article in Therapeutic Issues section of this handbook) observed a common pattern of emotional experience by these clients: guilt and shame, grief over the loss of a relationship, anger or rage, depression and loss of self-esteem, ambivalence and confusion, fear and massive distrust.

These findings are supported by similar clinical observations made by Sonne, Meyer, Borys, and Marshall (1985) with a group of eight female victims at the UCLA Psychology Clinic.

Vinson (1984) located 28 client victims through newspaper advertisement and grapevine solicitation. Sixty-three percent had paid full fee for some or all of the therapy in which the sexual exploitation took place. "Most of these subjects continued to pay the regular fees after the sexual relationship started, regardless of whether the session was spent in sexual activity or remained focused on the subject's issues." Students may find themselves in a similar position of paying registration or other fees connected with the professor who is attempting to sexually harass them.

Similarities Between Counselors and Professors

The next comparison will be between counselors and professors sexually involved with their clients or students. Similarities will be considered in the areas of incidence and beliefs, situational factors, psychological characteristics, and countertransference.

Holroyd and Brodsky (1977) conducted a random sample of psychologists, surveying 666 members of the American Psychological Association (a 70% return rate). Four percent of this sample admitted to having sexual relations with clients during the course of therapy and another 4.1% within three months of the termination of therapy. These therapists had been sexual with an average of 5.3 clients each. Only 2 to 4% of the entire sample believed that such erotic contact might ever be beneficial to patients.

Pope, Levenson, and Schover (1979) also surveyed APA members, and they also attempted to subgroup respondents. Forty-nine percent (481) of those polled comprised the sample and 247 of these responded as psychology professors. Of this subgroup, 12% admitted to sexual contact with their students. Only 2% of the entire sample believed that "sexual relationships between students and the psychology teachers, administrators, or clinical supervisors can be beneficial to both parties." While this survey did not ask about the number of students with which each professor had been erotic, Till (1980) hypothesized from the results of a national call for information on sexual harassment of students that "the behavior is often repetitive."

While only one scientific study has touched briefly on the possible situational or psychological contributors that may lead therapists to be sexual with their clients, a number of authors have commented on these factors from their clinical work. Marmor (1976) pointed to the physical isolation of the therapy relationship and the lack of, or poor quality of, sexual relationships in the therapist's private life as situational contributors to the problem. Stone (1976) describes "the high risk therapist" as one who is not currently in psychotherapy and who is out of touch with other members of the profession. Dahlberg (1970) observed that the therapy situation is a low-risk opportunity for shy therapists to develop sexual relationships and also cited three instances of middle-aged men becoming sexual with clients while in the throes of marital breakups.

In the one random sample study that touches tangentially on such possible contributors, Kardener, Fuller and Mensh (1973 and 1979) surveyed 460 physicians (a 46% response rate), including 114 psychiatrists, on their use of erotic and nonerotic physical contact with patients. They concluded, "It would appear that the freer a physician is with nonerotic contact, the more statistically likely he is to also engage in erotic practices with... his patient."

In a 1974 opinion article Kardener also comments:

> The physician's protestation that by being his patient's lover he is really proving he cares and is therefore offering a valuable gift is best viewed as an emotional Trojan horse that conceals not only his own needs, but hostility and antipathy toward his patients as persons, and their struggle for emotional well-being.

Butler and Zelen (1977) interviewed 20 psychologists and psychiatrists who admitted to having had sexual relationships with one or more clients. They concluded that "their own neurotic maelstroms led to non-therapeutic behavior" and that more than half of these therapists were fleeing from their own fear of intimacy. Almost half of them had "used rationalizations in order to permit otherwise unacceptable behavior during the therapeutic process." Garetz, Raths, and Morse (1976) report one case of an overtly psychotic psychiatric resident whose impaired controls led to a "sexual indiscretion" with a patient.

Schoener, in "Assessment of the Counselor or Therapist Who Has Become Sexually Involved with a Client" (Therapeutic Issues section of this handbook), proposes a continuum of the psychological underpinning of sexual exploitation. He describes the following types of therapist- perpetrators: those lacking in knowledge; neurotic practitioners; those with compulsive character disorders, sociopathy, and narcissistic character disorders; and those who are psychotic or have borderline personalities.

A related issue is that of countertransference. While many authors (e.g., Karasu, 1980) discuss it as a serious source of problems in psychotherapy, Edelwich and Brodsky (1982) deliver the strongest indictment when they say that any therapist who engages in sexual activity with a client, past or present, has failed to master countertransference feelings for that client, and it therefore constitutes a failure of therapy.

Unfortunately there are no scientific studies on the situational or personality variables that might lead to sexual vulnerability on the part of professors. Very little has even been written by way of conjecture. One professor, interviewed by Edelwich and Brodsky (1982), does comment that professors are surrounded by young people who are at their height of beauty and openness and that the opportunity to take advantage of one's position of relative power is ever-present.

Similarities Between The Two Power Relationships

Observers of client/therapist and of professor/student relationships have commented on the important power differential in both. Pope, Levenson, and Schover (1979), for example, state, "Both as educators and as therapists, psychologists clearly seem to be more powerful or less vulnerable than their students or clients."

In order to explore these power relationships, let us first turn to the social psychology literature on power and social influence.

Shaver (1977) defines social power as "the capacity of a person or group to affect the behavior of another person or group." Perhaps the most influential view of power in social psychology was provided by French and Raven (1959). They elaborated five sources, or bases, of power: 1) Reward power—control of valued resources; 2) Coercive power—control of punishments; 3) Legitimate power—internalized values that dictate that "the powerholder, by virtue of his role, has the right to prescribe behavior;" 4) Expert power—possession of superior knowledge or ability; and 5) Referent power—the powerholder is admired and identified with another's wish to emulate or please that person.

Relating French and Raven's five sources of power to the two types of relationships in question is an easy task. Therapists have the reward power to give and the coercive power to withhold the emotional help and support which the client seeks upon entering therapy (Edelwich and Brodsky, 1982). Professors hold reward and coercive power through the giving of grades and other academic sanctions and through the influence they may hold in the student's chosen profession (Till, 1980). For many female students and clients, the fact that their professor or therapist is male is a potential source of legitimate power. The American Psychological Association (1975) and Benson and Thomson (1982) have observed that frequently traditional sex roles still hold: females look to male counselors and teachers as legitimate authority figures.

Both therapists and professors may also be viewed as having expert power. Clients and students seek them out for knowledge and help. Taylor and Wagner (1976) point to the fact that the therapist has access to information about the client and the client does not have similar access to information about the therapist as another source of power for the therapist. In many cases, this is also true of the professor/student relationship.

Karasu (1979) reminds us that "the patient tends to model his or her behavior after that of the therapist by identification," thus offering a source of referent power. With the teacher, this is apt to be an even more powerful source, since the professor is likely to serve as a professional role model, as well as a personal role model.

Kipnis (1976) points out that, "Each formal grouping in our society possesses some unique repertoire of influence means that are considered proper to use in that setting," and that "access to institutional powers transforms insignificant men and women into giants." Indeed, it is the very abuse of the power of these "giants" that makes the sexual relationships under discussion a problem. Somers (1982) notes that without the abuse of power, sexual relationships between persons who are students and persons who are faculty may not be a problem. It is the abuse of power which causes them to be labeled as sexual harassment. The University of

Minnesota Policies and Procedures on Sexual Harassment (1984) state that:

> Sexual harassment is a specific form of discrimination in which power inherent in a faculty member's or supervisor's relationship to his or her students or subordinates is unfairly exploited... The professor-student relationship is one of professional and client.

The respect and trust accorded a professor by a student, as well as the power exercised by the professor in giving praise or blame, grades, recommendations for further study and future employment, etc. greatly diminish the student's actual freedom of choice, should sexual favors be included among the professor's other, legitimate demands.

Kipnis (1976) further argues that the corruption of power occurs when "commonly held norms and values are ignored by powerholders when such norms and values appear to threaten or restrict the powerholder's use of his resources." He also asserts that:

> The most destructive psychological consequence of one-sided power relationships [is] the transformation that occurs in how the more powerful see the less powerful. From individuals with both strengths and weaknesses, the less powerful become objects of manipulation with a lesser claim on human rights than is claimed by the powerholder. In Martin Buber's terms, it is the transformation of one person's perception of another from 'thou' to 'it,' from individual to object.

As Edelwich and Brodsky (1982) put it, the real question is, who are the therapeutic and educational experiences really for?—the clients and students or the therapists and professors?

Conclusions about Similarities

Generalization of comparisons of students and clients is problematic because of the absence of random sample studies of clients; however, some tentative hypotheses may be offered. It would appear that clients and students who become victims of sexual exploitation and sexual harassment by their therapists or professors differ from those clients and students who have not experienced similar victimization in only a handful of ways: students differ somewhat on a few positive characteristics and clients differ only in an increased rate of psychiatric hospitalization (which may have been an iatrogenic response to the sexual exploitation). Students and clients have assumed their respective roles for two very different reasons, and so may be vulnerable in different ways.

The most obvious harmful consequence for both groups is the possible loss of a chance to receive the help or education for which the person entered the role of client or student. Additionally, the potential emotional damage is great. For clients, a wide range of emotional problems has been noted. For both groups a loss of self-confidence has been reported. Additionally, both groups have paid financially for the experience. In the case of most clients and some students, they may have to pay again for extensive therapy to repair the iatrogenic damage done to them.

Transference is important in most, if not all, therapeutic relationships. It is not so clear how transference relates to academic relationships, but it has been hypothesized that the nature of some classes, very likely to be found in counselor training programs, is likely to result in the formation of transference feelings on the part of students.

The incidence of psychologists admitting to erotic contact with clients (8.1%) is less than that for psychology professors admitting to sexual relationships with their students (12%). In contrast, only 2 to 4% of both groups believe that such contact is beneficial.

Temptation and opportunity have been noted as possible situational contributors to the problem under consideration for both groups. Additionally, personal and intimacy problems in the lives of therapists have also been observed as possible correlates. Nonerotic involvement with clients is correlated with sexual involvement for therapists but is unexamined for professors. A host of psychological contributors have also been hypothesized for counselors, including neurotic, characterological and psychotic problems. Similar information is not available for professors. Failure to master countertransference feelings has been cited as a problem for therapists, but has not been discussed for professors. It would appear that the psychological dynamics of these powerholders may afford more predictive value for occurrence of severe exploitation than any client characteristics.

The most startling similarities exist in the comparison of the power dynamics of these two types of relationships. Both professors and therapists have ample access to all of French and Raven's (1959) sources of power: reward, coercive, legitimate, expert, and referent power. In both cases, it is the abuse of the power that creates the problem. It appears that when sexual interaction occurs within the context of such unequal power relationships, the result is usually sexual harassment or sexual exploitation. In both cases, the victim is objectified and manipulated, raising the question of whom the experience is actually for.

With the information currently available, it is difficult to find much support for Bouhoutsos' hypothesis that the modeling of professor/student sexual intimacy in psychology training programs affects future counselor/client sexual behavior. It would appear doubtful that modeling would generate characterological or psychotic responses in future practitioners. On the other hand, modeling might prove to be a permission-giving contributor to situational and neurotic acting-out. This is not to imply that modeling is not a significant part of psychology training but to emphasize that much more research is needed in order to draw this specific cause-and-effect relationship with any confidence.

Ethical Considerations

There are other ethical considerations that apply to sexual intimacies between therapists and their clients, and between psychology professors and their students. As an illustration, portions of the "Ethical Principles of Psychologists" of the American Psychological Association (1981) are quoted below:

1. e. As teachers, psychologists recognize their primary obligation to help others acquire knowledge and skill.

1. f. As practitioners, psychologists know that they bear a heavy social responsibility because their recommendations and professional actions may alter the lives of others. They are alert to personal, social, organizational, financial, or political situations and pressures that might lead to misuse of their influence.

6. a. Psychologists are continually cognizant of their own need and of their potentially influential position vis-a-vis persons such as clients, students, and subordinates. They avoid exploiting the trust and dependency of such persons. Psychologists make every effort to avoid dual relationships which could impair their professional judgement or increase the risk of exploitation. Examples of such dual relationships include, but are not limited to, research with, and treatment of, employees, students, supervisees, close friends, or relatives. Sexual intimacies with clients are unethical.

6. e. Psychologists terminate a clinical or consulting relationship when it is reasonably clear that the consumer is not benefiting from it. They offer to help the consumer locate alternative sources of assistance.

7. d. Psychologists do not exploit their professional relationships with clients, supervisees, students, employees, or research participants sexually or otherwise. Psychologists do not condone nor engage in sexual harassment. Sexual harassment is defined as deliberate or repeated comments, gestures, or physical contact of a sexual nature that are unwanted by the recipient.

Hare-Mustin (1974) contends that three other sections of these guidelines which do not mention sexual contact directly still apply. First, the guidelines charge psychologists with staying within the bounds of their professional expertise. She notes that since there are "no reputable psychotherapy courses or seminars dealing with how to provide sexual contact for patients, when it is indicated, what are the risks involved for the patient and for the therapist, and when is it contraindicated." It would be unethical, she says, for a psychotherapist to claim this as an area of competence. Secondly, Hare-Mustin refers to the injunction for the psychologist to adhere to "the social codes and moral expectations of the community in which he works," and comments that even the most liberal communities are unlikely to condone "arrangements that involve payment for sexual activities" that occur within licensed practice. Thirdly, she points to the principle that mandates that psychologists inform potential clients of "the important aspects of the potential relationship that might affect the client's decision to enter the relationship." She comments that possible sexual involvement is one of those important factors which the client should be told of in advance, in order to achieve informed consent.

Marmor (1972) also asserts that if therapists believe that sexual contact with patients may be therapeutically

valuable, they are ethically obligated to treat it like any other tool. That is, they must submit these practices to scientific scrutiny and their findings to review by other qualified professionals.

Possible Implications for the Field of Mental Health

Clearly, sexual exploitation is a problem for both professors and practitioners and for the students and clients over whom they have influence. Butler and Zelen (1977) observe that such sexual involvement is likely to taint the image of psychologists and impair their ability to render services to the public. Some of the possible implications for the field of counseling will be explored in relationship to training, practice, and research.

The education of mental health service providers is an important part of dealing with the problem. To begin with, graduate training programs are the initial gatekeepers for who is admitted to the field. More careful screening is apparently necessary. Moreover, Van Hoose and Kottler (1977) point out that sophisticated skills and hard work are necessary in order for therapists to deal with their sexual attraction to clients. Unfortunately, the training necessary to cope with these inevitable situations is not present in many educational programs. Kenworthy, Koufacos, and Sherman (1976) sampled the population of "known clinical or counseling internship programs in the United States" by mailing questionnaires to all of them. With a return rate of 40.6%, their sample included 94 responses. Only two of these programs indicated that "sexual feelings and/or intimacy with clients" were covered in their training and only 16.9% indicated that "sexual aspects of the therapist-client relationship" were dealt with in supervision of their interns. Every program that trains mental health service providers should cover these subjects in both coursework and supervision. Included should be thorough coverage of transference and countertransference and how to harness them as positive therapeutic tools.

Faculty of institutions which train counselors and therapists need to take much greater responsibility for the ethical conduct of their colleagues. For example, since the sexual involvement of psychology professors with their students is clearly forbidden in the APA code of ethics, it would seem that departments have a great responsibility to prevent this problem and to deal with it effectively when it does occur. It would seem that the ethical injunction to report colleagues who are known to be violating the guidelines applies to professors who exploit their students. Therefore, their fellow psychology faculty members need to begin to report these violations to the APA. Additionally, appropriate departmental and university administrative sanctions should be brought to bear on offending individuals. These institutions should be held ethically and legally accountable for the sexually harassing behavior of their staff.

White (1986) has written about organizational incest. There is seeming danger in the faculty of any department keeping the sexual secrets of one or more of their number. This has the potential to do great harm to the system or program itself. It is also difficult for students to take any ethical education seriously when faculty members are in flagrant, unchecked violation of ethical principles. The fact that students avoid working with faculty members known or rumored to have made sexual advances to students (Adams, Kattke, and Padgitt, 1983) argues that such practices may become common knowledge among students. Students ought to be able to count on positive professional role models and unimpeded access to academic opportunity.

When students graduate and join the ranks of professional practitioners, they have an ongoing need for quality supervision covering, among many other things, sexual attraction to clients and transference and countertransference. As in academe, there is a great need for reporting of ethical violations by colleagues and fair enforcement of consequences for sexual acting-out with clients.

Research is needed to establish when an impaired practitioner should no longer have contact with students or clients. Information is also called for to determine what constitutes adequate rehabilitation.

Since clinicians have indicated that psychological characteristics of the perpetrators may be the most useful predictors of sexual exploitation by counseling psychologists, research in this area is warranted. Offending professors and practitioners need to be studied carefully. This may offer clues as to how to do more effective gatekeeping for entry into the profession and how to both deliver consequences and to rehabilitate offending counselors and therapists in an effective manner.

Additionally, more research is needed on psychological and other harm resulting for both students and clients. This would assist practitioners who attempt

to help these victims recover from their painful experiences.

Clearly the problem of sexual harassment and sexual exploitation by mental health professors and practitioners is very complex. Fresh, creative thinking and compassion will be needed in finding solutions.

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Prohibition of Sexual Contact between Clinical Supervisors and Psychotherapy Students: an Overview and Suggested Guidelines

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Introduction

Clinical supervision of a counseling or therapy student is a personal relationship in which the supervisor has significant influence on the supervisee as a mentor, role model, and evaluator. The supervisee is in a position of lesser power, and therefore, has few safeguards against inappropriate behavior by a supervisor. One clear area in which this vulnerability is apparent is that of sexual involvement. Here, the supervisee may be the recipient of unwanted sexual advances, or may be seduced into a seemingly consensual sexual relationship. A small but growing literature indicates that sexual involvement between supervisee and supervisor is a significant and widespread problem.

This paper's major premise is that sexual overtures and/or sexual contact between clinical supervisor and supervisee are expressly forbidden. It begins with a review of pertinent literature, and then proposes four assumptions regarding sexual contact in clinical supervision and uses those assumptions to propose 13 guidelines as to how it may be addressed from both a preventive and a remedial perspective at the professional, academic, and clinical levels. The paper does not aim to be exhaustive. Rather, it seeks to stimulate thinking, and to aid the process of developing an appropriate standard of conduct.

Terminology

For the purposes of this paper, *sexual contact* or *sexual involvement* is defined as any interaction of a sexual nature between a clinical supervisor and student supervisee. It encompasses a broad spectrum of behavior from subtle sexual seduction to forcible rape. The consent of the student is not an issue. It is the thesis of this paper that such interaction should be completely forbidden and that it is always the supervisor's responsibility not to engage in such behavior, even if the student consented or initiated the sexual contact. Sexual contact/involvement is considered to be an abuse of the power relationship inherent in the supervisory role.

Sexual contact/involvement should not be confused with sexual harassment, a legal term which varies in definition from one locale to another. Sexual harassment hinges on the issue of consent: in order to qualify as sexual harassment, the recipient of the sexual behaviors must not want to participate in them. Most colleges and universities have developed their own sexual harassment policies for staff/student relationships. For example, here is part of the sexual harassment policy from the University of Minnesota:

> Sexual harassment is *unwelcome* [emphasis added] sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature which constitutes sexual harassment when (1) submission to such conduct is either explicitly or implicitly a term or condition of an individual's advancement in supervision, (2) submission to or rejecting of such conduct has the purpose or effect of unreasonably interfering with an individual's clinical performance, creating an intimidating, hostile, or offensive supervision environment.

Sexual contact/involvement may not always fit into the legal definition of sexual harassment, and it is important not to use the terms interchangeably. For the purposes of this paper, it is assumed that institutions that train counselors and therapists already have sexual harassment policies which pertain to faculty in all departments. The focus here is upon the more specific regulations governing relationships between clinical supervisors and student supervisees.

Given the relative prevalence of male supervisors and female supervisees, the order of personal pronouns used for supervisors in this paper will be *he or she,* and for supervisees they will be *she or he.*

* The authors would like to express appreciation to Laura Booth, Raina Eberly, Nancy Johnston, Patricia Mullen, and Barbara Shank for their contributions to this paper.

Literature Review

Psychological counseling is a special relationship which rests upon the counselor's "use of self" for its effectiveness (Balint, 1972). Learning to become a counselor involves examining one's assumptions, expectations, and feelings towards self and how they impact on clients (Montgomery, 1978). To do so, one forms a relationship with a supervisor, who guides the arduous, challenging, and often painful process of recognizing when and how one helps and harms.

Like counseling, supervision is a personal relationship. The supervisor has significant influence on the supervisee, as mentor, as role model, and as evaluator (Doehrman, 1976; Montgomery, 1978; Peterson, 1984). How the supervisor and supervisee relate to each other affects how the supervisee relates to the client and the eventual outcome of the counseling (Doehrman, 1976; Mueller and Kell, 1972).

As Doehrman (1976) states, "Hearing students talk about their supervisors and their supervisory experiences, one cannot doubt that the supervisee-therapist [supervisor] relationship is important in ways not ordinarily recognized in the standard conception of such a relationship." Indeed the supervisor and the supervisee may view supervision from very different perspectives. The supervisee is likely to be more sensitive to the emotionally-charged nature of the relationship than the supervisor. The supervisee has far more at stake personally and professionally in supervision, to the extent that even very ordinary actions on the supervisor's part may profoundly affect the supervisee.

The supervisor, on the other hand, may overlook the power he or she possesses and the vulnerability the supervisee experiences. At the extreme the supervisor may be content to maintain a seemingly casual, collegial role or in some other way may structure the relationship primarily to meet personal needs, thereby abdicating responsibility for his or her own behavior.

Unfortunately, the supervisee may be left to her or his own devices to guard against a supervisor who acts from a need to manipulate, control, or dominate (Doehrman, 1976; Montgomery, 1978). This vulnerability is greatest when sexual feelings and needs are involved and the supervisee becomes the one who has to confront the supervisor about sexual overtures.

Supervisors who are psychologists have ethical standards which prohibit sexual involvement with supervisees. Principle 7d of the American Psychological Association's Ethical Principles of Psychologists (1981) states that "Psychologists do not exploit their professional relationship with...supervisees...sexually or otherwise."

The meager data which is available on sexual involvement between supervisor and supervisee suggest that adherence to this principle by psychologists and by other mental health professions is wanting. Pope, Levenson, & Schover (1979) found in their sample of psychology graduate students and clinical supervisors that 5% of their student respondents (8% of the female sample and 2% of the male) and 4% of their supervisory respondents (6% of the male and 2% of the female) reported having been involved in either genital stimulation or sexual intercourse with their supervisor/supervisee.

In a study of bachelors- and masters-level social workers, Shank and Johnston (1986) found that 10% of the masters-level respondents and 15% of the bachelors-level respondents reported having been sexually harassed when in training. Approximately one-third of the reported incidents involved agency field instructors. Such harassment most commonly took the form of sexually explicit remarks about the person's clothing, body, or sexual activity; subtle pressure for sexual activity; and leering at or ogling the person's body. Once again, the preponderance of incidents were reported by females.

Glaser & Thorpe (1986), in their survey of female members of the APA Division of Clinical Psychology, found, like Pope, Levenson, & Shover (1979), that 5% of their respondents reported sexual contact with clinical supervisors prior to or during the supervisory relationship. In the Glaser & Thorpe (1986) survey, 12% of the sample reported having received sexual overtures, propositions, or advances from clinical supervisors.

Each of these articles cited above contained additional disturbing notes. Pope, Levenson, & Schover (1979) inferred from their data that sexual contact between supervisor and supervisee has been increasing in recent years. Shank & Johnston (1986) observed that none of their respondents reporting sexual harassment had ever discussed the matter with appropriate college or university faculty or staff. Furthermore, very few students ever requested a change in placement as a result of the incident(s). Glaser & Thorpe (1986) found a higher incidence of sexual involvement between graduate students and psychology educators, among recently

graduated students and among students who were divorced or separated at the time the sexual contact took place. Almost all respondents viewed sexual contact between an educator and student during a relationship to be unethical and viewed sexual overtures to be overwhelmingly negative. Forty-five percent of those reporting sexual advances reported punitive action from an educator when they declined overtures. Only 12% of those surveyed claimed they had received any graduate training in the issue of educator-student sexual contact.

Sexual involvement between supervisor and supervisee distorts and diminishes clinical supervision in several ways. (1) The supervisor, in the position of role model, serves to model the abuse of power by introducing this dynamic to the relationship with the supervisee. This behavior may then be carried over into future counseling relationships by the supervisee. (2) Actual involvement or overtures for potential involvement may impede free and open discussion about the supervisee's work with clients. For instance, a supervisee concerned about sexual overtures made by a supervisor is unlikely to discuss freely information about a client's sexuality for fear of initiating a parallel discussion of sexuality with the supervisor (Brodsky, 1980). Supervision thereby suffers because the supervisee cannot explore two of the most critical issues in therapy: one's own and the client's sexual feelings in the relationship. (3) The boundaries between supervisor and supervisee are blurred to the point that the supervisor loses objectivity in evaluating the supervisee's progress, and the supervisee fears her or his identity, training, and career are in jeopardy for not responding to perceived overtures (Pope, Schover, & Levenson, 1980).

Even under ideal circumstances, a supervisor relies on subjective and ambiguous measures of highly complex and personal behaviors when assessing a supervisee's performance (Doehrman, 1980). When sexual involvement with the supervisee is added as a criterion, evaluation becomes even more subjective and potentially harmful. The most blatant example of impaired objectivity occurs when sexual intimacy is traded for a favorable performance review (Pope, Schover, & Levenson, 1980).

The professional community has largely denied that sexual contact between supervisor and supervisee can be damaging. Supervisees have been viewed as mature, psychologically stable individuals who become sexually involved with their supervisors of their own free accord (Brodsky, 1980). Some people also have argued that, given the lack of an adequate definition of good supervision, one cannot definitely state that sexual contact would be harmful. Finally, the professional community has maintained a "conspiracy of silence," believing that the practice has continued unnoticed for years on campus and in clinics, and is most comfortably kept that way. That community has allowed the misguided notion to persist of the older, experienced (and usually male) supervisor showing the younger, inexperienced (and usually female) supervisee the "ways of the world" through sexual involvement.

Though such arguments regarding the degree of consent may remain pertinent to the determination of the legal issue of sexual harassment, they carry no weight in defense of sexual involvement between supervisor and supervisee. Sexual behavior of any kind is unethical and inappropriate within such a relationship, and should be clearly and thoroughly discouraged. Indeed, several authors have stated that there can be no benevolent motives when supervisors engage in sexual contact with students.

Peterson (1984) and Shank and Johnston (1986) view such activity as exploitative of the power dynamics of that relationship. They question whether initiation of sexual contact is indeed consensual, and they voice concern that the supervisee's learning needs become secondary to the supervisor's personal needs. Rozsnafsky (1979) sees sexual involvement as leading to "psychonoxious" supervision. She contends that supervisors who initiate sexual contact do so because of unresolved issues regarding sexual appeal that result in a need for power and conquest. Building upon Rozsnafsky's observation, one can conclude that the supervisor is motivated more by ignorance, personal vulnerability, and ongoing characterological problems than by altruism or genuine affection. As is true with a counselor in relationship to a client, a supervisor may seek sexual involvement with a supervisee with outer signs of caring and loving in order to mask inner hostility and antipathy towards the supervisee and her or his emotional well-being (Kardener, 1974).

Proposed Guidelines

Assumptions

The literature review points to sexual involvement in clinical supervision as a serious and frequently overlooked problem. While these studies provide useful information on the incidence of the problem, none take

the crucial next step toward proposing guidelines as to how to deal with sexual involvement between supervisor and supervisee. The existing literature does, however, provide a basis for formulating the following four assumptions about sexual exploitation upon which a model for action regarding the problem can be built.

(1) *Mutual consent is not a defensible rationale for a supervisor to make sexual overtures or to develop a sexual relationship with a supervisee.* Considerable question has been raised (Cnudde & Nesvold, 1985; Glaser & Thorpe, 1986; Peterson, 1984; Pope, Schover, & Levenson, 1980) as to the extent to which a sexual relationship between supervisor and supervisee can ever be considered as consenting, given the existing power differential. Furthermore, Glaser and Thorpe's work indicates that a supervisee who becomes involved in such a relationship may initially view it as benign, but begin to perceive it as more damaging and coercive over time. Their findings call into question the basis on which the supervisee supposedly offered consent.

(2) *The supervisor bears ultimate responsibility for monitoring both covert and overt sexual behavior in supervision, regardless of whether the supervisor or supervisee is seen as initiating such behavior.* As is true in the counselor-client relationship, the supervisor and supervisee may both contribute to the sexual attraction generated between them (Edelwich & Brodsky, 1982). However, the power differential between supervisor and supervisee places clear responsibility on the supervisor to prevent such behavior from occurring on his/her part and for taking appropriate steps should a student make sexual advances.

The notion of a supervisee having "invited a relationship" when one develops is irrelevant and needs to be viewed as such by the supervisor and by all who ultimately become involved in investigating any incidents of such sexual involvement (Cnudde & Nesvold, 1985; Glaser & Thorpe, 1986).

(3) *Filing a complaint about sexual involvement is likely to be a traumatic experience for the supervisee.* Data collected by Shank & Johnston (1986) and by Glaser & Thorpe (1986) indicate that only a fraction of those who believe they have been sexually exploited take any informal or formal action. Factors which may deter a supervisee from reporting include: feeling vulnerable, fearing placing one's own or the supervisor's career in jeopardy, fearing losing credit for a clinical placement, blaming oneself for having caused the incident or having agreed to become sexually involved, and questioning whether anyone is going to believe that the incident or involvement took place. Clearly, a supervisee needs encouragement to come forth and pursue her or his concerns.

(4) *The educational institution bears ultimate responsibility for processing and investigating a supervisee's allegations of sexual contact.* When the training site is a part of the educational institution, little question arises as to how complaints of sexual contact should be handled. The institution can take action directly against the supervisor, because the supervisor is an employee. The matter becomes more complicated when the student is at an independent clinical agency. Unless the supervisor has some employment ties with the educational institution, he or she cannot be disciplined by the institution. Nevertheless, the educational institution must assume responsibility for the student's welfare throughout the time she or he matriculates.

Therefore, it is the institution's obligation to investigate charges of sexual contact at independent field sites and to proceed in whatever way it deems necessary to stop the sexual contact and to protect the student from retribution. As part of the process, the institution may encourage the student to file a formal complaint through the agency which employs the supervisor, through the professional association to which the supervisor belongs, or through the licensing board which regulates the supervisor's professional practice.

The clinical site should be actively involved in the investigation, both in assisting the university and in deciding whether it will take action on its own.

Proposed Action Steps

Combating sexual exploitation of supervisees by supervisors involves taking action at three levels. Level 1 is the *Professional Level*, which encompasses the codes of conduct, ethical standards, accreditation criteria, and licensing laws which govern and regulate the respective mental health professions. Level 2 is the *Academic Level*, which entails the policies and procedures which educational institutions and their respective schools, departments, and programs need to institute to handle

complaints and to prevent such incidents from occurring. Level 3 is the *Clinical Level*, which involves preventive and remedial measures for the clinical site to take on an agency-wide basis and at the level of supervisor-supervisee intervention. What follows is a series of recommendations organized according to these three levels.

Level 1—Professional

1. All professional associations representing mental health practitioners and educators should contain a statement as part of their ethical standards or code of conduct forbidding sexual involvement between clinical supervisors and supervisees and clearly defining such involvement as any sexual contact, sexual overtures, advances and propositions. The consent of the student should not be considered as a mitigating factor. The standards should be explicit in describing the potential for abuse in intimate supervisor-supervisee relationships which arises from the supervisor's role as evaluator of the supervisee. (Glaser & Thorpe, 1986).

2. Any accrediting body of a professional organization should include as a criterion of accreditation of relevant educational institutions and/or clinical training sites the existence of policies and procedures in this area and proof of easy access to, and availability of, grievance mechanisms to potential claimants. The record of the institution in following through on such complaints should also be considered.

3. All state licensing boards which regulate the practice of any mental health profession should include a similar statement in their ethical standards and/or codes of conduct.

Level 2—Academic

4. Every college and university program that trains counselors and therapists should develop an explicit policy prohibiting sexual harassment and specifying those behaviors which are forbidden (Shank & Johnston, 1986). It should have readily available mechanisms for dealing with complaints and for providing information and counsel to potential claimants. A specific person or persons should be clearly identified as responsible for handling such matters and for providing such information. Procedures for handling claims that occur during clinical training should contain a mechanism for involving the clinical training site in the investigation.

5. Once developed, the policy statement should be published in appropriate faculty and student handbooks and in other relevant official publications. The policy should also be included in faculty and student orientation packets and should be discussed explicitly as part of any formal orientation. It should be posted on prominent bulletin boards. These materials should also be mailed to all sites where students are doing their clinical training (Shank & Johnston, 1986).

6. Two types of pamphlets should be published and distributed: one advising students of their rights and of how to cope with and prevent sexual contact with their supervisors, and the other informing faculty and staff. Once again, copies should be sent to sites where field training takes place. The student pamphlet should contain information on: determining what to do and what not to do when confronting an abusive supervisor, keeping records of incidents and individuals present who could serve as witnesses, talking with others regarding the incident, and locating appropriate campus offices for help (Shank & Johnston, 1986).

7. Special attention needs to be paid to the trauma experienced by the student in openly discussing an alleged incident of sexual contact. Sensitivity to what the supervisee wants or needs is required. Supervisees need to be afforded the room to take any action that they want to take rather than being pushed into what the institution perceives that supervisees should do. The supervisee should be afforded the opportunity to express both positive and negative feelings toward the supervisor. Common negative feelings include anger, fear, sadness, shame, and guilt, or blame over what transpired. Abused supervisees may need help in recognizing that such feelings are normal and are not reasons to preclude desired further action. Such individuals may feel very

ambivalent and confused and will need to respect the timing of their emotional reactions. In large enough settings, establishment of support groups for such students might be considered.

8. The educational institution should enter into a formal affiliation agreement with each clinical training site it uses. This agreement should clearly delineate what constitutes sexual contact and what steps the respective bodies would take, separately and conjointly, should a supervisee allege sexual contact.

9. Faculty of programs that train counselors and therapists should be mandated to report to the head of the program their colleagues who have sexual contact with students to whom they are providing clinical supervision. The consequences for engaging in such behavior should be made clear to all clinical supervisors.

Level 3—Clinical

10. A field agency bears responsibility for developing its own mechanisms for addressing and investigating sexual contact complaints. However, as was stated above, it should act in coordination with the educational institution when dealing with a student complaint, consistent with the affiliation agreement.

11. A field agency bears responsibility for sensitizing its supervisors to issues of sexual contact and for making known the consequences should supervisors engage in such behavior. It also should provide relevant ongoing educational programming for supervisors.

12. Clinical supervision should be based on an explicit contract between supervisor and supervisee (Bobbitt, Conroe and Loeffler, 1985). A supervisor should seek to update his or her supervisory skills on an ongoing basis. By developing and maintaining an explicit ethical framework for a supervisor-supervisee relationship, the supervisor is more likely to maintain adequate boundaries with the supervisee. Such boundaries should allow the supervisee to discuss sexual feelings for clients without being concerned that the disclosure will be taken by the supervisor as provocative or seductive or as inviting or legitimizing sexual involvement with the supervisor (Pope, Keith-Speigel, & Tabachnick, 1986). The supervisor should monitor his or her own and the supervisee's sexual behavior. The supervisor should recognize that sexual conduct with a supervisee can never be considered as consenting. Should the supervisor find sexual issues interfering in the supervisory relationship, he or she should seek consultation immediately in order to determine how to handle the situation appropriately.

Conclusion

This paper has provided an overview of the issue of sexual involvement in clinical supervision and has proposed a series of preventive and remedial steps that might be taken at the professional, academic, and clinical levels. The literature on sexual involvement is growing and it consistently substantiates that the problem is not uncommon.

The growing awareness of sexual involvement in supervision demands greater attention to steps which can be taken to confront this problem. Unfortunately, the literature offers little assistance. A continued effort needs to be made in developing and refining guidelines. Meanwhile, those who do clinical supervision need to heed Pope, Keith-Speigel, & Tabachnick's (1986) suggestion that they display the same frankness and integrity regarding sexual attraction that they would wish their supervisees to emulate; that they acknowledge their sexual feelings towards supervisees; and that they seek to establish and maintain clear and consistent standards for the appropriate handling of such feelings.

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Administrative Issues

Introduction

Barbara E. Sanderson

The administrators of agencies and institutions that provide counseling and therapy services have important roles to play in preventing sexual exploitation of clients and in handling complaints responsibly after the problem has occurred. This section of the handbook addresses some of the helpful things that are within the power of such employers.

The first article, "Using Administrative Procedures to Prevent Sexual Exploitation by Counselors and Therapists," by Shultz, Milillo, Couchman, and Lundin describes what constitutes a healthy organization in which the likelihood of sexual abuse of clients is diminished. The need for a mission statement, open communication, procedures for hiring psychotherapists, a client complaint mechanism, collegial feedback, staff development, and quality clinical supervision is discussed. Tips are also given for selecting an outside consultant when a case of sexual exploitation is reported.

In a companion article by Milillo, Shultz, Couchman, and Lundin entitled "Strategies for Organizational Intervention with an Agency Where Sexual Exploitation Has Occurred," the rationale for using an outside consultant is given and a process is suggested for the work of such a consultant. Information on how to deal with the complaining client, the accused psychotherapist, other staff members, the agency director, the clinical supervisor, and the board of directors is presented. The consultant's role in examining the agency's policies and procedures, management style, and the quality of the work environment is also discussed.

"Employer Liability for Sexual Exploitation of Clients", by Sanderson relates to the 1986 Minnesota civil statute which the Task Force on Sexual Exploitation by Counselors and Therapists helped to pass into legislation. Some background is given on the employer liability section of the law, and the three major requirements of employers in this area are discussed. These provisions require employers to: 1) do explicit background checks on prospective employees to be hired as psychotherapists; 2) provide information to other employers who are making similar employment decisions; and 3) take prompt and appropriate action when they know or should know that sexual exploitation is occurring.

The third selection is a checklist for employers to use to determine their agency's strengths and weaknesses. These items were listed by the Administrative Issues Work Group of the task force and are not designed to be exhaustive. Rather they are to be a starting place and a method for employers to organize their thinking about sexual exploitation as it applies to their agencies.

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Using Administrative Procedures to Prevent Sexual Exploitation by Counselors and Therapists

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Introduction

This article presents recommendations for creating and maintaining a healthy organization for the purpose of preventing sexual exploitation of clients by counselors and therapists. The first section outlines management practices which are designed to reduce the likelihood that sexual exploitation will occur. As with any form of victimization, prevention measures reduce the likelihood of exploitation, but do not totally eliminate the possibility that it will occur. Consequently, the second section of the paper contains guidelines for selecting an organizational consultant when a complaint of sexual misconduct has been filed against a staff member.

Characteristics and Management Practices of a Healthy Organization

Clear Mission Statement

All organizations are complex structures to which individuals, personal needs, roles, products, services, and organizational goals meld in a constantly changing environment. It is the task of the human service organization to understand and respect these complexities, while maintaining a clear view of its mission.

A healthy human services organization begins with a mission statement which sets down its reason for being. The founding members determine the purpose by understanding the needs and wants of the receiving community, i.e., counseling/therapy clients. Thus, the mission statement embodies the philosophy of the organization, as well as the central beliefs and the principal values which guide the organization's provision of services. The mission statement of a mental health system will direct the organization toward serving its clients with the best possible therapeutic interventions. However, each agency may define the overall means to accomplish this and through quite different, but specific, aims and goals. This is the beginning of establishing the identity of the organization. With the "who-we-are" statement in place, the board of directors has a guide for hiring an executive director and creating policy for the organization. The mission statement communicates to the staff the underlying direction of the agency and provides the framework for generating more specific policies and practices. Organizations which are clear about their purpose and how they are going to achieve it are less likely to foster conditions which may lead to the sexual exploitation of clients.

In mental health organizations, the mission should not only be understood; it should be accepted by everyone who is part of the organization. Every member of the staff is integral to the efficient and effective functioning of a mental health agency. If staff members' personal goals supersede their commitment to the mission of the organization, they may be at risk to engage in abusive behavior with clients. This is likely to subvert the mission of the agency.

Openness and Communication

In addition to clearly enunciating the mission of the agency, there are two key dimensions which combine to reduce the level of risk of violations. These elements are communication and openness. In healthy organizations, the cultural atmosphere is one of sharing information in a direct and honest manner. Information is not distorted for political reasons or to serve the vested personal interests of a few members.

In the healthy organization, mistakes and failures are recognized as real world events. It is imperative that staff be encouraged to share their mistakes or concerns so they may be dealt with constructively. Most social services providers are comfortable with complimentary feedback which acknowledges that someone has worked up to standard. It is with corrective feedback that mental health professionals may fall short. Mental health staff, accustomed to playing a supportive role in therapy, often shy away from being critical of colleagues. Feedback skills are developed when members of the organization respect one another for raising concerns about potentially questionable practices, even though they may disagree.

*The authors wish to acknowledge Gary Schoener and Bill White: their work in the area of organizational dynamics has been inspirational in the development of this paper.

These principles of healthy communication can be expressed through the management practices of the organization. It is important to develop a model of management practices which coordinates and directs the organization in a systematic way to consider its method of achieving goals and assuring high standards of care. Management procedures provide a means of communicating the expectations of the organization to the staff.

Hiring Process and Practices

Management policy and practices dictate the course of action to guide present and future decisions. One of the most crucial agency methods of reducing the likelihood of sexual exploitation comes in the process of hiring new counselors and therapists. Organizations should establish practices which provide for careful screening of potential staff and the employment of persons who have demonstrated professional competence and high ethical standards. This includes asking job applicants about past resignations, complaints, or lawsuits. If the applicant is a licensed practitioner, it involves contacting state boards to inquire about complaints or practice limitations. It also means contacting past employers and/or supervisors to discuss the applicant's strengths and weaknesses and their concerns or complaints about the applicant. It is also important for past employers to disclose any known past incidents of sexual misconduct by the applicant to prospective employers. For more specific information on the requesting and giving of information in the hiring process, see the article by Sanderson in this section.

Finally, an adequate process requires a meaningful interview which allows for an assessment of the applicant's professional qualifications and ethical standards. It is particularly important that organizations which have difficulty attracting job applicants do not compromise these practices in order to fill positions.

Policy Statement Forbidding Sexual Involvement with Clients and Sexual Harassment of Staff

Equally important is a clear written policy statement declaring that sexual involvement with clients is forbidden. This written policy communicates clearly to the staff that such behavior contradicts the organization's commitment to serve its clients. The policy conveys the message that staff must get their emotional needs met elsewhere. It is particularly important in agencies which employ paraprofessionals or minimally trained providers that staff be made aware that their professional task is one of helping the client and not of developing personal relationships or gratifying the therapist's own needs. This policy statement should be specific enough to leave no doubt for employees about what behaviors are forbidden

It is also essential that the agency adopts similar policies that relate to trainees, volunteers, paraprofessionals, and staff who come into contact with clients but do not do counseling or therapy with them. Additionally, a clear policy statement prohibiting sexual harassment of employees by other staff members helps to protect clients as well; in many agencies the sexual exploitation of clients is preceded by a breakdown in appropriate professional boundaries between staff members.

Organizational Accountability and Professional Review Structure

It is also important for organizations to develop an accountability and review structure which assures that the work of all staff members is adequately monitored. This includes a system of job descriptions, administrative supervision, and performance reviews to assess behavior on the job and address problems as they develop. It also involves a system of clinical supervision which promotes professional growth and allows a forum to discuss sexual concerns in a nonpunitive fashion before they become a problem. For further information on clinical supervision, see the Therapeutic Issues section of this handbook. Finally, it means establishing a peer review system which allows colleagues to learn about each other's work and give feedback to one another. This is particularly important in long-term therapy cases where the opportunity for sexual victimization is greater.

Collegial Feedback

In addition to the bureaucratic aspects of accountability and review practices, collegial sharing needs to be encouraged. This is especially true in mental health settings, where the therapeutic relationships cannot be directly observed. These settings necessitate strong accountability and peer review practices among staff members. Mental health professionals are often reluctant to raise questions about their colleagues' work, even in the face of evidence that inappropriate sexual activity may be occurring. Organizations must encourage and find ways for staff members to provide such feedback to colleagues so that problems can be clarified and addressed. It is important that this feedback be clear, but not shaming. Organizations must be careful not to isolate staff members in positions where they are left alone to struggle with problems.

Staff Development

Organizations must also establish practices which provide for the continuing education of staff. Organizations which are closed to outside influences are most likely to develop an environment where sexual exploitation can occur. Exposure of staff to new ideas which stimulate professional growth helps to assure that organizations keep an open, creative environment. Regular inservice programs should be provided for staff, including discussions of the issue of eroticism in psychotherapy.

It is particularly important that discussions occur regularly in organizations with a high incidence of staff turnover. Staff members should also be encouraged to participate in professional activities and attend continuing education programs outside of the agency. Exposure to the activities of professional organizations, different conceptual frameworks, and research of reputable professionals will reduce the likelihood that staff will develop rigid, distorted, or unhealthy attitudes.

Accountability to the Client

Finally, organizations need to establish practices for communicating directly with clients. Frequently, clients feel powerless and vulnerable, particularly if there are sexual or seductive overtures by their therapists. It must be clear that the client's viewpoint is respected by the organization. It is also vitally important that the client not be blamed. New clients should be given written information about their rights, seeking their feedback, and providing a formal mechanism for complaints. This packet of materials should include a specific statement that the agency's therapists are forbidden sexual contact with clients. The agency should have complete procedures for investigating client complaints, and a range of consequences (including firing) for employees who are determined to have sexually exploited clients. It is also helpful to survey clients periodically regarding their level of satisfaction with the service they receive. These practices help an organization to listen to its clients and provide clients with a vehicle to make their concerns known.

Compliance with Reporting Requirements

When a client alleges sexual exploitation by a counselor or therapist, the agency or other individual mental health professionals may be legally mandated to report the allegation to authorities outside the agency. In Minnesota these reporting duties may include, but are not limited to: criminal complaints, reports, state boards that license or register individual counselors and therapists, and reports concerning vulnerable adults and child abuse. Agencies should be familiar with all these legal requirements and should establish procedures for complying with them.

Selecting an Organizational Consultant When a Complaint of Sexual Misconduct Has Been Made Against A Staff Member

Once an accusation of sexual misconduct has been registered, it is recommended that a consultant to the organization be obtained. The consultant, by definition, must be independent and external to the organizational system in order to provide a neutral, objective viewpoint. Second, the consultant should be trained and experienced in the professional practice of psychotherapy. Third, the consultant should have specific expertise in both organizational consulting and in the area of sexual exploitation. These qualifications will safeguard against internal biases, vendettas, witch-hunts, and further abuse. The outside consultant's only vested interests should be in providing a comprehensive evaluation and effective intervention services.

Conclusion

Preventive practices are strongly advocated as a first line defense against sexual exploitation of clients by staff members. This paper suggests philosophical, as well as practical guidelines, which are means to developing a healthy management system in an organization. When sexual exploitation is reported, it is recommended that the proper legal reporting requirements be observed. Lastly, criteria are outlined for selecting a consultant who will assist the organization in comprehensively examining itself. The method of the organizational evaluation and potential intervention strategies are described in the following paper.

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Strategies for Organizational Intervention With an Agency Where Sexual Exploitation Has Occurred

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Introduction

The organizational consultant to an agency where there has been sexual misconduct plays an instrumental role in the intra-agency processing of the event, in developing coping strategies, and in reassessing the dynamics of the system with regard to the abusive event. In working with the organization, the consultant promotes and fosters the agency's evolvement into a healthy system as it deals with the accused therapist, the exploited client, and the system fallout from the misconduct. The areas that the consultant must cover in the implementation of appropriate strategies are outlined in this paper, along with specific suggestions for actual interventions.

Intervention

Rationale for Selecting an Independent Consultant

The rationale for retaining the services of an independent consultant is to assure accountability through an objective intervention. The practice of psychotherapy entails inherent vulnerabilities because of the issues of privacy and confidentiality and the intimate nature of self-disclosure which occurs in therapy. Misconduct can occur within the context of the therapeutic relationship. However, dysfunction in the organization as a whole can also set the stage for a staff member to act out sexually with a client. It is necessary to investigate and expose both questionable organizational and therapeutic practices, as well as secrets, rumors, and inappropriate interpersonal alignments among the staff.

The consultant's goals in working with an organization are to help to correct the immediate problem and to help to establish a process that attempts to ensure that no further victimization will occur. With this mandate in mind, the consultant begins working with the organization.

Evaluation and Assessment Process

In the case of alleged misconduct, a consultant usually begins by interviewing other staff members, for the purpose of allowing them to tell their story regarding what happened. At a minimum, this process typically includes the accused therapist, the executive director, the therapist's clinical supervisor, and any other staff members directly involved. If the director is being accused, the consultant will also need to interview the agency's board. This interviewing process permits piecing together the case from multiple perspectives, finding common threads, and providing an opportunity for staff members to ventilate feelings.

In the investigation process, the consultant will also be focusing on the politics and systems dynamics of the organization. The following questions must be answered: Where does the manager's style stand on the continuum of authoritarianism-permissiveness? What is the flow of power and influence within the organization (i.e., is power wielded through intimidation, passivity, or helplessness)? Are there any special vested interests which unduly control the direction of practice? How are decisions made and carried out? Are the conflict resolution strategies utilized by the organization situationally appropriate? Are any staff members projecting unresolved interpersonal conflicts onto colleagues? Are there maladaptive communication patterns (rumors, gossip, or back-biting), and what purpose do they serve? These questions may direct the consultant in trying to understand the interpersonal workings of the system.

Consideration of the Client

By this time, the consultant has collected sufficient data to understand the complaint and the dynamics of the organization. The first step in an intervention is making sure that the client has been properly treated. Has the agency's complaint procedure been followed? If not, then the consultant may need to monitor compliance with processing the complaint according to the established protocol. If there is no complaint procedure, the consultant must provide an interim course of action. Later, an intra-agency committee should determine a permanent set of procedures for clients to follow in lodging complaints about therapists.

* The authors wish to acknowledge Gary Schoener and Bill White: their work in the area of organizational dynamics has been inspirational in the development of this paper.

Additionally, the consultant will want to make sure that the exploited client has been directed to appropriate resources. The following questions must be answered: Has an appropriate transfer been made to a new therapist? Has the client been assessed for self-destructive or suicidal reactions since the disclosure of the sexual violations? Has the client been referred to an advocate outside the agency who will assist the client in deciding how to further handle the complaint, including the possibility of confronting the violating therapist?

In cases of sexual exploitation of clients there is the potential for agency professionals to withdraw from the conflict and abandon the client or to further abuse the client by attributing the sexual abuse to client pathology. The consultant's efforts to safeguard the client's well-being serves as a model of appropriate behavior toward the client.

The consultant will also need to review the case file of the complaining client. It is recommended that the consultant direct the agency to photocopy the client's file before anyone has an opportunity to alter the contents or remove any data. Photocopying of case documents should be witnessed by a minimum of two persons. The original file should be kept in the agency's safe or an equally secure location. A photocopy should be maintained by the administration.

Agency Management of the Accused Therapist

The foremost task of the consultant and the agency is the protection of clients. This includes reporting the violation to the appropriate regulatory board or professional organization. The consultant may have to help the organization report the misconduct to the appropriate state licensing or registration board and/or to a professional monitoring or watchdog group. The agency may be reluctant to involve outside authorities in what is already an embarrassing and humiliating situation. Working through this unwillingness for more exposure can be an important function of the consultant. The staff members may be afraid to examine the depth of the conflict, and may view the conflict as a threat to their own jobs. Likewise, the consultant may need to assist the agency head in approaching the board of directors and informing them of the infraction. The director may need to be encouraged to maintain ongoing contact with the board to keep them apprised of how the matter is being handled.

The agency director and/or supervisor of the therapist must prevent the individual from engaging in any more violating behavior. In order to do this, the entire personnel file and clinical records of the accused therapist should be carefully scrutinized. It is also important to review the therapist's clinical performance evaluations, references from previous employers, and any past complaints which have been filed against the therapist. At a minimum, this entails terminating the entire relationship between the accused therapist and the exploited client with proper provisions for the client's psychotherapeutic needs (as mentioned earlier). In addition, the therapist may be required to cease practicing altogether, or be suspended from treating certain types of clients. If the therapist continues to practice, close supervision of all cases should be required. For more information on supervision, see the Therapeutic Issues section of this handbook.

The consultant may also need to evaluate whether the accused therapist's supervisor has been effective in monitoring the therapist's work in the past, and can be successful in doing so in the future. If covert collusion has developed or the supervisee's unethical behavior has been hidden from the supervisor, a change in supervisors may be indicated. All these actions are taken in the interest of holding the therapist accountable for the way that clients are treated. With the provision of supervision, the agency is establishing a system of accountability for its therapists that will better serve the therapeutic needs of its clients.

In cases where the director is the alleged perpetrator, the consultant must deal directly with the board to determine an interim plan for administering the agency. The board members may feel shocked and guilty about their blindness to the director's behavior. The consultant in this case should offer an opportunity for board members to work through feelings of disbelief and self-blame. One of the problems may be that the board has not laid down either specific expectations of the director or the means to make performance reviews of the director on a timely schedule. The consultant can be an important resource to the board in creating these guidelines and role expectations for the director.

It is also possible that a consultant will find a board of directors who do not realize their full range of prerogatives and responsibilities. Moreover, a board may be too removed from the operations of the agency. The consultant can serve as a facilitator for the board members to expand their knowledge, awareness, and rightful position of influence.

Intervention with the Staff of the Organization

The next task the consultant faces is addressing the entire agency staff regarding the alleged or confirmed misconduct. It is imperative to bring the staff together to confront their colleague's violation, in order to eliminate it as the "Big Secret" in the organization. Information that remains secret supports a negative, and sometimes sordid, communication network. A variety of untoward communication patterns can emerge, including rumors, gossip, spying, and talebearing. A closed communication system which only permits the sharing of favorable information creates an unhealthy environment which inevitably undermines competent staff performance. An open communication format is essential for dealing with the complexity of human emotions and behavior. Without it there can be no growth or maturity in the system, and the quality of the staff's performance will be severely limited. It can be difficult and uncomfortable for social service professionals to give critical feedback to colleagues, such as telling them that they are not making satisfactory progress. However, corrective feedback can be experienced as positive reinforcement by those who receive it, when it is seen as a way of helping them to do a good job.

Members of a system become protective of each other for a variety of reasons. In not giving corrective feedback, individuals let themselves think that they are being sensitive to the feelings of others when, in fact, it may be more of a concern and protection for their own feelings and vulnerabilities. In some agencies, staff may surrender their right to give corrective feedback because there is a fear of reprisal, a threat to their status in the organization, or even fear for job security. Sometimes the political climate in an agency is such that information is withheld and distorted. In this instance, the members' vested interests in vying for power, control, or influence may determine what is communicated.

In discussing the situation openly with the staff, the consultant is watchful for possible dysfunction in the communication patterns within the agency. If feasible, the accused therapist should be present at meetings with the staff. Using a direct but supportive and non-judgmental manner, the consultant must facilitate the airing of staff members' reactions to the incident. The emergence of unspoken suspicions and rumors, within small enclaves of staff, or on an agency-wide basis, can be confirmed and corrected or dispelled.

Individual and collective guilt can be faced as staff members process their views of themselves and the workings of the agency relative to the misconduct. Staff feelings and reactions need to be heard and validated, especially in agencies where conflict and acknowledgment of frustration have been forbidden or discouraged. The accused therapist should be encouraged to participate in these meetings, so there can be an exchange and a clearing of the tension. This will model a healthy system where people are accountable to each other.

The consultant creates the setting where an understanding of how a violation of boundaries and abrogation of clients' rights could have occurred. In this capacity, the consultant will become a teacher, directing the discussion toward a review of communication patterns. The resulting emotional catharsis will permit restoration of staff morale, open communication patterns, and promote professional growth. The consultant in the role of facilitator and teacher reinforces a model for handling conflict in an emotionally honest, direct, and healing manner.

Review of Policies and Procedures

Another task of the consultant is to review the current policies and operating procedures of the organization. The purpose is to identify deficiencies in existing policies which may have enabled the professional misconduct. The consultant should review the written ethical codes of the organization, charting procedures, and supervision requirements. The availability of crisis services to clients should be assessed, because boundary violations can be facilitated by inappropriate after-hours client-therapist contact.

Each agency needs to have a protocol for handling emergency phone calls during business hours, as well as after-hours crises. Without such a protocol, boundary violations may occur due to therapists responding to clients' emergencies outside the therapy setting. These boundary violations may be the beginning of the breakdown of the therapeutic relationship, as the therapist provides more personal attention and special consideration to a client.

It is imperative that agencies have clearly-stated policies and procedures. It is not enough for an agency to have an unstated expectation that each therapist will act in a professional manner, naturally rising to high standards of ethical conduct. A consultant may recommend that an organization develop or redefine agency guidelines to include the following: 1) a written

policy forbidding sexual involvement with clients or ex-clients; 2) a peer review system; 3) a method of soliciting feedback from clients; 4) surveys which periodically evaluate consumer satisfaction; 5) methods to follow-up on negative client feedback or complaints; 6) a policy on home visits, if permitted at all; 7) a policy on locked doors during therapy sessions; 8) a review of cases where there is a great deal of phone calling or an unusually long treatment; and 9) hiring procedures. For more information on policies and procedures, see the article by Sanderson in this section.

Remediation of Ineffectual Management Practices

The unhealthy management style of an agency director or others in supervisory roles may contribute to an atmosphere of tension among staff members. Such tension could contribute to acting out behavior by a staff member. Problems of those in leadership may range from a lack of direction to an overly authoritarian or even charismatic style of leadership.

There may be several different types of leadership positions within a mental health organization. These include the executive director, the clinical supervisor, and the professional-technical specialist. The director of the agency oversees the entire organization, and is responsible for planning, organizing, staffing, directing, controlling, and facilitating. There are times when the director must exercise authority to react in a timely fashion to emergencies or to implement unpopular action for the sake of the system and its members. When the director's style is authoritarian, staff members may be fearful to express differing views than those which are allowed. Staff morale and feelings of competence may be undermined. Frustration and anger may mount throughout the system and be acted out in covert ways, including therapists inappropriately asserting power over clients to regain a sense of professional adequacy.

If a permissive or laissez-faire stance is taken by the director, feelings of indecisiveness and weakness may prevail throughout the agency. Various staff members may assume decision-making responsibilities, but be either inadequately informed, or burdened by the extra demands. Crucial decisions may not be forthcoming from the director, and therefore, may be made by default. Power struggles may emerge in an atmosphere of permissiveness, as people feel insecure because of a lack of leadership. The end result may be a system where there is organizational turmoil and chaos, where client needs are ineffectively met, and where staff members feel stressed and unable to do their work properly.

The consultant must work toward a change in either extreme of leadership style. In the case of authoritarianism, the consultant may enlist the board to assume a more active role in determining expectations and overseeing the director. The consultant may also be able to expose the fear and disgruntlement of the staff toward the director. In some instances, the consultant will work toward setting limits on the director's control and dispersing responsibility to other staff members.

At the other extreme, a director who avoids decisions or surrenders control will need assistance in assuming appropriate responsibility. The director may need to be assisted in seeing the value of taking a firmer stand. The consultant may work to bolster the decision-making skills of a permissive director. The consultant can assist the board in defining its expectations of the director and in establishing a realistic appraisal of the performance levels that are required for the job.

Clinical supervisors teach and monitor the work of the therapy staff. Often, they have direct authority over the staff. There are several questions regarding supervisors that a consultant may need to address: Is sufficient supervision provided to mental health staff? How are the supervisors chosen? Is there cronyism in the selection of supervisors? Are the supervisors able to confront therapists and give appropriate direction in difficult cases where the therapist's emotions are involved? Do supervisors have a thorough knowledge of sexual exploitation issues and of the boundary violations which usually precede such sexual contact?

If an agency has become too inbred, like a closed family system, it may be necessary to obtain supervisors or case consultants from outside the agency. The consultant may give recommendations to the agency regarding the supervision structure that is most appropriate for them.

Many times organizational hierarchies include professional-technical leaders who have special work-related skills and experience. They may oversee other staff in the provision of services. For example, in a residential treatment center, there may be a senior mental health worker who is in charge of a number of mental health workers. Though not primary therapists, mental health workers in a residential center are the people who are available in the evenings and on weekends to help clients handle crises, and to intervene therapeutically. There is an expectation for the senior worker to be an exemplar for the others. The consultant must consider

the quality of direction and leadership which the professional-technical hierarchy provides in running the organization and intervene when it is inappropriate or inadequate.

The roles and responsibilities of agency staff also sometimes require clarity and redefinition. Difficulties may arise when staff members: 1) assume a role they are not ready for; 2) perform functions which are outside the stated boundaries of their job; 3) become involved in activities for which no role definition exists; or 4) take on more responsibility than their authority permits. The consultant may point out problems with role definition and direct the agency to begin solving them. Additionally, the consultant may recommend that staff meetings be supervised to help unravel inappropriate role shifts, dissipate excessive power holdings, or prevent staff fragmentation due to mishandling of role relationships.

Building Professional Expertise and Satisfaction

When analyzing the organizational operations and the staff members' levels of functioning, the consultant may find areas where broader knowledge, understanding, experience, or awareness is highly desirable, if not imperative, for building competent performance. The consultant may recommend that specific or general educational training be provided for the staff. Staff training which introduces new theoretical frameworks, or offers different methods or models of intervention may be helpful in sharpening clinical skills. It may also serve to deepen and affirm existing therapeutic concepts and practices. The consultant may suggest experiential workshops that require self-examination by the participants, including personal and professional boundaries, ethics, transference-countertransference, etc. Such experiences can be most important for raising awareness and influencing change in therapeutic roles and practices. In general, the members of the organization may be encouraged by the consultant to utilize continued education outside the agency to broaden their bases of knowledge and to serve as a means of inspiring and rewarding staff.

Finally, the consultant will want to impress upon the agency that addressing the quality of life within the agency will enhance the overall success of the staff. In assessing the quality of life, questions to be answered include the following: Is there sufficient time off, or compensation for extra hours worked? How does the agency encourage or reward staff members? Is there a yearly retreat? Are there provisions for celebrating the work efforts of the agency staff on a routine or special case basis? Are there other measures which would improve the morale of the staff and help to assure that they are treated respectfully?

Conclusion

This paper has presented conceptual considerations and intervention procedures for consulting with an organization where sexual misconduct has occurred. A thorough organizational intervention with an agency can be a decisive step toward prevention of any continued sexual exploitation of clients.

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Employer Liability For Sexual Exploitation Of Clients

Barbara E. Sanderson *

Introduction

On August 21, 1986 a new law, Minnesota Statutes, 148A (See Appendix A-2), went into effect in Minnesota that specifies employer liability for sexual exploitation of psychotherapy clients. Prior to that time, all civil cases against sexually exploitative psychotherapists and their employers were brought under common law provisions (law determined by case decisions, as opposed to legislated statutes). Any sexual misconduct between therapists and clients that happened before the effective date of the new law may still be brought under the common law.

Before the Minnesota Legislature passed this law, most employers of psychotherapists had evidenced very little interest in their ethical responsibility toward the clients that were served in their agencies and institutions. These employers did not have policies that prohibited staff from being sexual with clients and many employers did not have procedures established for clients to file complaints. In the hiring of new psychotherapists, there was often not even the simplest checking with past employers or credentialing authorities to see if applicants were competent and ethical. In many agencies, clinical supervision of psychotherapists was haphazard or nonexistent, and even blatant negative changes in behavior on the part of impaired practitioners was ignored. In other cases, when clients complained to administrators of sexual misconduct by psychotherapists, the clients were shamed into silence, the cases were not investigated or were dropped, or the psychotherapists were allowed to resign and were given good recommendations and promises that the sexual exploitation would never be revealed. When abusers were members of the counseling clergy, their denominations would frequently move them to another congregation. Members of all the counseling professions have moved successfully from one job to another, leaving trails of victims behind them in each workplace.

When clients decided to sue sexually abusive therapists and their employers under the common law, they consistently ran into difficulty. To start with, there was no definition of what constituted actionable sexual misconduct on the part of psychotherapists. In each case, the client would have to establish through expert testimony that sexual contact with clients was unacceptable professional behavior. Often such testimony was very costly for the complaining client. Then, each judge had to interpret this evidence. This resulted in an unnecessarily costly and time-consuming process that netted an uneven set of judicial decisions.

Additionally, different statutes of limitations were applied to therapists and their employers. For therapists, a two-year statute of limitations applied, which did not give victims adequate time to realize that they had been victimized, and then gather enough strength and support to take the awesome step of taking legal action. For employers of therapists, the statute of limitations was six years, creating a more reasonable time limit for victims, but making such employers much more vulnerable to civil suit than the therapist-perpetrators. Some suits were brought successfully against employers for vicarious liability, but the standards were never clear as to exactly what constituted responsibility for employers in this area. Many employers did not know that they could be held liable for the sexually exploitative acts of their psychotherapists. Those employers who had lost money, often large sums, in such cases welcomed the work of the Task Force on Sexual Exploitation by Counselors and Therapists, knowing that it would clarify their responsibilities.

The Walk-In Counseling Center in Minneapolis has helped over 1,000 victims of sexual exploitation by counselors and therapists in the past 12 years. Gary Schoener, Executive Director of the Center, asserts that if employers of psychotherapists had attended to the following factors, most of these instances of abuse could have been prevented: 1) Checking of professional backgrounds prior to hiring psychotherapists, and the willingness of former employers to release such information they have about past instances of sexual exploitation to prospective employers; 2) Dealing with blatant personal problems and obvious impairment on the part of psychotherapists; and 3) Setting up the agency so that the employer knows what is going on and then acting promptly when there are signs of problems developing. Additionally, attorneys who have litigated civil suits for victims of sexual exploitation by psychotherapists say that many clients decide to sue because employers have failed to listen to their complaints. Clients report that it is vital to their recovery from the abuse to tell their story to someone in authority who will listen and act. In many cases, if the employer shirks this responsibility, the client's only other choice is to file a civil suit.

* The following people provided ideas and/or editorial consultation for this article: Don Gemberling, Phil Getts, Don Horton, Virginia Marso, Gary Schoener, and M. Sue Wilson.

What follows are suggestions for employers to use in implementing this new law. Four major cautions accompany this information:

1) This is *not* legal advice. Before implementing any policy relating to the sexual exploitation of psychotherapy clients, employers should consult an attorney. Legal advice may also be necessary at various stages of implementing such policies.

2) These suggestions are not intended to be an exhaustive list of what constitutes a responsible employer. They are simply a description of some of the more obvious measures within an employer's power. It is hoped that they will serve as a starting place.

3) While this article is focused on Minnesota Statutes 148A., employers creating sound policy for organizations, should first assume responsibility by thinking about the clients being served and how to best protect them. Efforts that are focused strictly on avoiding liability for the employer are likely to be confusing and inadequate. Any future legal cases will probably go more smoothly for employers who begin by examining their ethical responsibility to clients.

4) This law does not purport to define the full extent of employer liability. Until a number of cases have been litigated under Minnesota Statutes 148A., the full extent of employer liability will not be known.

Who Is a Psychotherapist?

The State of Minnesota has not put any legal restrictions on the use of the term "psychotherapist" or on who may practice the behaviors that constitute psychotherapy. Five of the professional groups that practice psychotherapy are licensed by the state: psychologists, physicians, nurses, social workers, and marriage and family therapists. The 1987 session of the Minnesota Legislature created a new regulatory board to register everyone who is a "mental health services provider." "Mental health services" are defined as "the professional treatment, assessment, or counseling of another person for a cognitive, behavioral, emotional, mental or social dysfunction, including intrapersonal or interpersonal dysfunction." The board will place no restrictions or qualifications on who may be a mental health service provider, so anyone may still provide psychotherapy. Until the board decides who must register, psychotherapy will still be a vague concept.

Consequently, the criminal and civil statutes governing the sexual exploitation of psychotherapy clients were designed to cover anyone who might be performing the behaviors that comprise psychotherapy, or who claim to perform those services. This means that it is sometimes challenging for agencies to determine which of their employees are acting as psychotherapists.

Minnesota Statutes 148A. defines "psychotherapist" as "a physician, psychologist, nurse, chemical dependency counselor, social worker, member of the clergy, or other person, whether or not licensed by the state, who performs or purports to perform psychotherapy." Psychotherapy is defined as "the professional treatment, assessment, or counseling of a mental or emotional illness, symptom, or condition."

It is easy to determine whether or not most employees are performing psychotherapy as all or part of their jobs; however, in many institutional settings the employer must decide which individuals in gray area groups are performing psychotherapy. It is helpful to think about which of these employees or categories of employees the employer wants to have perform psychotherapy with clients, and then specify in organizational policy who is authorized to provide this service. It should be clearly stated that no one else is to do so without written permission.

Complying with the Provisions of Minnesota Statutes 148A.

The new law specifies three things that employers of psychotherapists must do, or they may be held liable in civil suits. Employers who comply in good faith with these provisions will not be civilly liable or subject to discipline by any Minnesota licensing board for doing so. These three duties of employers are described below.

Checking Backgrounds of Prospective Employees

The law states that an employer of a psychotherapist may be liable if "the employer fails or refuses to make inquiries of an employer or former employer, whose name and address have been disclosed to the employer and who employed the *psychotherapist* as a psychotherapist within the last five years, concerning the occurrence of *sexual contacts* by the psychotherapist with *patients* or *former patients* of the psychotherapist." (All of the terms italicized above are defined in the law.)

In order to implement this provision, employers must devise a way to collect this information, and a policy for what to do with specific types of information received about past sexual exploitation of clients. First, the employer must ask the prospective employee for a list of his or her employers during the past five years. Then, for any workplace where the job candidate performed psychotherapy as all or part of his or her job, the hiring employer must ask in writing if the employer or former employers have any information about this psychotherapist having had sexual contact, as defined in the statute, with any clients or former clients. A broad interpretation of what has constituted the delivery of psychotherapy services is suggested. It is preferable to err on the side of asking questions of too many employers rather than of too few.

It is not necessary to make inquiries about all of the applicants for a job, just to make sure that you obtain this information about the person you would like to offer the job to *before* you hire him or her. You may find it helpful to advise all applicants early in the application process that such inquiries will be made. Candidates who do not wish to submit to this scrutiny may choose to withdraw from consideration.

It is essential to plan for what decisions will result from receipt of specific categories of information. You may decide that some things may automatically cause you to drop a candidate from consideration (e.g., conviction under the Minnesota Criminal Sexual Conduct Code, successful litigation against the applicant under Minnesota Statutes 148A., or loss of professional licensure for sexual exploitation of clients). If this is done, it is suggested that there be an appeal process to reconsider unusual cases.

It is important to obtain an authorization to release information signed by the applicant for *each* employer that you intend to ask for information. Use of carbon copies from one original for this purpose has resulted in some misunderstandings and subsequent legal entanglements between prospective employers and applicants. It is also essential that applicants be advised of exactly what you plan to do in investigating their professional backgrounds. They should be asked to sign such an advisory, which the prospective employer should retain. If applicants are asked for their social security numbers to help identify them to past employers, be as precise as possible about how that number will be used. Failure to do so is a violation of federal law.

In communicating with past employers of an applicant, be very specific about the information you want. It is helpful to provide them with the statutory reference and to supply all relevant definitions from the law. This is especially critical for employers outside of Minnesota. Out-of-state employers will probably be unfamiliar with Minnesota statutes and may be constrained by their own state laws from giving information that they have. The important thing is that you ask for it. If you are fearful that the question might be misconstrued, you may want to state in your letter of request that it implies no suspicion of this individual's conduct. Many employers are documenting their requests for this information by sending these letters "Registered Mail, Return Receipt Requested." If out-of-state employers are constrained from giving specific information, then broader questioning about competency and ethical standards may be helpful in eliciting signs of concern about the prospective employee. This may necessitate a broader permission from the prospective employee for release of information from past employers.

In addition to the step-by-step procedures that you set up to collect this information, it is also important to pay attention to the whole process. The information given you by an applicant should make sense in light of the information that you receive from his or her employers. While you are forced to some extent to rely on the information given you by an applicant, it is essential to keep thinking about it critically. It is also important to document all of the constructive measures taken to gain information regarding the prior conduct of a prospective employee.

Since the implementation of this civil law, questions have arisen about whether employers are obligated to do similar background checks of current employees who were hired before August 1, 1986 and for whom such checks were never made. That was *not* the legislative intent of this law. However, there have been successful lawsuits brought under the common law against employers of psychotherapists who did not investigate the background of new employees, and therefore did not learn of a past history of sexual abuse of clients. Any employer who chooses to investigate the professional backgrounds of employees in this category should decide *before* the information is collected how it will be used, and should communicate these procedures to all involved employees. In lieu of such after-the-fact checks, the third provision discussed in this section should take on even greater importance for employers.

In addition to what the law *specifically* requires in checking the backgrounds of psychotherapist applicants, it is also important to make other inquiries in many cases. If the practitioner has ever been licensed, registered, or certified in one of the professions that provide psychotherapy, then those licensing agencies should be asked if the applicant has ever been disciplined for sexual contact with clients. If the candidate was a student in a training program for psychotherapy or any form of counseling within the past five years, the same question should be asked of the training program as that sent to former applicants. Any of these actions will require informing the applicant and getting a signed authorization to release information from him or her.

All of these suggestions are designed to enhance a comprehensive hiring plan. There are, of course, many other questions that responsible employers may ask in the hiring process.

Responding to Background Inquiries from Other Employers

The new law also states that if an employer or former employer "knows of the occurrence of sexual contact by the psychotherapist with patients or former patients of the psychotherapist" and "receives a specific written request by another employer or prospective employer of the psychotherapist, engaged in the business of psychotherapy" and "fails or refuses to disclose the occurrence of the sexual contacts," then that employer may be held liable.

This provision also necessitates the development of a policy as to what information may be disclosed and how it will be communicated. Any such response should include only facts. The legislative intent of this provision was that information on substantiated cases of sexual contact must be passed on in such circumstances, *not* unsubstantiated allegations or unresolved cases. Every effort should be made to protect the due process rights of the accused therapist, as well as the well-being of the complaining client(s). If a decision is made to provide information about anything other than substantiated complaints and subsequent disciplinary actions related to sexual misconduct, great care should be taken and legal advice sought.

It is recommended that a signed authorization to release information from the psychotherapist in question be requested. No identifying information about any clients should be included. This would be unnecessary, unethical, and illegal. Keep the letters of request received from other employers and copies of all of your responses.

Situations in which the accused therapist refuses to cooperate with an investigation or quits in the hope of escaping an investigation, can put the employer in an untenable position in meeting this requirement of the civil law. Therefore, it is recommended that employers make efforts to investigate and reach conclusions on all complaints of sexual contact with clients, whether or not the accused employee cooperates. This will make it much clearer to the employer what information to pass on in compliance with the law. The same thing is true when a client or former client makes an allegation against a former employee. If the complaining client disappears or subsequently drops the complaint or refuses to cooperate with the investigation, then the employer may not be able to substantiate the accusation.

Taking Action When a Client Complains

Minnesota Statutes 148A. states that an employer may be held liable when a client is sexually exploited if "the employer fails or refuses to take reasonable action when the employer knows or has reason to know that the psychotherapist engaged in sexual contact with the plaintiff or any other patient or former patient of the psychotherapist." The obvious part of this provision is that employers are expected to take action when they receive client complaints.

In order to make this possible, employers must implement a client complaint procedure that is readily accessible to clients, and then let clients know that it exists by informing them individually with a handout and/or by posting the information in a prominent place in the agency where all clients will see it. Some agencies ask clients to sign a statement that they have received such a document and have read it. As a part of this client education effort, it is important to let clients know that it is not therapeutic for their therapist to be sexual with them or to request sexual favors from them, and that it is the therapist's responsibility to see that this does not happen. This statement is often included in a clients' bill of rights. Client complaints are an essential source of feedback for an organization, and it is important that clients are treated respectfully and appreciatively in the complaint process.

Good investigative procedures are crucial to an organization's determination of whether allegations are accurate. It is important to investigate every complaint, even if the employer's first reaction is that it couldn't

possibly be true. Treat the complaint as a complaint and not as a therapeutic event; don't try to play therapist to a complaining client. It is appropriate to offer the client a referral to another therapist, preferably outside of the agency, to deal with the negative effects of the sexual exploitation.

One of the ways in which employers sometimes antagonize victims is by billing them for the sessions in which the alleged sexual exploitation occurred while a complaint is being processed. More than once this has precipitated the client's filing a civil suit.

A more basic concept inherent in this provision of the statute is that it is the employer's responsibility to create a work atmosphere where all employees know that sexual contact with clients will not be condoned. The reader is referred to the article by Schultz, Milillo, Couchman, and Lundin in this section of the handbook which describes the characteristics of a healthy organization that are helpful in preventing the sexual exploitation of clients. The leadership of an organization is responsible for integrating these concepts into the everyday life of the agency.

It is important for all of the employees of an organization, not just the therapists, to be familiar with organizational policies and with the problem of sexual exploitation of clients and its warning signals. Often it is the receptionist or another support staff person who has the most opportunity to observe irregular behavior on the part of psychotherapists.

Good clinical supervision for therapists is one of the most important ways employers can have access to information they need about the behavior and potential problems of staff psychotherapists. Supervisors must be trained and experienced in helping therapists to identify behaviors and issues that may lead to the sexual exploitation of clients. See the articles on clinical supervision in the Therapeutic Issues section of this handbook for more detailed information. Long-term treatment of clients should always be carefully monitored because it presents much greater opportunity for abuse by virtue of the length of contact and the strength of the relationship which is likely to build between the therapist and the client. Also, when therapists are exhibiting signs of burnout or personal distress that may impair their judgement with clients, it is the employer's responsibility to take constructive action.

When an allegation of sexual exploitation has been confirmed, it is the employer's responsibility to take the lead in examining what problems in the organization culminated in this abuse. Employers who fail to make the needed subsequent changes to protect other clients from similar mistreatment are generally considered to be more negligent, and consequently more liable, if another case arises.

Clear, written policies on the matters covered in this section are essential. Once these policies are in place, it is of the utmost importance that they always be followed. Employers who do not adhere to and enforce their own policies are in a very poor legal position if they are sued for behavior which violates these policies.

Business Relationships Not Specifically Covered in the Statute

The following business relationships in which psychotherapy services are delivered are not specifically covered in the new statute: independent contractors, partners, collective members, professionals who only share office space, grantees, or volunteers. Because it is often difficult for the public to distinguish these kinds of relationships from direct employment situations, it behooves employers or psychotherapists who enter into these agreements with each other to follow similar procedures to the ones described above. It is usually much more cost-effective to take prevention action than to have to prove in court that you should not be subject to civil suit when a colleague is charged with sexually exploiting a client. Individuals who fall in these categories do not always succeed in avoiding liability in such cases.

No Easy Answers

As is evident from reading this handbook, the issues related to sexual exploitation are very complex. The laws in this area reflect this complexity. As this handbook goes to press, there have been few, if any, civil cases that have been fully litigated under this new law. So, the law has yet to unfold. This means that there are no easy answers as employers seek to determine how to be as responsible as possible in regard to sexual exploitation issues.

The partial efforts of three Minnesota employers are included in Appendixes B-1, B-2 and B-3 of this handbook. Appendix B-3 contains policies and forms used by the Walk-In Counseling Center (WICC) in Minneapolis. WICC is a national award-winning private, free, short-term,

drop-in counseling service which utilizes many volunteer counselors and clinical supervisors. WICC staff members have pioneered in the field of sexual exploitation. They have long had much more thorough screening procedures for their volunteers than most agencies have for employees.

Appendix B-2 contains the sexual exploitation policies and procedures for Ramsey County, which includes the City of St. Paul. This county's mental health system employs hundreds of people who fall under the definition of "psychotherapist."

Appendix B-1 includes the sexual exploitation policies of the Minnesota Department of Corrections, which housed the Task Force on Sexual Exploitation by Counselors and Therapists. The clients of this division of state government are inmates of correctional facilities (i.e. prisons).

These three examples are presented as fuel for the thinking of creative administrators. All of these agencies consider their policies to be in flux; as new ideas, weaknesses, gaps, etc. occur, they will be amended. Any new policies and procedures devised in this area should be considered experimental, and should be reconsidered in the light of experiences with their use.

Conclusion

Employer liability in cases of sexual exploitation by psychotherapists has been described here. The employer liability provisions of Minnesota Statutes 148A. have been detailed. They are: 1) the duty to ask about past instances of sexual contact with clients when hiring psychotherapists; 2) the duty to tell other employers about past occurrences of therapists' sexual contact with clients when that person is being considered for employment; and 3) the duty to take prompt and appropriate action when the employer knows or should have known that sexual contact between a psychotherapist and client(s) was occurring.

This third provision is believed to include: 1) a policy that prohibits sexual contact with clients; 2) accessible client complaint procedures; 3) adequate investigative procedures, followed through in a timely manner with appropriate disciplinary action if the allegations are substantiated; 4) a work atmosphere that promotes openness and organizational health; 5) adequate training for all staff on sexual exploitation; and 6) quality clinical supervision. The limitations of the information presented are stressed. Sexual exploitation is a complex problem. The civil law described here reflects that complexity; consequently, there are no simple answers for employers who are seeking to implement policy and procedures in this area.

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A Checklist For Employers Of Counselors And Therapists

Administrative Procedures Work Group of the Task Force on Sexual Exploitation by Counselors and Therapists*

This checklist is designed to help employers of counselors and therapists in exploring their organizational strengths and weaknesses in addressing the issues related to the sexual exploitation of clients. It is not intended to be a comprehensive list of what constitutes a responsible employer; it is designed to be a springboard for creative, ethical action.

I. Policy Prohibiting Sexual Exploitation

☐ A written policy that prohibits sexual exploitation of clients/patients which:

- ☐ Clearly defines the behaviors that constitute sexual exploitation
- ☐ Clearly states to which employees it applies (in some settings the policy may go beyond counselors and therapists)
- ☐ States that termination of employment may result from sexual exploitation
- ☐ Makes it clear that is is always the counselor's or therapist's responsibility to refrain from the prohibited behaviors
- ☐ Provides a clients' bill of rights that communicates this information to all clients/patients of the agency

II. Hiring Procedures

These items are intended to address only that portion of hiring procedures which pertain to the prevention of sexual exploitation. Thorough employment procedures will seek many other kinds of data on applicants.

A. Application Form

Asks for the following:

- ☐ All past and present licenses and certificates relevant to the practice of counseling and therapy (including those granted in other states or jurisdictions)
- ☐ Any disciplinary actions taken against such licenses or certificates or by any professional organizations for sexual exploitation of clients/patients.
- ☐ Any civil suits or criminal action brought against the applicant for sexual exploitation with a statement of the outcome and an explanation from the applicant
- ☐ Names and addresses of employers and/or supervisors for at least the past five years
- ☐ Any instances where the applicant has been asked to resign or has been terminated by a training program or an employer
- ☐ A statement signed and dated by the applicant that does the following:
  - ☐ Acknowledges that the applicant has read the policies and procedures of the agency and agrees to abide by them
  - ☐ Authorizes the agency to check with employers, training institutions, and other relevant sources on the applicant's character, competence, and ethical qualifications and frees the agency from liability, provided such a background check is done in good faith, without malice
  - ☐ States that the applicant will inform the agency if there is any change in job or training status, licensure or certification, censure or sanction by professional organizations or legal authorities, or other information relevant to the performance of the job in question
  - ☐ Advises applicants of the requirements of Minnesota Statutes 148A.

* Members of this work group are listed in the beginning of this handbook.

- ☐ Attests that all of the information on the application is true and acknowledges that any misstatement or omission may result in the denial of appointment or in dismissal after employment

B. Background Check

- ☐ Form letter to send to past employers (during at least the last five years) of the applicant, which includes the following:
  - ☐ Information on what is required of employers in Minnesota Statutes 148A.
  - ☐ A specific request for any information that the employer has about the applicant having had sexual contact with clients or former clients
  - ☐ A deadline by which the information is needed and at which time the employing agency will proceed whether or not the past employer has responded
  - ☐ A statement that this is a standard request and reflects no suspicion of this applicant
  - ☐ An enclosed, signed release-of-information form from the applicant which frees the responding employer from liability if the information is given in good faith, without malice
- ☐ A method of checking with licensure, registration, or certification boards; professional organizations, and training institutions for any disciplinary action against the applicant for sexual exploitation
- ☐ A method for soliciting information from employers outside of Minnesota, who are not covered by Minnesota statutes
- ☐ A procedure for following up on written responses with phone contacts with former employers
- ☐ Documentation procedures to keep careful records on how background information was sought on applicants who were hired
- ☐ Procedures for dealing with information received that the applicant has had sexual contact with clients (what will be grounds to deny employment to an applicant and how will gray area situations be handled?)
- ☐ An internal appeal process that allows for reconsideration when a decision has been made to deny employment
- ☐ A decision about how employers will handle counselors and therapists hired before August 1, 1986 on whom they did not do extensive background checks

C. Responding to Requests for Information from Other Employers

- ☐ A clear policy about what will constitute an adequate request for information on sexual contact between a therapist and client(s) and what to do if the request is too vague to be answered safely
- ☐ A clear policy about what kinds of information will be passed on when sexual exploitation information is requested on a current or former employee (what constitutes a substantial complaint and what will not be passed on)
- ☐ A timeline for responding to such requests and person(s) designated to make the response
- ☐ A policy that prohibits passing on identifying information about clients
- ☐ A guideline about when to consult legal counsel in responding to requests from other employers

III. Complaint And Investigation Procedures

Agencies that already have general complaint and investigation procedures may only have to alter them to allow for respectful processing of client complaints of sexual exploitation.

- ☐ A written procedure to clients to follow in filing complaints against anyone in the agency, which is readily accessible to all clients
- ☐ An ongoing ethics committee (composed of members of the staff and of others from outside the agency) which will process all complaints
- ☐ Investigation procedures to follow when a complaint has been made that include the following:
  - ☐ A timeline that requires prompt processing of the complaint by a designated person (with an alternate specified, in case the first designee is the person being complained about)
  - ☐ Provision for the immediate securing of all files and records that might pertain to the case, so that they cannot be altered
  - ☐ A meeting with the accused employee to inform him/her of the charges and outline the procedure that will be followed in investigating the complaint
  - ☐ Information gathering which includes:
    - ☐ What occurred
    - ☐ When and where the alleged incident(s) occurred
    - ☐ Any witnesses or others aware of the incident(s)
    - ☐ Other relevant information about the accused counselor or therapist and about his/her practice
    - ☐ Interviewing of any witnesses or agency staff who may be able to corroborate information on the case
  - ☐ Provisions for treating the complaining client respectfully during this process, for protecting client confidentiality, and for keeping the client informed as the investigation progresses
  - ☐ Provision for assisting complaining clients to find other counseling and advocacy resources if they desire such help
  - ☐ Provisions for treating the accused therapist respectfully during the process and for protecting his/her due process rights
  - ☐ A range of possibilities for what to do with the accused therapist while the complaint is being processed
  - ☐ Prohibition of any contact between the therapist and the alleged victim
  - ☐ Provision for careful documentation of the entire investigation process

IV. Disciplinary Procedures and the Aftermath of Sexual Exploitation

- ☐ A range of disciplinary actions that may be taken by the agency in cases of substantial sexual exploitation, including termination of the employee
- ☐ Upon substantiation of an allegation of sexual exploitation, notification to the employee of the disciplinary action delivered in one or both of the following ways:
  - ☐ Written notice of the action taken sent to the last known address of the employee by registered mail with a return receipt requested, prior to the effective date of the action
  - ☐ Written notice of the action presented in person with the request the employee sign all copies to acknowledge receipt (if the employee refuses, this should be noted on all forms)
- ☐ Provision to retain a copy of such a notice as part of the record of employment
- ☐ Provision to inform the complainant of the disposition of the case (the findings and the action taken)
- ☐ A range of mechanisms for dealing with other clients/patients of a counselor or therapist when a charge of sexual exploitation has been substantiated

- ☐ Consultation from outside the agency to help the staff cope with the situation and to make changes in the organization to decrease the likelihood of a recurrence of sexual exploitation

V. Reporting Sexual Exploitation

- ☐ Knowledge of the laws that mandate reporting of sexual exploitation and clear-cut policies and procedures for when and how to report allegations and/or substantiated cases of sexual exploitation to authorities outside of the agency, such as:
  - ☐ Vulnerable Adults authorities
  - ☐ Child Abuse authorities
  - ☐ State licensure or registration boards
  - ☐ Private accreditation and/or certification boards
  - ☐ Ethics committees of professional organizations
  - ☐ Criminal authorities (county attorneys)
  - ☐ State agencies that regulate agencies and institutions

VI. Ongoing Organizational Health Designed to Prevent Sexual Exploitation

- ☐ Maintenance of an open organizational environment that encourages all employees to express concerns about themselves and others
- ☐ Quality clinical supervision by persons well-versed in boundary problems, transference and countertransference, and the other issues related to sexual exploitation of clients
- ☐ A mechanism for periodic review of staff by supervisors and peers
- ☐ Encouragement of professional development of staff that includes exposure to new ideas and to professionals outside of the agency
- ☐ Sensitivity to staff burnout and the agency conditions that lead to it and help for staff who exhibit signs of stress
- ☐ Education for all staff (at time of hiring and on an ongoing basis) which includes:
  - ☐ Information on how to prevent sexual exploitation
  - ☐ Information on all of the items in this checklist

VII. Legal Counsel

- ☐ Consultation with an attorney before adoption of policy and implementation of procedures

Appendices

Contents of Appendices

Minnesota Statutes

MINNESOTA STATUTES 1988, SECTION 609.341
CRIMINAL SEXUAL CONDUCT CODE

609.341 DEFINITIONS.

Subdivision 1. For the purposes of sections 609.341 to 609.351, the terms in this section have the meanings given them.

Subd. 2. "Actor" means a person accused of criminal sexual conduct.

Subd. 3. "Force" means the infliction, attempted infliction, or threatened infliction by the actor of bodily harm or commission or threat of any other crime by the actor against the complainant or another, which (a) causes the complainant to reasonably believe that the actor has the present ability to execute the threat and (b) if the actor does not have a significant relationship to the complainant, and also causes the complainant to submit.

Subd. 4. "Consent" means a voluntary uncoerced manifestation of a present agreement to perform a particular sexual act with the actor.

Subd. 5. "Intimate parts" includes the primary genital area, groin, inner thigh, buttocks, or breast of a human being.

Subd. 6. "Mentally impaired" means that a person, as a result of inadequately developed or impaired intelligence or a substantial psychiatric disorder of thought or mood, lacks the judgment to give a reasoned consent to sexual contact or to sexual penetration.

Subd. 7. "Mentally incapacitated" means that a person under the influence of alcohol, a narcotic, anesthetic, or any other substance, administered to that person without the person's agreement, lacks the judgment to give a reasoned consent to sexual contact or sexual penetration.

Subd. 8. "Personal injury" means bodily harm as defined in section 609.02, subdivision 7, or severe mental anguish or pregnancy.

Subd. 9. "Physically helpless" means that a person is (a) asleep or not conscious, (b) unable to withhold consent or to withdraw because of a physical condition, or (c) unable to communicate nonconsent and the condition is known or reasonably should have been known to the actor.

Subd. 10. "Position of authority" includes but is not limited to any person who is a parent or acting in the place of a parent and charged with any or a parent's rights, duties or responsibilities to a child, or a person who is charged with any duty or responsibility for the health, welfare, or supervision of a child, either independently or through another, no matter how brief, at the time of the act.

Subd. 11. (a) "Sexual contact," for the purposes of sections 609.343, subdivision 1, clauses (a) to (f), and 609.345, subdivision 1, clauses (a) to (e), and (h) to (j), includes any of the following acts committed without the complainant's consent, except in those cases where consent is not a defense, and committed with sexual or aggressive intent:

(i) The intentional touching by the actor of the complainant's intimate parts, or

(ii) The touching by the complainant of the actor's, the complainant's, or another's intimate parts effected by coercion or the use of a position of authority, or by inducement if the complainant is under 13 years of age or mentally impaired, or

(iii) The touching by another of the complainant's intimate parts effected by coercion or the use of a position of authority, or

(iv) In any of the cases above, the touching of the clothing covering the immediate area of the intimate parts.

(b) "Sexual contact," for the purposes of sections 609.343, subdivision 1, clauses (g) and (h), and 609.345, subdivision 1, clauses (f) and (g), includes any of the following acts committed with sexual or aggressive intent:

(i) the intentional touching by the actor of the complainant's intimate parts;

(ii) the touching by the complainant of the actor's, the complainant's, or another's intimate parts;

(iii) the touching by another of the complainant's intimate parts; or

(iv) in any of the cases listed above, touching of the clothing covering the immediate area of the intimate parts.

Subd. 12. "Sexual penetration" means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any intrusion however slight into the genital or anal openings of the complainant's body, of any part of the actor's body or any object used by the actor for this purpose, where the act is committed without the complainant's consent, except in those cases where consent is not a defense. Emission of semen is not necessary.

Subd. 13. "Complainant" means a person alleged to have been subjected to criminal sexual conduct, but need not be the person who signs the complaint.

Subd. 14. "Coercion" means words or circumstances that cause the complainant reasonably to fear that the actor will inflict bodily harm upon, or hold in confinement, the complainant or another, or force the complainant to submit to sexual penetration or contact, but proof of coercion does not require proof of a specific act or threat.

Subd. 15. **Significant relationship.** "Significant relationship" means a situation in which the actor is:

(1) the complainant's parent, stepparent, or guardian;

(2) any of the following persons related to the complainant by blood, marriage, or adoption: brother, sister, stepbrother, stepsister, first cousin, aunt, uncle, nephew, niece, grandparent, great-grandparent, great-uncle, great-aunt; or

(3) an adult who jointly resides intermittently or regularly in the same dwelling as the complainant and who is not the complainant's spouse.

Subd. 16. "Patient" means a person who seeks or obtains psychotherapeutic services.

Subd. 17. "Psychotherapist" means a physician, psychologist, nurse, chemical dependency counselor, social worker, clergy, marriage and family therapist, mental health service provider, or other person, whether or not licensed by the state, who performs or purports to perform psychotherapy.

Subd. 18. "Pyschotherapy" means the professional treatment, assessment, or counseling of a mental or emotional illness, symptom, or condition.

Subd. 19. "Emotionally dependent" means that the nature of the patient's or former patient's emotional condition and the nature of the treatment provided by the psychotherapist are such that the psychotherapist knows or has reason to know that the patient or former patient is unable to withhold consent to sexual contact or sexual penetration by the psychotherapist.

Subd. 20. "Therapeutic deception" means a representation by a psychotherapist that sexual contact or sexual penetration by the psychotherapist is consistent with or part of the patient's treatment.

History: 1975 c 374 s 2; 1977 c 130 s 8; 1979 c 258 s 9-11; 1981 c 51 s 1; 1982 c 385 s 1; 1982 c 469 s 9; 1984 c 525 s 3; 1984 c 588 c 5,6; 1985 c 24 s 3,4; 1985 c 286 s 14; 1985 c 297 s 1-5; 1986 c 351 s 6,7; 1986 c 444; 1987 c 198 s 1,2,3; 1987 c 347 art 1 s 22; 1988 c 413 s 1.

609.342 CRIMINAL SEXUAL CONDUCT IN THE FIRST DEGREE.

Subdivision 1.**Crime defined**. A person who engages in sexual penetration with another person is guilty of criminal sexual conduct in the first degree if any of the following circumstances exists:

(a) the complainant is under 13 years of age and the actor is more than 36 months older than the complainant. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense;

(b) the complainant is at least 13 but less than 16 years of age and the actor is more than 48 months or older than the complainant and in a position of authority over the complainant, and uses this authority to cause the complainant to submit. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense;

(c) circumstances existing at the time of the act cause the complainant to have a reasonable fear of imminent great bodily harm to the complainant or another;

(d) the actor is armed with a dangerous weapon or any article used or fashioned in a manner to lead the complainant to reasonably believe it to be a dangerous weapon and uses or threatens to use the weapon or article to cause the complainant to submit;

(e) the actor causes personal injury to the complainant, and either of the following circumstances exist:

(i) the actor uses force or coercion to accomplish sexual penetration; or

(ii) the actor knows or has reason to know that the complainant is mentally impaired, mentally incapacitated, or physically helpless;

(f) the actor is aided or abetted by one or more accomplices within the meaning of section 609.05, and either of the following circumstances exists:

(i) an accomplice uses force or coercion to cause the complainant to submit, or

(ii) an accomplice is armed with a dangerous weapon or any article used or fashioned in a manner to lead the complainant reasonably to believe it to be a dangerous weapon and uses or threatens to use the weapon or article to cause the complainant to submit;

(g) the actor has a significant relationship to the complainant and the complainant was under 16 years of age at the time of the sexual penetration. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense; or

(h) the actor has a significant relationship to the complainant, the complainant was under 16 years of age at the time of the sexual penetration, and:

(i) the actor or an accomplice used force or coercion to accomplish the penetration;

(ii) the actor or an accomplice was armed with a dangerous weapon or any article used or fashioned in a manner to lead the complainant to reasonably believe it could be a dangerous weapon and used or threatened to use the dangerous weapon;

(iii) circumstances existed at the time of the act to cause the complainant to have a reasonable fear of imminent great bodily harm to the complainant or another;

(iv) the complainant suffered personal injury; or

(v) the sexual abuse involved multiple acts committed over an extended period of time.

Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense.

Subd. 2. **Penalty.** A person convicted under subdivision 1 may be sentenced to imprisonment for not more than 20 years or to a payment of a fine of not more than $35,000, or both.

Subd. 3. **Stay.** Except when imprisonment is required under section 609.346, if a person is convicted under subdivision 1, clause (g), the court may stay imposition or execution of the sentence if it finds that:

(a) a stay is in the best interests of the complainant or the family unit; and

(b) a professional assessment indicates that the offender has been accepted by and can respond to a treatment program.

If the court stays imposition or execution of sentence, it shall include the following as conditions of probation:

(1) incarceration in a local jail or workhouse; and

(2) a requirement that the offender complete a treatment program.

History: 1975 c 374 s 3; 1981 c 51 s 2; 1983 c 204 s 1; 1984 c 628 art 3 s 11; 1985 c 24 s 5; 1985 c 286 s 15; 1986 c 444.

609.343 CRIMINAL SEXUAL CONDUCT IN THE SECOND DEGREE.

Subdivision 1. **Crime defined.** A person who engages in sexual contact with another person is guilty of criminal sexual conduct in the second degree if any of the following circumstances exists:

(a) the complainant is under 13 years of age and the actor is more than 36 months older than the complainant. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense. In a prosecution under this clause, the state is not required to prove that the sexual contact was coerced;

(b) the complainant is at least 13 but less than 16 years of age and the actor is more than 48 months older than the complainant and in a position of authority over the complainant, and uses this authority to cause the complainant to submit. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense;

(c) circumstances existing at the time of the act cause the complainant to have a reasonable fear of imminent great bodily harm to the complainant or another;

(d) the actor is armed with a dangerous weapon or any article used or fashioned in a manner to lead the complainant to reasonably believe it to be a dangerous weapon and uses or threatens to use the dangerous weapon or article to cause the complainant to submit;

(e) the actor causes personal injury to the complainant, and either of the following circumstances exist:

(i) the actor uses force or coercion to accomplish the sexual contact; or

(ii) the actor knows or has reason to know that the complainant is mentally impaired, mentally incapacitated, or physically helpless;

(f) the actor is aided or abetted by one or more accomplices within the meaning of section 609.05, and either of the following circumstances exists:

(i) an accomplice uses force or coercion to cause the complainant to submit; or

(ii) an accomplice is armed with a dangerous weapon or any article used or fashioned in a manner to lead the complainant to reasonably believe it to be a dangerous weapon and uses or threatens to use the weapon or article to cause the complainant to submit;

(g) the actor has a significant relationship to the complainant and the complainant was under 16 years of age at the time of the sexual contact. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense; or

(h) the actor has a significant relationship to the complainant, the complainant was under 16 years of age at the time of the sexual contact, and:

(i) the actor or an accomplice used force or coercion to accomplish the contact;

(ii) the actor or an accomplice was armed with a dangerous weapon or any article used or fashioned in a manner to lead the complainant to reasonably believe it could be a dangerous weapon and used or threatened to use the dangerous weapon;

(iii) circumstances existed at the time of the act to cause the complainant to have a reasonable fear of imminent great bodily harm to the complainant or another;

(iv) the complainant suffered personal injury; or

(v) the sexual abuse involved multiple acts committed over an extended period of time.

Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense.

Subd. 2. **Penalty.** A person convicted under subdivision 1 may be sentenced to imprisonment for not more than 15 years or to a payment of a fine of not more than $30,000, or both.

Subd. 3. **Stay.** Except when imprisonment is required under section 609.346, if a person is convicted under subdivision 1, clause (g), the court may stay imposition or execution of the sentence if it finds that:

(a) a stay is in the best interest of the complainant or the family unit; and

(b) a professional assessment indicates that the offender has been accepted by and can respond to a treatment program.

If the court stays imposition or execution of sentence, it shall include the following as conditions of probation:

(1) incarceration in a local jail or workhouse; and

(2) a requirement that the offender complete a treatment program.

History: 1975 c 374 s 4; 1979 c 258 s 12; 1981 c 51 s 3; 1983 c 204 s 2; 1984 c 628 art 3 s 11; 1985 c 24 s 6; 1985 c 286 s 16; 1986 c 444.

609.344 CRIMINAL SEXUAL CONDUCT IN THE THIRD DEGREE.

Subdivision 1. **Crime defined.** A person who engages in sexual penetration with another person is guilty of criminal sexual conduct in the third degree if any of the following circumstances exists:

(a) the complainant is under 13 years of age and the actor is no more than 36 months older than the complainant. Neither mistake as to the complainant's age nor consent to the act by the complainant shall be a defense;

(b) the complainant is at least 13 but less than 16 years of age and the actor is more than 24 months older than the complainant. In any such case it shall be an affirmative defense, which must be proved by a preponderance of the evidence, that the actor believes the complainant to be 16 years of age or older. If the actor in such a case is no more than 48 months but more than 24 months older than the complainant, the actor may be sentenced to imprisonment for not more than five years. Consent by the complainant is not a defense;

(c) the actor uses force or coercion to accomplish the penetration;

(d) the actor knows or has reason to know that the complainant is mentally impaired, mentally incapacitated, or physically helpless;

(e) the complainant is at least 16 but less than 18 years of age and the actor is more than 48 months older than the complainant and in a position of authority over the complainant, and uses this authority to cause the complainant to submit. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense;

(f) the actor has a significant relationship to the complainant and the complainant was at least 16 but under 18 years of age at the time of the sexual penetration. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense; or

(g) the actor has a significant relationship to the complainant, the complainant was at least 16 but under 18 years of age at the time of the sexual penetration, and:

(i) the actor or an accomplice used force or coercion to accomplish the penetration;

(ii) the actor or an accomplice was armed with a dangerous weapon or any article used or fashioned in a manner to lead the complainant to reasonably believe it could be a dangerous weapon and used or threatened to use the dangerous weapon;

(iii) circumstances existed at the time of the act to cause the complainant to have a reasonable fear of imminent great bodily harm to the complainant or another;

(iv) the complainant suffered personal injury; or

(v) the sexual abuse involved multiple acts committed over an extended period of time.

Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense.

(h) the actor is a psychotherapist and the complainant is a patient of the psychotherapist and the sexual penetration occurred during the psychotherapy session. Consent by the complainant is not a defense;

(i) the actor is a psychotherapist and the complainant is a patient or former patient of the psychotherapist and the patient or former patient is emotionally dependent upon the psychotherapist;

(j) the actor is a psychotherapist and the complainant is a patient or former patient and the sexual penetration occurred by means of therapeutic deception. Consent by the complainant is not a defense; or

(k) the actor accomplishes the sexual penetration by means of false representation that the penetration is for a bona fide medical purpose by a health care professional. Consent by the complainant is not a defense.

Subd. 2. **Penalty.** A person convicted under subdivision 1 may be sentenced to imprisonment for not more than ten years or to a payment of a fine of not more than $20,000, or both.

Subd. 3. **Stay.** Except when imprisonment is required under section 609.346, if a person is convicted under subdivision 1, clause (f), the court may stay imposition or execution of the sentence if it finds that:

(a) a stay is in the best interest of the complainant or the family unit; and

(b) a professional assessment indicates that the offender has been accepted by and can respond to a treatment program.

If the court stays imposition or execution of sentence, it shall include the following as conditions of probation:

(1) incarceration in a local jail or workhouse; and

(2) a requirement that the offender complete a treatment program.

History: 1975 c 374 s 5; 1979 c 258 s 13; 1983 c 204 s 3; 1984 c 588 s 7; 1984 c 628 art 3 s 11; 1985 c 24 s 7; 1985 c 286 s 17; 1985 c 297 s 6; 1986 c 351 s 8; 1986 c 444; 1Sp1986 c 3 art 1 s 80; 1987 c 94 s 1.

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609.345 CRIMINAL SEXUAL CONDUCT IN THE FOURTH DEGREE.

Subdivision 1.**Crime defined.** A person who engages in sexual contact with another person is guilty of criminal sexual conduct in the fourth degree if any of the following circumstances exists:

(a) the complainant is under 13 years of age and the actor is no more than 36 months older than the complainant. Neither mistake as to the complainant's age or consent to the act by the complainant is a defense. In a prosecution under this clause, the state is not required to prove that the sexual contact was coerced;

(b) the complainant is at least 13 but less than 16 years of age and the actor is more than 48 months older than the complainant or in a position of authority over the complainant and uses this authority to cause the complainant to submit. In any such case, it shall be an affirmative defense which must be proved by a preponderance of the evidence that the actor believes the complainant to be 16 years of age or older;

(c) the actor uses force or coercion to accomplish the sexual contact;

(d) the actor knows or has reason to know that the complainant is mentally impaired, mentally incapacitated, or physically helpless;

(e) the complainant is at least 16 but less than 18 years of age and the actor is more than 48 months older than the complainant and in a position of authority over the complainant, and uses this authority to cause the complainant to submit. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense;

(f) the actor has a significant relationship to the complainant and the complainant was at least 16 but under 18 years of age at the time of the sexual contact. Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense;

(g) the actor has a significant relationship to the complainant, the complainant was at least 16 but under 18 years of age at the time of the sexual contact, and:

(i) the actor or an accomplish used force or coercion to accomplish the contact;

(ii) the actor or an accomplice was armed with a dangerous weapon or any article used or fashioned in a manner to lead the complainant to reasonably believe it could be a dangerous weapon and used or threatened to use the dangerous weapon;

(iii) circumstances existed at the time of the act to cause the complainant to have a reasonable fear of imminent great bodily harm to the complainant or another;

(iv) the complainant suffered personal injury; or

(v) the sexual abuse involved multiple acts committed over an extended period of time.

Neither mistake as to the complainant's age nor consent to the act by the complainant is a defense.

(h) the actor is a psychotherapist and the complainant is a patient of the psychotherapist and the sexual contact occurred during the psychotherapy session. Consent by the complainant is not a defense;

(i) the actor is a psychotherapist and the complainant is a patient or former patient of the psychotherapist and the patient or former patient is emotionally dependent upon the psychotherapist;

(j) the actor is a psychotherapist and the complainant is a patient or former patient and the sexual contact occurred by means of therapeutic deception. Consent by the complainant is not a defense; or

(k) the actor accomplishes the sexual contact by means of false representation that the contact is for a bona fide medical purpose by a health care professional. Consent by the complainant is not a defense.

Subd. 2. **Penalty.** A person convicted under subdivision 1 may be sentenced to imprisonment for not more than five years or to a payment of a fine of not more than $10,000, or both.

Subd. 3. **Stay.** Except when imprisonment is required under section 609.346, if a person is convicted under subdivision 1, clause (f), the court may stay imposition or execution of the sentence if it finds that:

(a) a stay is in the best interest of the complainant or the family unit; and

(b) a professional assessment indicates that the offender has been accepted by and can respond to a treatment program.

If the court stays imposition or execution of sentence, it shall include the following as conditions of probation:

(1) incarceration in a local jail or workhouse; and

(2) a requirement that the offender complete a treatment program.

History: 1975 c 374 s 6; 1976 c 124 s 9; 1979 c 258 s 14; 1981 c 51 s 4; 1983 c 204 s 4; 1984 c 588 s 8; 1984 c 628 art 3 s 11; 1985 c 24 s 8; 1985 c 286 s 18; 1985 c 297 s 7; 1986 c 351 s 9; 1986 c 444; 1Sp1986 c 3 art 1 s 81; 1987 c 94 s 2.

609.3451 CRIMINAL SEXUAL CONDUCT IN THE FIFTH DEGREE.

Subdivision 1.**Crime Defined.** A person is guilty of criminal sexual conduct in the fifth degree if the person engages in nonconsensual sexual contact. For purposes of this section, "sexual contact" has the meaning given in section 609.341, subdivision 11, paragraph (a), clauses (i) and (iv), but does not include the intentional touching of the clothing covering the immediate area of the buttocks.

Subd. 2. **Penalty.** A person convicted under subdivision 1 may be sentenced to imprisonment for not more than one year or to a payment of a fine of not more than $3,000, or both.

History: 1988 c 529 s 2,3.

609.346 SUBSEQUENT OFFENSES.

Subdivision 1.**Definition; conviction of offense.** For purposes of this section, the term "offense" means a completed offense or an attempt to commit an offense.

Subd. 2. **Subsequent offense; penalty.** If a person is convicted of a second or subsequent offense under sections 609.342 to 609.345 within 15 years of the prior conviction, the court shall commit the defendant to the commissioner of corrections for imprisonment for a term of not less than three years, nor more than the maximum sentence provided by law for the offense for which convicted, notwithstanding the provisions of sections 242.19, 243.05, 609.11, 609.12, and 609.135. The court may stay the execution of the sentence imposed under this section only if it finds that a professional assessment indicates the offender is accepted by and can respond to treatment at a long-term inpatient program exclusively treating sex offenders and approved by the commissioner of corrections. If the court stays the execution of a sentence, it shall include the following as conditions of probation: (1) incarceration in a local jail or workhouse; and (2) a requirement that the offender successfully complete the treatment program and aftercare as directed by the court.

Subd. 3. **Prior convictions under similar statutes.** For the purposes of section, an offense is considered a second or subsequent offense if conviction of the actor for the offense follows or coincides with a conviction of the actor under sections 609.342 to 609.345 or under any similar statute of the United States, or this or any other state.

History: 1975 c 374 s 7; 1978 c 723 art 1 s 16; 1981 c 273 s 4; 1984 c 588 s 9; 1984 c 655 art 1 s 77; 1986 c 351 s 10,11; 1Sp1986 c 3 art 1 s 70,71; 1987 c 224 s 1,2.

609.347 EVIDENCE.

Subdivision 1.In a prosecution under sections 609.342 to 609.346, the testimony of a victim need not be corroborated.

Subd. 2. In a prosecution under sections 609.342 to 609.346, there is no need to show that the victim resisted the accused.

Subd. 3. In a prosecution under section 609.342 to 609.346 or 609.365, evidence of the victim's previous sexual conduct shall not be admitted nor shall any reference to such conduct be made in the presence of the jury, except by court order under the procedure provided in subdivision 4. The evidence can be admitted only if the probative value of the evidence is not substantially outweighed by its inflammatory or prejudicial nature and only in the circumstances set out in paragraphs (a) and (b). For the evidence to be admissible under paragraph (a), subsection (i), the judge must find by a preponderance of the evidence that the facts set out in the accused's offer of proof are true. For the evidence to be admissible under paragraph (a), subsection (ii) or paragraph (b), the judge must find that the evidence is sufficient to support a finding that the facts set out in the accused's offer of proof are true, as provided under Rule 901 of the Rules of Evidence.

(a) When consent of the victim is a defense in the case, the following evidence is admissible:

(i) evidence of the victim's previous sexual conduct tending to establish a common scheme or plan of similar sexual conduct under circumstances similar to the case at issue. In order to find a common scheme or plan, the judge must find that the victim made prior allegations of sexual assault which were fabricated; and

(ii) evidence of the victim's previous sexual conduct with the accused.

(b) When the prosecution's case includes evidence of semen, pregnancy, or disease at the time of the incident or, in the case of pregnancy, between the time of the incident and trial, evidence of specific instances of the victim's previous sexual conduct is admissible solely to show the source of the semen, pregnancy, or disease.

Subd. 4. The accused may not offer evidence described in subdivision 3 except pursuant to the following procedure:

(a) A motion shall be made by the accused at least three business days prior to trial, unless later for good cause shown, setting out with particularity the offer of proof of the evidence that the accused intends to offer, relative to the previous sexual conduct of the victim;

(b) If the court deems the offer of proof sufficient, the court shall order a hearing out of the presence of the jury, if any, and in such hearing shall allow the accused to make a full presentation of the offer of proof;

(c) At the conclusion of the hearing, if the court finds that the evidence proposed to be offered by the accused regarding the previous sexual conduct of the victim is admissible under subdivision 3 and its probative value is not substantially outweighed by its inflammatory or prejudicial nature, the court shall make an order stating the extent to which evidence is admissible. The accused may then offer evidence pursuant to the order of the court;

(d) If new information is discovered after the date of the hearing or during the course of trial, which may make evidence described in subdivision 3 admissible, the accused may make an offer of proof pursuant to clause (a) of this subdivision and the court shall order an in camera hearing to determine whether the proposed evidence is admissible by the standards herein.

Subd. 5. In a prosecution under sections 609.342 to 609.346, the court shall not instruct the jury to the effect that:

(a) It may be inferred that a victim who has previously consented to sexual intercourse with persons other than the accused would be therefore more likely to consent to sexual intercourse again; or

(b) The victim's previous or subsequent sexual conduct in and of itself amy be considered in determining the credibility of the victim; or

(c) Criminal sexual conduct is a crime easily charged by a victim but very difficult to disprove by an accused because of the heinous nature of the crime; or

(d) The jury should scrutinize the testimony of the victim any more closely than it should scrutinize the testimony of any witness in any felony prosecution.

Subd. 6. (a) In a prosecution under sections 609.342 to 609.346 involving a psychotherapist and patient, evidence of the patient's personal or medical history is not admissible except when:

(1) the accused requests a hearing at least three business days prior to trial and makes an offer of proof of the relevancy of the history; and

(2) the court finds that the history is relevant and that the probative value of the history outweighs its prejudicial value.

(b) The court shall allow the admission only of specific information or examples of conduct of the victim that are determined by the court to be relevant. The court's order shall detail the information or conduct that is admissible and no other evidence of the history may be introduced.

(c) Violation of the terms of the order is grounds for mistrial but does not prevent the retrial of the accused.

Subd. 7. **Effect of statute on rules.** Rule 404, paragraph (c) of the Rules of Evidence is superseded to the extent of its conflict with this section.

History: 1975 c 374 s 8; 1984 c 588 s 10; 1985 c 297 s 8; 1986 c 351 s 12; 1986 c 444; 1Sp1986 c 3 art 1 s 72; 1987 c 114 s 1.

609.3471 RECORDS PERTAINING TO VICTIM IDENTIFY CONFIDENTIAL.

Notwithstanding any provision of law to the contrary, no data contained in records or reports relating to petitions, complaints, or indictments issues pursuant to sections 609.342, clause (a), (b), (g), or (h); 609.343, clause (a), (b), (g), or (h); 609.344, clause (a), (b), (e), (f), or (g); or 609.345, clause (a), (b), (e), (f), or (g) which specifically identifies the victim shall be accessible to the public, except by order of the court. Nothing in this section authorizes denial of access to any other data contained in the records or reports, including the identity of the defendant.

History: 1984 c 573 s 9; 1985 c 119 s 1; 1986 c 351 s 13; 1Sp1986 c 3 art 1 s 73; 1987 c 331 s 9.

609.348 MEDICAL PURPOSES; EXCLUSION.

Sections 609.341 to 609.351 do not apply to sexual penetration or sexual contact when done for a bona fide medical purpose.

History: 1975 c 374 s 9; 1981 c 273 s 5; 1986 c 351 s 14; 1Sp1986 c 3 art 1 s 74.

609.349 VOLUNTARY RELATIONSHIPS.

A person does not commit criminal sexual conduct under sections 609.342, clauses (a) and (b), 609.343, clauses (a) and (b), 609.344, clauses (a), (b), (d), and (e), and 609.345, clauses (a), (b), (d), and (e), if the actor and complainant were adults cohabitating in an ongoing voluntary sexual relationship at the time of the alleged offense, or if the complainant is the actor's legal spouse, unless the couple is living apart and one of them has filed for legal separation or dissolution of the marriage. Nothing in this section shall be construed to prohibit or restrain the prosecution for any other offense committed by one legal spouse against the other.

History: 1975 c 374 s 10; 1978 c 772 s 62; 1980 c 544 s 2; 1986 c 351 s 15; 1986 c 444.

609.35 COSTS OF MEDICAL EXAMINATION.

No costs incurred by a county, city, or private hospital or other emergency medical facility or by a private physician for the examination of a complainant of criminal sexual conduct when the examination is performed for the purpose of gathering evidence for possible prosecution, shall be charged directly or indirectly to the complainant. The reasonable costs of the examination shall be paid by the county in which the alleged offense was committed. Nothing in this section shall be construed to limit the duties, responsibilities, or liabilities of any insurer, whether public or private.

History: 1975 c 374 s 11; 1981 c 273 s 6; 1986 c 351 s 16; 1Sp1986 c 3 art 1 s 75.

609.351 APPLICABILITY TO PAST AND PRESENT PROSECUTIONS.

Except for section 609.347, crimes committed prior to August 1, 1975, are not affected by its provisions.

History: 1975 c 374 s 12.

609.352 SOLICITATION OF CHILDREN TO ENGAGE IN SEXUAL CONDUCT.

Subdivision 1. **Definitions.** As used in this section:

(a) "child" means a person under the age of 15 years;

(b) "sexual conduct" means sexual contact of the individual's primary genital area, sexual penetration as defined in section 609.341, or sexual performance as defined in section 617.246; and

(c) "solicit" means commanding, entreating, or attempting to persuade a specific person.

Subd. 2. **Prohibited act.** A person 18 years of age or older who solicits a child to engage in sexual conduct with intent to engage in sexual conduct is guilty of a felony and may be sentenced to imprisonment for not more than three years, or to payment of a fine of not more than $5,000, or both.

Subd. 3. **Defenses.** Mistake as to age is not a defense to a prosecution under this section.

History: 1986 c 445 s 3.

MINNESOTA STATUTES 1988, SECTION 148A
ACTION FOR SEXUAL EXPLOITATION; PSYCHOTHERAPISTS

148.01 DEFINITIONS.

Subdivision 1. **General.** The definitions in this section apply to sections 148A.01 to 148A.04, 148A.05, and 148A.06.

Subd. 2. **Emotionally dependent.** "Emotionally dependent" means that the nature of the patient's or former patient's emotional condition and the nature of the treatment provided by the psychotherapist are such that the psychotherapist knows or has reason to believe that the patient or former patient is unable to withhold consent to sexual contact by the psychotherapist.

Subd. 3. **Former patient.** "Former patient" means a person who was given psychotherapy within two years prior to sexual contact with the psychotherapist.

Subd. 4. **Patient.** "Patient" means a person who seeks or obtains psychotherapy.

Subd. 5. **Psychotherapist.** "Psychotherapist" means a physician, psychologist, nurse, chemical dependency counselor, social worker, member of the clergy, marriage and family therapist, mental health service provider, or other person, whether or not licensed by the state, who performs or purports to perform psychotherapy.

Subd. 6. **Psychotherapy.** "Psychotherapy" means the professional treatment, assessment, or counseling of a mental or emotional illness, symptom, or condition.

Subd. 7. **Sexual contact.** "Sexual contact" means any of the following, whether or not occurring with the consent of a patient or former patient:

(1) sexual intercourse, cunnilingus, fellatio, anal intercourse or any intrusion, however slight, into the genital or anal openings of the patient's or former patient's body by any part of the psychotherapist's body or by any object used by the psychotherapist for this purpose, or any intrusion, however slight, into the genital or anal openings of the psychotherapist's body by any part of the patient's or former patient's body or by any object used by the patient or former patient for this purpose, if agreed to by the psychotherapist;

(2) kissing of, or the intentional touching by the psychotherapist of the patient's or former patient's genital area, groin, inner thigh, buttocks, or breast or of the clothing covering any of these body parts;

(3) kissing of, or the intentional touching by the patient or former patient of the psychotherapist's genital area, groin, inner thigh, buttocks, or breast or of the clothing covering any of these body parts if the psychotherapist agrees to the kissing or intentional touching.

"Sexual contact" includes requests by the psychotherapist for conduct described in clauses (1) to (3).

"Sexual contact" does not include conduct described in clause (1) or (2) that is a part of standard medical treatment of a patient.

Subd. 8. **Therapeutic deception.** "Therapeutic deception" means a representation by a psychotherapist that sexual contact with the psychotherapist is consistent with or part of the patient's or former patient's treatment.

History: 1986 c 372 s 1; 1Sp1986 c 3 art 2 s 22; 1987 c 347 art 1 s 19.

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148.02 CAUSE OF ACTION FOR SEXUAL EXPLOITATION.

A cause of action against a psychotherapist for sexual exploitation exists for a patient or former patient for injury caused by sexual contact with the psychotherapist, if the sexual contact occurred:

(1) during the period the patient was receiving psychotherapy from the psychotherapist; or

(2) after the period the patient received psychotherapy from the psychotherapist if (a) the former patient was emotionally dependent on the psychotherapist; or (b) the sexual contact occurred by means of therapeutic deception.

The patient or former patient may recover damages from a psychotherapist who is found liable for sexual exploitation. It is not a defense to the action that sexual contact with a patient occurred outside a therapy or treatment session or that it occurred off the premises regularly used by the psychotherapist for therapy or treatment sessions.

History: 1986 c 372 s 2.

148A.03 LIABILITY OF EMPLOYER.

(a) An employer of a psychotherapist may be liable under section 148A.02 if:

(1) the employer fails or refuses to take reasonable action when the employer knows or has reason to know that the psychotherapist engaged in sexual contact with the plaintiff or any other patient or former patient of the psychotherapist; or

(2) the employer fails or refuses to make inquiries of an employer or former employer, whose name and address have been disclosed to the employer and who employed the psychotherapist as a psychotherapist within the last five years, concerning the occurrence of sexual contacts by the psychotherapist with patients or former patients of the psychotherapist.

(b) An employer or former employer of a psychotherapist may be liable under section 148A.02 if the employer or former employer:

(1) knows of the occurrence of sexual contact by the psychotherapist with patients or former patients of the psychotherapist;

(2) receives a specific written request by another employer or prospective employer of the psychotherapist, engaged in the business of psychotherapy, concerning the existence or nature of the sexual contact; and

(3) fails or refuses to disclose the occurrence of the sexual contacts.

(c) An employer or former employer may be liable under section 148A.02 only to the extent that the failure or refusal to take any action required by paragraph (a) or (b) was a proximate and actual cause of any damages sustained.

(d) No cause of action arises, nor may a licensing board in this state take disciplinary action, against a psychotherapist's employer or former employer who in good faith complies with this section.

History: 1986 c 372 s 3.

148A.04 SCOPE OF DISCOVERY.

In an action for sexual exploitation, evidence of the plaintiff's sexual history is not subject to discovery except when the plaintiff claims damage to sexual functioning; or

(1) the defendant requests a hearing prior to conducting discovery and makes an offer of proof of the relevancy of the history; and

(2) the court finds that the history is relevant and that the probative value of the history outweighs its prejudicial effect.

The court shall allow the discovery only of specific information or examples of the plaintiff's conduct that are determined by the court to be relevant. The court's order shall detail the information or conduct that is subject to discovery.

History: 1986 c 373 s 4.

148A.05 ADMISSION OF EVIDENCE.

In an action for sexual exploitation, evidence of the plaintiff's sexual history is not admissible except when:

(1) the defendant requests a hearing prior to trial and makes an offer of proof of the relevancy of the history; and

(2) the court finds that the history is relevant and that the probative value of the history outweighs its prejudicial effect.

The court shall allow the admission only of specific information or examples of the plaintiff's conduct that are determined by the court to be relevant. The court's order shall detail the information or conduct that is admissible and no other such evidence may be introduced.

Violation of the terms of the order may be grounds for a new trial.

History: 1986 c 372 s 6.

148A.06 LIMITATION PERIOD.

An action for sexual exploitation shall be commenced within five years after the cause of action arises.

History: 1986 c 372 s 7.

Appendix A-3

CHART OF DIFFERENCES BETWEEN CRIMINAL AND CIVIL LAW

Action	Criminal	Civil
Effective Date:	Acts on or after 8/1/85	Acts on or after 8/1/86
Attorneys who present the victim's case:	County Attorney	Private Attorney
Results of successful case:	Prison (or probation) and/or fine paid to State	Monetary damages paid to victim
Who action may be brought against:	Offending Therapist	Offending therapist and his/her employer
Statute of Limitations:	3 years from last sexual event	5 years from last sexual event
Grounds:	Felony if:	Actionable if:
	*1) In therapy session	*1) During entire period that person is a client
	*2) "Deception" between sessions or after termination	*2) "Deception" within 2 years post termination
	*3) "Emotional dependence" between sessions or after termination (ability to consent is the issue).	*3) "Emotional dependence" within 2 years post termination (ability to consent is the issue).
Sexual Activity covered:	Any form of intercourse and touching breasts, genitals and clothing covering.	Somewhat more extensive.
What must be proved:	1) Person was "client" or "former "client" of "psychotherapist".	1) Person was "client" or former "client" of "psychotherapist".
	2) The sexual activity occurred.	2) The sexual activity occurred.
		3) How the client was damaged by the sexual activity.
		4) In cases where employer is being sued, how the employer was negligent.
Standard of Proof:	"Beyond a reasonable doubt" - highest.	"The preponderance of the evidence".

*Consent of the client may not be used as a defense of the therapist or employer.

MINNESOTA STATUTES 1988, 148B
SOCIAL WORK AND MENTAL HEALTH

148B.01 DEFINITIONS.

Subdivision 1.**Terms.** For the purposes of this chapter, the following terms have the meanings given.

Subd. 2. **Office.** "Office" means the office of social work and mental health boards established in section 148B.02.

Subd. 3. **Board of social work.** "Board of social work" means the board of social work established in section 148B.19.

Subd. 4. **Board of marriage and family therapy.** "Board of marriage and family therapy" means the board of marriage and family therapy established in section 148B.30.

Subd. 5. **Board of unlicensed mental health service providers.** "Board of unlicensed mental health service providers" means the board of unlicensed mental health service providers established in section 148B.41.

Subd. 6. **Social work and mental health boards.** "Social work and mental health boards" or "boards" means the board of social work, the board of marriage and family therapy, and the board of unlicensed mental health service providers.

Subd. 7. **Regulated individual.** "Regulated individual means a person licensed by the board of social work or the board of marriage and family therapy, or required to file with the board of unlicensed mental health service providers.

History: 1987 c 347 art 1 s 1.

148B.02 OFFICE OF SOCIAL WORK AND MENTAL HEALTH BOARDS.

Subdivision 1.**Creation.** The office of social work and mental health boards is established to coordinate the administrative and staff functions of the boards of social work, marriage and family therapy, and unlicensed mental health service providers, and to collect and publish information as provided in this chapter. The office of social work and mental health boards consists of an executive secretary and other staff as provided in section 214.04.

Subd. 2. **Reports.** The office shall compile the report required by section 214.07 on behalf of the boards. The office shall present the information according to the category of educational credential held by the regulated individual, if any. Notwithstanding section 214.07, the office shall provide an interim report including this information to the commissioner of health on or before July 1, 1990.

History: 1987 c 347 art 1 s 2.

148B.03 APPLICABILITY.

Sections 148B.04 to 148B.17 apply to all of the social work and mental health boards and the regulated individuals within their respective jurisdictions, unless superseded by an inconsistent law that relates specifically to a particular board.

History: 1987 c 347 art 1 s 3.

148B.04 DISCLOSURE.

Subdivision 1.**Classification of data.** Subject to the exceptions listed in this subdivision, all communications or information received by or disclosed to a board relating to any person or matter subject to its regulatory jurisdiction, and all records of any action or proceedings thereon, except a final decision of the board, are confidential and privileged and any disciplinary hearing must be closed to the public.

Subd. 2. **Contested case proceedings.** Upon application of a party in a contested case proceeding before a board, the board shall produce and permit the inspection and copying, by or on behalf of the moving party, of any designated documents or papers relevant to the proceedings, in accordance with rule 34, Minnesota rules of civil procedure.

Subd. 3. **Information on adverse actions.** If a board imposes disciplinary measures or takes adverse action of any kind, the name and business address of the regulated individual, the nature of the misconduct, and the action taken by the board are public data.

Subd. 4. **Exchange of information.** The boards shall exchange information with other boards, agencies, or departments within the state, as required under section 214.10, subdivision 8, paragraph (d), and may release information in the reports required under section 148B.02.

History: 1987 c 347 art 1 s 4.

148B.05 RIGHT TO PRACTICE.

Subdivision 1.**Adverse action by a board.** A suspension, revocation, condition, limitation, qualification, or restriction of a regulated individual's license, filing, or right to practice is in effect pending determination of an appeal unless the court, upon petition and for good cause shown, orders otherwise. The right to provide services is automatically suspended if (1) a guardian of the person of a regulated individual is appointed by order of a probate court pursuant to section 525.54 to 525.612, for reasons other than the minority of the individual, or (2) the individual is committed by order of a probate court pursuant to chapter 253B or section 526.09 to 526.11. The right to provide services remains suspended until the individual is restored to capacity by a court and, upon petition by the individual, the suspension is terminated by the board after a hearing. In its discretion, a board may restore and reissue permission to provide services, but as a condition thereof may impose any disciplinary or corrective measure that it might originally have imposed.

Subd. 2. **Temporary suspension of right of practice.** In addition to any other remedy provided by law, a board may, without a hearing, temporarily suspend the right of a regulated individual to provide services if the board finds that the regulated individual has violated a statute or rule that the board is empowered to enforce and continued practice would create a serious risk of harm to the public. The suspension is effective upon written notice to the individual specifying the statute or rule violated and remains in effect until the board issues a final order in the matter after a hearing. At the time it issues the suspension notice, the board shall schedule a disciplinary hearing to be held pursuant to the administrative procedure act. The individual must be provided with at least 20 days' notice of any hearing held pursuant to this subdivision. The hearing must be scheduled to begin no later than 30 days after the suspension order is issued.

History: 1987 c 347 art 1 s 5.

148B.06 TAX CLEARANCE CERTIFICATE.

Subdivision 1.**Certificate required.** A board may not issue or renew a filing if the commissioner of revenue notifies the board and the regulated individual or applicant for a license or filing that the individual or applicant owes the state delinquent taxes in the amount of $500 or more. A board may issue or renew a license or filing only if the commissioner of revenue issues a tax clearance certificate and the commissioner of revenue or the individual or applicant forwards a copy of the clearance to the board. The commissioner of revenue may issue a clearance certificate only if the individual or applicant does not owe the state any uncontested delinquent taxes. For purposes of this section, "taxes" means all taxes payable to the commissioner of revenue, including penalties and interest due on those taxes. "Delinquent taxes" do not include a tax liability if (i) an administrative or court action that contests the amount or validity of the liability has been filed or served, (ii) the appeal period to contest the tax liability has not expired, or (iii) the regulated individual or applicant has entered into a payment agreement to pay the liability and is current with the payments.

Subd. 2. **Hearing.** In lieu of the notice and hearing requirements of section 148B.16, when a regulated individual or applicant is required to obtain a clearance certificate under this subdivision, a contested case hearing must be held if the individual or applicant requests a hearing in writing to the commissioner of revenue within 30 days of the date of the notice required in subdivision 1. The hearing must be held within 45 days of the date the commissioner of revenue refers the case to the office of administrative hearings. Notwithstanding any other law, the individual or applicant must be served with 20 days' notice in writing specifying the time and place of the hearing and the allegations against the regulated individual or applicant. The notice may be served personally or by mail.

Subd. 3. **Information required.** The boards shall require all regulated individuals or applicants to provide their social security number and Minnesota business identification number on all license or filing applications. Upon request of the commissioner of revenue, the board must provide to the commissioner of revenue a list of all regulated individuals and applicants, including the name and address, social security number, and business identification number. The commissioner of revenue may request a list of the individuals and applicants no more than once each calendar year. Notwithstanding sections 290.61 and 297A.43, the commissioner of revenue may release information necessary to accomplish the purpose of this subdivision.

History: 1987 c 347 art 1 s 6.

148B.07 REPORTING OBLIGATIONS.

Subdivision 1.**Permission to report.** A person who has knowledge of any conduct constituting grounds for discipline or adverse action relating to licensure or filing under this chapter may report the violation to the appropriate board.

Subd. 2. **Institutions.** A state agency, political subdivision, agency of a local unit of government, private agency, hospital, clinic, prepaid medical plan, or other health care institution or organization located in this state shall report to the appropriate board any action taken by the agency, institution, or organization or any of its administrators or medical or other committees to revoke, suspend, restrict, or condition a regulated individual's privilege to practice or treat patients or clients in the institution, or as part of the organization, any denial of privileges, or any other adverse action or disciplinary action for conduct that might constitute grounds for adverse action or disciplinary action by a board under this chapter. The institution or organization shall also report the resignation of any regulated individuals prior to the conclusion of any disciplinary or adverse action proceeding for conduct that might constitute grounds for disciplinary or adverse action under this chapter, or prior to the commencement of formal charges but after the individual had knowledge that formal charges were contemplated or in preparation.

Subd. 3. **Professional societies.** A state or local professional society for regulated individuals shall report to the appropriate board any termination, revocation, or suspension of membership or any other disciplinary or adverse action taken against a regulated individual. If the society has received a complaint that might be grounds for discipline under this chapter against a member on which it has not taken any disciplinary or adverse action, the society shall report the complaint and the reason why it has not taken action on it or shall direct the complainant to the appropriate board.

Subd. 4. **Regulated individuals and licensed professionals.** A regulated individual or a licensed health professional shall report to the appropriate board personal knowledge of any conduct that the regulated individual or licensed health professional reasonably believes constitutes grounds for disciplinary or adverse action under this chapter by any regulated individual, including conduct indicating that the individual may be medically incompetent, or may be medically or physically unable to engage safely in the provision of services. If the information was obtained in the course of a client relationship, the client is another regulated individual, and the treating individual successfully counsels the other individual to limit or withdraw from practice to the extent required by the impairment, the board may deem this limitation of or withdrawal from practice to be sufficient disciplinary action.

Subd. 5. **Insurers.** Four times each year as prescribed by a board, each insurer authorized to sell insurance described in section 60A.06, subdivision 1, clause (13), and providing professional liability insurance to regulated individuals, or the medical joint underwriting association under chapter 62F, shall submit to the appropriate board a report concerning the regulated individuals against whom malpractice settlements or awards have been made to the plaintiff. The report must contain at least the following information:

(1) the total number of malpractice settlements or awards made to the plaintiff;

(2) the date the malpractice settlements or awards to the plaintiff were made;

(3) the allegations contained in the claim or complaint leading to the settlements or awards made to the plaintiff;

(4) the dollar amount of each malpractice settlement or award;

(5) the regular address of the practice of the regulated individual against whom an award was made or with whom a settlement was made; and

(6) the name of the regulated individual against whom an award was made or with whom a settlement was made.

The insurance company shall, in addition to the above information, report to the board any information it possesses that tends to substantiate a charge that a regulated individual may have engaged in conduct violating this chapter.

Subd. 6. **Courts.** The court administrator of district court or any other court of competent jurisdiction shall report to the board any judgment or other determination of the court that adjudges or includes a finding that a regulated individual is mentally ill, mentally incompetent, guilty of a felony, guilty of a violation of federal or state narcotics laws or controlled substances act, or guilty of an abuse or fraud under Medicare or Medicaid; or that appoints a guardian of the regulated individual pursuant to section 525.54 to 525.61 or commits a regulated individual pursuant to chapter 253B or section 526.09 to 526.11.

Subd.7. **Self-reporting.** A regulated individual shall report to the appropriate board any personal action that would require that a report be filed with the board by any person, health care facility, business, or organization pursuant to subdivisions 2 to 6.

Subd. 8. **Deadlines; forms.** Reports required by subdivisions 2 to 7 must be submitted not later than 30 days after the occurrence of the reportable event or transaction. The boards may provide forms for the submission of reports required by this section, may require that reports be submitted on the forms provided, and may adopt rules necessary to assure prompt and accurate reporting.

Subd. 9. **Subpoenas.** The boards may issue subpoenas for the production of any reports required by subdivisions 2 to 7 or any related documents.

History: 1987 c 347 art 1 s 7.

148B.08 IMMUNITY.

Subdivision 1.**Reporting.** Any person, health care facility, business, or organization is immune from civil liability or criminal prosecution for submitting a report to a board under section 148B.07 or for otherwise reporting to the board violations or alleged violations of this chapter. All the reports are confidential and absolutely privileged communications.

Subd. 2. **Investigation.** Members of the boards of social work, marriage and family therapy, and unlicensed mental health professionals, and persons employed by the office or engaged in the investigation of violations and in the preparation and management of charges of violations of this chapter on behalf of the office or boards, are immune from civil liability and criminal prosecution for any actions, transactions, or publications in the execution of, or relating to, their duties under this chapter.

History: 1987 c 347 art 1 s 8.

148B.09 PROFESSIONAL COOPERATION.

A regulated individual who is the subject of an investigation by or on behalf of a board shall cooperate fully with the investigation. Cooperation includes responding fully and promptly to any question raised by or on behalf of the board relating to the subject of the investigation and providing copies of client records, as reasonably requested by the board, to assist the board in its investigation. The board shall pay for copies requested. If the board does not have a written consent from a client permitting access to the client's records, the regulated individual shall delete any data in the record that identifies the client before providing it to the board. The board shall maintain any records obtained pursuant to this section as investigative data pursuant to chapter 13.

History: 1987 c 347 art 1 s 9.

148B.10 DISCIPLINARY RECORD ON JUDICIAL REVIEW.

Upon judicial review of any board disciplinary or adverse action taken under this chapter, the reviewing court shall seal the administrative record, except for the board's final decision, and shall not make the administrative record available to the public.

History: 1987 c 347 art 1 s 10.

148B.11 PROFESSIONAL ACCOUNTABILITY.

Subdivision 1. **Investigation.** Each board shall maintain and keep current a file containing the reports and complaints filed against regulated individuals within the board's jurisdiction. Each complaint filed with a board pursuant to section 214.10, subdivision 1, must be investigated according to section 214.10, subdivision 2. If the files maintained by a board show that a malpractice settlement or award to the plaintiff has been made against a regulated individual as reported by insurers under section 148B.07, the executive director of the board shall notify the board and the board may authorize a review of the provider's practice.

Subd. 2. **Attorney general investigates.** When a board initiates a review of a regulated individual's practice it shall notify the attorney general who shall investigate the matter in the same manner as provided in section 214.10. If an investigation is to be made, the attorney general shall notify the regulated individual, and, if the incident being investigated occurred there, the administrator and chief of staff at the health care facilities or clinics in which the professional serves, if applicable.

Subd. 3. **Access to records.** The board shall be allowed access to records of a client treated by the regulated individual under review if the client signs a written consent permitting access. If no consent form has been signed, the hospital, clinic, or regulated individual shall first delete data in the record that identifies the client before providing it to the board.

History: 1987 c 347 art 1 s 11.

148B.12 MALPRACTICE HISTORY.

Subdivision 1.**Submission.** Regulated individuals who have previously practiced in another state shall submit with their filing or application the following information:

(1) number, date, and disposition of any malpractice settlement or award made to the plaintiff or other claimant relating to the quality of services provided by the regulated individual; and

(2) number, date, and disposition of any civil litigation or arbitrations relating to the quality of services provided by the regulated individual in which the party complaining against the individual prevailed or otherwise received a favorable decision or order.

Subd. 2. **Board action.** The board shall give due consideration to the information submitted under this section. A regulated individual who willfully submits incorrect information is subject to disciplinary action under this chapter.

History: 1987 c 347 art 1 s 12.

148B.13 PUBLICATION OF DISCIPLINARY ACTIONS.

At least annually, each board shall publish and release to the public a description of all disciplinary measures or adverse actions taken by the board. The publication must include, for each disciplinary measure or adverse action taken, the name and business address of the regulated individual, the nature of the misconduct, and the measure or action taken by the board.

History: 1987 c 347 art 1 s 13.

148B.14 EVIDENCE OF PAST SEXUAL CONDUCT.

In a proceeding for the suspension or revocation of the right to practice or other disciplinary or adverse action involving sexual contact with a client or former client, the board or administrative law judge shall not consider evidence of the client's previous sexual conduct nor shall any reference to this conduct be made during the proceedings or in the findings, except by motion of the complainant, unless the evidence would be admissible under the applicable provisions of section 609.347, subdivision 3.

History: 1987 c 347 art 1 s 14.

148B.15 DISPUTE RESOLUTION.

Subdivision 1.**Arbitration.** Each board shall encourage regulated individuals to submit all fee disputes to binding arbitration.

Subd. 2. **Mediation.** Each board shall encourage regulated individuals to submit all disputes that are not related to violations of a code of professional conduct to voluntary mediation.

History: 1987 c 347 art 1 s 15.

148B.16 CONTESTED CASES.

Chapters 14 and 214 apply to any disciplinary proceedings or adverse action relating to filing taken under this chapter.

History: 1987 c 347 art 1 s 16.

148B.17 FEES.

Each board shall by rule establish fees, including late fees, for licenses or filings and renewals so that the total fees collected by the board will as closely as possible equal anticipated expenditures during the fiscal biennium, as provided in section 16A.128, plus the prorated costs of the office of social work and mental health boards. Fees must be credited to the special revenue fund.

History: 1987 c 347 art 1 s 17.

148B.171 EMERGENCY RULES.

The office or boards may adopt emergency rules under sections 14.29 to 14.385 to carry out the provisions of the chapter. Notwithstanding contrary provisions of chapter 14, the authority to use sections 14.29 to 14.385 expires on December 31, 1988.

History: 1987 c 347 art 1 s 23.

BOARD OF UNLICENSED MENTAL HEALTH SERVICE PROVIDERS

148B.40 DEFINITIONS.

Subdivision 1.**Terms.** As used in sections 148B.40 to 148B.47, the following terms have the meanings given them in this section.

Subd. 2. **Board.** "Board" means the board of mental health service providers as established in section 148B.41.

Subd. 3. **Mental health service provider.** "Mental health service provider" or "provider" means any person who provides, for a remuneration, mental health services as defined in subdivision 4. It does not include persons licensed by the board of medical examiners under chapter 147; the board of nursing under section 148.171 to 148.285; or the board of psychology under section 148.88 to 148.98; the board of social work under sections 148B.18 to 148B.28; the board of marriage and family therapy under section 148B.29 to 148B.39; or another licensing board if the person is practicing within the scope of the license.

Subd. 4. **Mental health services.** "Mental health services" means the professional treatment, assessment, or counseling of another person for a cognitive, behavioral, emotional, mental, or social dysfunction, including intrapersonal or interpersonal dysfunctions.

Subd. 5. **Mental health client.** "Mental health client" or "client" means a person who receives the services of a mental health service provider.

History: 1987 c 347 art 4 s 1.

NOTE: This section, as added by Laws 1987, chapter 347, article 4, section 1, is repealed effective July 1, 1991. See Laws 1987, chapter 347, article 4, section 11.

148B.41 BOARD OF UNLICENSED MENTAL HEALTH SERVICE PROVIDERS.

Subdivision 1.**Composition.** The board of unlicensed mental health service providers consists of 17 members, including two chemical dependency counselors, two professional counselors, two pastoral counselors, five members representing other identifiable specialities and subgroups of providers subject to filing requirements, and six public members as defined in section 214.02. Within 90 days after the effective date of rules adopted by the board to implement sections 148B.40 to 148B.47, members of the board specified must be mental health service providers who have filed with the board pursuant to section 148B.42.

Subd. 2. **Appointment.** Members of the board are appointed by the governor and serve under section 214.09.

Subd. 3. **Board administration.** The board shall elect from among its members a chair and a vice-chair to serve for one year or until a successor is elected and qualifies. The members of the board have authority to administer oaths and the board, in session, to take testimony as to matters pertaining to the duties of the board. Six members of the board constitute a quorum for the transaction of business.

Subd. 4. **Rulemaking.** The board shall adopt rules necessary to implement, administer, or enforce section 148B.40 to 148B.47 under chapter 14 and section 214.001, subdivisions 2 and 3. The board shall consult with the commissioner of health, the commissioner of human services, and the commissioner of employee relations in the development of rules. The board may not adopt rules that restrict or prohibit persons from providing mental health services on the basis of education, training, experience, or supervision, or that restrict the use of any title.

History: 1987 c 347 art 4 s 2.

NOTE: This section, as added by Laws 1987, chapter 347, article 4, section 2, is repealed effective July 1, 1991. See Laws 1987, chapter 347, article 4, section 11.

148B.42 FILING REQUIRED.

Subdivision 1.**Filing.** All mental health service providers shall file with the state, on a form provided by the board, their name; home and business address; telephone number, degrees held, if any, major field, and whether the degrees are from an accredited institution and how the institution is accredited; and any other relevant experience. An applicant for filing who has practiced in another state shall authorize, in writing, the licensing or regulatory entity in the other state or states to release to the board any information on complaints or disciplinary actions pending against that individual, as well as any final disciplinary actions taken against that individual. The board shall provide a form for this purpose. The board may reject a filing if there is evidence of a violation of or failure to comply with this chapter. Filings under this subdivision are public data.

Subd. 2. **Acknowledgment of filing.** The board shall issue an acknowledgment of filing to each mental health service provider who files under subdivision 1 and relevant rules of the board, and who is determined by the board to be in compliance with this chapter. The acknowledgment of filing must not be displayed in any manner nor shall it be shown to mental health clients. The acknowledgment of filing shall contain, in bold print, the phrase: "This acknowledgment of filing does not imply or certify in any way that this mental health professional has met any standards or criteria of education or training."

Subd. 3. **Nontransferability.** Acknowledgments of filing are nontransferable.

Subd. 4. **Penalties.** Failure to file with the board, or supplying false or misleading information on the filing form, application for registration, or any accompanying statements shall constitute grounds for adverse action.

Subd. 5. **Provision of mental health services without filing.** Except as otherwise provided in this chapter, it is unlawful for any person not filing with the board to provide mental health services in this state as defined in section 148B.40, subdivision 4. Any person violating subdivision 1 is guilty of a gross misdemeanor.

History: 1987 c 347 art 4 s 3; 1988 c 689 art 2 s 49.

NOTE: This section, as added by Laws 1987, chapter 347, article 4, section 3, is repealed effective July 1, 1991. See Laws 1987, chapter 347, article 4, section 11.

148B.43 PROHIBITED USE OF ACKNOWLEDGMENT.

No mental health service provider may display the acknowledgment received under section 148B.42, subdivision 2, or refer to it in any advertising, on stationary, or in any communication to a client or the public, or otherwise use the fact that the provider has filed with the state as an indication of state approval or endorsement or satisfaction of standards of conduct, training, or skill.

History: 1987 c 347 art 4 s 4.

NOTE: This section, as added by Laws 1987, chapter 347, article 4, section 4, is repealed effective July 1, 1991. See Laws 1987, chapter 347, article 4, section 11.

148B.44 PROHIBITED CONDUCT.

Subdivision 1. **Prohibited conduct.** Notwithstanding any law to the contrary, the board may reject a filing or application, or may impose adverse action as described in section 148B.45 against any mental health service provider for failure to comply with the provisions of this chapter. The following conduct is prohibited and is grounds for adverse action:

(a) Conviction of a crime reasonably related to the provision of mental health services. Conviction, as used in this subdivision, includes a conviction of an offense which, if committed in this state, would be deemed a felony without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilty is made or returned but the adjudication of guilt is either withheld or not entered.

(b) Conviction of crimes against persons. For the purposes of this chapter, a crime against a person means violations of the following sections: sections 609.185; 609.19; 609.195; 609.20; 609.205; 609.21; 609.215; 609.221; 609.222; 609.223; 609.224; 609.23; 609.231; 609.235; 609.24; 609.245; 609.25; 609.255; 609.265; 609.26, subdivision 1, clause (1) or (2); 609.342; 609.343; 609.344; 609.345; 609.365; 609.498, subdivision 1; 609.50, clause (1); 609.561; 609.562; and 609.595.

(c) Revocation, suspension, restriction, limitation, or other disciplinary action against the mental health professional's license, certificate, registration, or right of practice in another state or jurisdiction, for offenses that would be subject to disciplinary action in this state, or failure to report to the board that charges regarding the person's license, certificate, registration, or right of practice have been brought in another state or jurisdiction.

(d) Advertising that is false or misleading.

(e) Filing with the board false or misleading statements of credentials, training, or experience.

(f) Conduct likely to deceive, defraud, or harm the public; or demonstrating a willful or careless disregard for the health, welfare, or safety of a client; or any other practice that may create unnecessary danger to any client's life, health, or safety, in any of which cases, proof of actual injury need not be established.

(g) Adjudication as mentally incompetent, or as a person who has a psychopathic personality as defined in section 526.09, or who is dangerous to self, or adjudication pursuant to chapter 253B, as chemically dependent, mentally ill, mentally retarded, or mentally ill and dangerous to the public.

(h) Inability to provide mental health services with reasonable safety to clients by reason of physical, mental, or emotional illness; drunkenness; or use of legend drugs, chemicals, controlled substances, or any other similar materials or mood-altering substances.

(i) Revealing a communication from, or relating to, a client except when otherwise required or permitted by law.

(j) Failure to comply with a client's request made under section 144.335, or to furnish a client record or report required by law.

(k) Splitting fees or promising to pay a portion of a fee to any other professional other than for services rendered by the other professional to the client.

(l) Engaging in abusive or fraudulent billing practices, including violations of the federal Medicare and Medicaid laws or state medical assistance laws.

(m) Engaging in sexual contact with a client or former client as defined in section 148A.01.

(n) Failure to make reports as required by section 148B.44, or cooperate with an investigation of the board as required by section 148B.46.

(o) Obtaining money, property, or services from a client, other than reasonable fees for services provided to the client, through the use of undue influence, harassment, duress, deception, or fraud.

(p) Undertaking or continuing a professional relationship with a client in which the objectivity of the professional would be impaired.

(q) Failure to provide the client with a copy of the client bill of rights or violation of any provision of the client bill of rights.

Subd. 2. **Evidence.** In adverse actions alleging a violation of subdivision 1, paragraph (a), (b), or (c), a copy of the judgment or proceeding under the seal of the court administrator or of the administrative agency that entered the same shall be admissible into evidence without further authentication and shall constitute prima facie evidence of its contents.

Subd. 3. **Mental examination; access to medical data.** (a) If the board has probable cause to believe that a mental health service provider comes under subdivision 1, paragraph (g) or (h), it may direct the provider to submit to a mental or physical examination or chemical dependency evaluation. For the purpose of this subdivision every mental health service provider is deemed to have consented to submit to a mental or physical examination or chemical dependency evaluation when directed in writing by the board and further to have waived all objections to the admissibility of the examining physicians', psychologists', or mental health professional's testimony or examination reports on the ground that the same constitute a privileged communication. Failure of a mental health service provider to submit to an examination when directed constitutes an admission of the allegations against the provider, unless the failure was due to circumstance beyond the provider's control, in which case a default and final order may be entered without the taking of testimony or presentation of evidence. A mental health service provider affected under this paragraph shall at reasonable intervals be given an opportunity to demonstrate that the provider can resume the provision of mental health services with reasonable safety to clients. In any proceeding under this paragraph, neither the record of proceedings nor the orders entered by the board shall be used against a mental health service provider in any other proceeding.

(b) In addition to ordering a physical or mental examination, the board may, notwithstanding section 13.42, 144.651, or any other law limiting access to medical or other health data, obtain medical data and health records relating to a mental health service provider without the provider's consent if the board has probable cause to believe that a provider comes under subdivision 1, paragraph (g), (h), or (m). The medical data may be requested from a health care professional, as defined in section 144.335, subdivision 1, paragraph (b), an insurance company, or a government agency, including the department of human services. A health care professional, insurance company, or government agency shall comply with any written request of the board under this subdivision and is not liable in any action for damages for releasing the data requested by the board if the data are released pursuant to a written request under this subdivision, unless the information is false and the person or organization giving the information knew, or had reason to believe, the information was false. Information obtained under this subdivision is private data under sections 13.01 to 13.87.

History: 1986 c 444; 1987 c 347 art 4 s 5.

NOTE: This section, as added by Laws 1987, chapter 347, article 4, section 5, is repealed effective July 1, 1991. See Laws 1987, chapter 347, article 4, section 11.

148B.45 ADVERSE ACTIONS.

Subdivision 1. **Forms of adverse action.** When the board finds that a mental health service provider has violated a provision or provisions of this chapter, it may do one or more of the following:

(1) deny or reject the filing;

(2) revoke the right to practice;

(3) suspend the right to practice;

(4) impose limitations or conditions on the provider's provision of mental health services, the imposition of rehabilitation requirements, or the requirement of practice under supervision;

(5) impose a civil penalty not exceeding $10,000 or each separate violation, the amount of the civil penalty to be fixed so as to deprive the provider of any economic advantage gained by reason of the violation charged or to reimburse the board for all costs of the investigation and proceeding;

(6) order the provider to provide unremunerated professional service under supervision at a designated public hospital, clinic, or other health care institution; or

(7) censure or reprimand the provider.

Subd. 2. **Procedures.** The board shall adopt a written statement of internal operating procedures for receiving and investigating complaints reviewing misconduct cases and imposing adverse actions.

Subd. 3. **Mandatory suspension or revocation of right of practice.** The board shall suspend or revoke the right of a provider to provide mental health services for violations of section 148B.43, subdivision 1, paragraphs (a), (b), and (m).

History: 1987 c 347 art 4 s 6.

NOTE: This section, as added by Laws 1987, chapter 347, article 4, section 6, is repealed effective July 1, 1991. See Laws 1987, chapter 347, article 4, section 11.

148B.46 MENTAL HEALTH CLIENT BILL OF RIGHTS.

Subdivision 1. **Scope.** All mental health service providers other than those providing services in a facility regulated under section 144.651 shall provide to each client prior to providing treatment a written copy of the mental health client bill of rights. A copy must also be posted in a prominent location in the office of the mental health service provider. Reasonable accommodations shall be made for those clients who cannot read or who have communication impairments and those who do not read or speak English. The mental health client bill of rights shall include the following:

(a) The name, title, business address, and telephone number of the provider.

(b) The degrees, training, experience, or other qualifications of the provider, followed by the following statement in bold print:

THE STATE OF MINNESOTA HAS NOT ADOPTED UNIFORM EDUCATIONAL AND TRAINING STANDARDS FOR MENTAL HEALTH SERVICE PROVIDERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATIONAL PURPOSES ONLY.

(c) The name, business address, and telephone number of the provider's supervisor, if any.

(d) Notice that a client has the right to file a complaint with the provider's supervisor, if any, and the procedure for filing complaints.

(e) The name, address, and telephone number of the board and notice that a client may file complaints with the board.

(f) The provider's fees per unit of service, the provider's method of billing for such fees, the names of any insurance companies that have agreed to reimburse the provider, or health maintenance organizations with whom the provider contracts to provide service, whether the provider accepts Medicare, medical assistance, or general assistance medical care, and whether the provider is willing to accept partial payment, or to waive payment, and in what circumstances.

(g) A statement that the client has a right to reasonable notice of changes in services or charges.

(h) A brief summary, in plain language, of the theoretical approach used by the provider in treating patients.

(i) Notice that the client has a right to complete and current information concerning the provider's assessment and recommended course of treatment, including the expected duration of treatment.

(j) A statement that clients may expect courteous treatment and to be free from verbal, physical, or sexual abuse by the provider.

(k) A statement that client records and transactions with the provider are confidential, unless release of these records is authorized in writing by the client, or otherwise provided by law.

(l) A statement of the client's right to be allowed access to records and written information from records in accordance with section 144.335.

(m) A statement that other services may be available in the community, including where information concerning services is available.

(n) A statement that the client has the right to choose freely among available providers, and to change providers after services have begun, within the limits of health insurance, medical assistance, or other health programs.

(o) A statement that the client has a right to coordinated transfer when there will be a change in the provider of services.

(p) A statement that the client may refuse services or treatment, unless otherwise provided by law.

(q) A statement that the client may assert the client's rights without retaliation.

Subd. 2. **Acknowledgment by client.** Prior to the provision of any service, the client must sign a written statement attesting that the client has received the client bill of rights.

History: 1987 c 347 art 4 s 7.

NOTE: This section, as added by Laws 1987, chapter 347, article 4, section 7, is repealed effective July 1, 1991. See Laws 1987, chapter 347, article 4, section 11.

148B.47 RENEWALS.

Notwithstanding any other law, the board shall adopt rules providing for the renewal of filings. The rules shall specify the period of time for which a filing is valid, procedures and information required for the renewal, and renewal fees.

History: 1987 c 347 art 4 s 8.

NOTE: This section, as added by Laws 1987, chapter 347, article 4, section 8, is repealed effective July 1, 1991. See Laws 1987, chapter 347, article 4, section 11.

148B.48 REPORTS.

Subdivision 1. **Commissioner of health.** The commissioner of health shall review the report of the office under sections 214.001, 214.13, and 214.141. The commissioner shall make recommendations to the legislature by January 15, 1991, on the need for registration or licensure of unlicensed mental health service providers and the need to retain the board of unlicensed mental health service providers.

Subd. 2. **Board of unlicensed mental health service providers.** The board of unlicensed mental health service providers must report on the board's findings and activities to the commissioner of health and the legislature by July 1, 1990. The board shall report to the legislature on or before January 15, 1991, with recommendations on whether providers who are not trained should be allowed to continue to practice.

Subd. 3. **Legislative intent.** Nothing in this section is intended to require the commissioner of health to delay review of applications for credentialing pursuant to sections 214.13 and 214.141 pending the outcome of the reports required under this section.

History: 1987 c 347 art 4 s 9.

Administrative Policies, Procedures and Forms on Sexual Exploitation

MINNESOTA DEPARTMENT OF CORRECTIONS
Management Memo
Volume 11 - Number 3
July 1, 1987

SUBJECT: Sexual Exploitation of Clients

INTRODUCTION

Per Minnesota Statutes Chapter 148A, the Minnesota Department of Corrections as an employer may have civil liability after August 1, 1986, if it does not take reasonable action when it knows or has reason to know that a psychotherapist has engaged in or requested sexual contact with a client or former client (client within the past two years). The department may also be liable if it fails to make inquiries of those who employed the psychotherapist within the last five years concerning request for or occurrences of sexual contact between the psychotherapist and his or her clients or former clients.

POLICY

Legal Definitions: "Psychotherapy" is defined as "the professional treatment, assessment, or counseling of a mental or emotional illness, symptom, or condition." Minn. Stat. Sec. 148A.01, Subd. 6.

"Psychotherapist" is defined as "a physician, psychologist, nurse, chemical dependency counselor, social worker, member of the clergy, or other person, whether or not licensed by the state, who performs or purports to perform psychotherapy." Minn. Stat. Sec. 148A.01, Subd. 5.

1. Prohibition of Sexual Contact with Clients:

   a. Resident clients -- No employee of the department shall make a request for or engage in "sexual contact" (as defined in Minn. Stat. Sec. 148A.01, Subd. 7) with any resident of any state correctional facility or Anishinabe Longhouse.

   b. Other clients under the supervision of the commissioner -- Any employee of the department who has direct contact with any client who is under the supervision of the commissioner of corrections or who has any form of power or authority over such a client by virtue of his/her employment with the department shall not make a request for or engage in "sexual contact" with that client.

   c. Former clients -- Any employee of the department who is a "psychotherapist" or who engages in "psychotherapy" (as defined in Minn. Stat. Sec. 148A.01) with anyone under the supervision of the commissioner of corrections shall not make a request for or engage in "sexual contact" or "sexual penetration" with any such client for a minimum of two years following final termination of the psychotherapy relationship. Persons performing psychotherapy should be aware that criminal liability for "sexual contact" and "sexual penetration" with former clients may extend indefinitely in some cases (Minn. Stat. Sec. 609.344 and 609.345).

2. Background Check: No psychotherapist shall be employed by the department to perform psychotherapy without prior investigation to determine if the individual had or proposed sexual contact with clients or former clients within the past five years. Minn. Stat. Sec. 148A.03.

3. Duty to Report: During the tenure of the psychotherapist if the supervisor or any other employee has reason to believe sexual exploitation (including requests for sexual contact, sexual contact, or penetration) is taking place, it is the responsibility of that employee to report such suspicion promptly to the supervisor or the appointing authority. Upon receipt of such report the unit's established complaint procedure shall be put into effect immediately.

4. Contractors and Grantees: All individuals or agencies who provide contracted services to clients who are under the supervision of the commissioner of corrections or who receive grants that are administered by the department must have policies and procedures in effect which are in compliance with the intent of this department policy and which have been approved by the department. The contract/grant authorized agent is responsible for monitoring compliance.

5. Volunteers and Interns: All department policies regarding sexual exploitation of clients by staff also pertain to volunteers and interns who work with clients who are under the supervision of the commissioner of corrections.

6. Violations: Violations of this policy may result in termination of employment or other forms of disciplinary action.

7. Who May Practice Psychotherapy: No employee in the Minnesota Department of Corrections will perform or practice psychotherapy without the written permission of the appointing authority. It has been determined that all employees of the department with the following job titles perform psychotherapy as all or part of their employment with the department: Psychologists, corrections behavior therapists, chaplains, and chemical dependency counselors. Within the department's institutional therapeutic treatment programs, institution heads will consult with program directors and then specify in writing which, if any, staff members of these programs are authorized to practice psychotherapy. The following programs fall into this category: Chemical dependency treatment, sex offender treatment, parenting programs, and the mental health unit. Appointing authorities will also specify in writing if any employees in the following categories or in any other job category are authorized to perform psychotherapy: Nurses, physicians, security caseworkers, and corrections agents. Only those employees authorized by the appointing authority to perform psychotherapy may do so. Anyone who is authorized to practice psychotherapy must be formally trained in one of the psychotherapy disciplines or be directly supervised by a professional who is so trained.

PROCEDURES

Detailed instructions regarding implementation of this policy are available from the appropriate institution or central office personnel section.

In the hiring process:

1. Prior to making a job offer to any person to be considered for employment in the above categories, the applicant must authorize, in writing, the appropriate institution or central office personnel section to contact all former employers for work which involved the practice of psychotherapy in the past five years. These former employers will be contacted for information regarding occurrences of or requests for sexual contact between the applicant and clients or former clients during the time of employment.

2. The appropriate institution or central office personnel section will contact all former employers of the applicant within the required five-year period requesting the above-mentioned information.

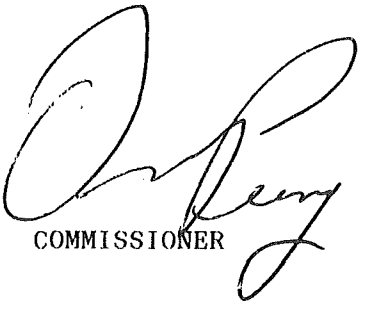
3. Upon receipt of approvable responses (see detailed instructions), the candidate may be appointed.

ADDITIONAL INFORMATION

Questions regarding this policy should be referred to the personnel director in central office at (612) 642-0227.

EFFECTIVE DATE

This policy is effective August 1, 1986, for all appointments in the categories described above.



COMMISSIONER

MINNESOTA DEPARTMENT OF CORRECTIONS

FORMS PACKET FOR

POSITIONS INVOLVING PROVISION OF PSYCHOTHERAPY

Return within five working days to:

Appendix B-1

MINNESOTA DEPARTMENT OF CORRECTIONS
Information Request
Psychotherapist Professional Credentials & Disciplinary Actions

Applicant: Please provide all of the information requested below.

1. Have you ever been licensed or certified in any discipline that provides counseling or psychotherapy? _____ Yes _____ No

2. Type (e.g., Licensed Psychologist, ACSW) _____

_____

State where held: _____

Expiration date: _____

Areas of competency or professional practice for which licensed/ certified: _____

_____

_____ Check if you hold more than one license or certification and list on the back of this page.

3. Has disciplinary action of any sort ever been taken against you by a licensing board, professional association, or educational/ training institution? _____ Yes _____ No

4. Are there complaints pending against you before any of the above-named bodies? _____ Yes _____ No

5. Have you ever had a civil suit brought against you relative to your professional work or is any such action pending? _____ Yes _____ No

NOTE: IF YOU HAVE ANSWERED "YES" TO 3, 4 OR 5, PLEASE ATTACH A WRITTEN EXPLANATION.

CR-00527-01b (7/87)

Appendix B-1

MINNESOTA DEPARTMENT OF CORRECTIONS
Advisory to Applicants

In order to comply with Minnesota Statutes Chapter 148A, employers must make inquiries of employers and former employers of "psychotherapists" concerning requests for and occurrences of "sexual contact" by psychotherapists with their "patients" or "former patients." (All terms in quotation marks on this page are defined on reverse side.)

A patient or former patient may bring legal action against a psychotherapist if sexual contact occurred during the period the patient was receiving psychotherapy from the psychotherapist or after the patient received psychotherapy if the former patient was "emotionally dependent" on the psychotherapist or if the sexual contact or request for sexual contact occurred by means of "therapeutic deception."

As of August 1, 1986, employers may be liable under the statute if they fail to make inquiries of former employers regarding requests for or occurrences of sexual contact and/or if they fail to respond to such inquiries. They are also liable if they fail to take timely and appropriate action when they know or had reason to know that an employee was engaging in or requesting sexual contact with a patient or former patient.

In order to avoid civil liability under Minnesota Statutes Chapter 148A, the Minnesota Department of Corrections will make inquiries of employers who have employed applicants as psychotherapists or as trainees of a professional program in psychotherapy within the past five years. It will also make inquiries of professional licensing or certification authorities.

APPLICANT: I have read and understand the above advisory and will provide the Minnesota Department of Corrections and/or its agents and/or representatives with the names, addresses, and telephone numbers of employers for whom I have worked in the past five years as a psychotherapist, as defined in Minnesota Statutes Chapter 148A. I further understand that failure to sign this advisory and provide the required information about previous employers will result in my name being removed from consideration for employment with the Minnesota Department of Corrections as a psychotherapist or in any position which involves the providing of psychotherapy as defined in Minnesota Statutes Chapter 148A.

Signature of Applicant	Date	Social Security Number*

* Your social security number is requested to distinguish you from all other applicants, and you are not legally obliged to provide it. If you furnish your social security number, it will be sent to your former employer(s) as the Minnesota Department of Corrections acts in compliance with Minnesota Statutes Chapter 148A.

DEFINITIONS

Minnesota Statutes Section 148A.01, Subd. 5 defines "psychotherapist" as "a physician, psychologist, nurse, chemical dependency counselor, social worker, member of the clergy, or other person ... who performs or purports to perform ... treatment, assessment, or counseling of a mental or emotional illness, symptoms, or condition." In short, a very broad range of people and activities are included. Any past work of a human services nature is of interest.

From the Civil Code -- Minnesota Statutes Section 148A.01:

Subd. 3. "Former patient" means a person who was given psychotherapy within two years prior to sexual contact with the psychotherapist.

Subd. 7. "Sexual contact" means any of the following, whether or not occurring with the consent of a patient or former patient:

(1) sexual intercourse, cunnilingus, fellatio, anal intercourse or any intrusion, however slight, into the genital or anal openings of the patient's or former patient's body by any part of the psychotherapist's body or by any object used by the psychotherapist for this purpose, or any intrusion, however slight, into the genital or anal openings of the psychotherapist's body by any part of the patient's or former patient's body or by any object used by the patient or former patient for this purpose, if agreed to by the psychotherapist;

(2) kissing of, or the intentional touching by the psychotherapist of the patient's or former patient's genital area, groin, inner thigh, buttocks, or breast or of the clothing covering any of these body parts;

(3) kissing of, or the intentional touching by the patient or former patient of the psychotherapist's genital area, groin, inner thigh, buttocks, or breast or of the clothing covering any of these body parts if the psychotherapist agrees to the kissing or intentional touching.

"Sexual contact" includes requests by the psychotherapist for conduct described in clauses (1) to (3).

"Sexual contact." does not include conduct described in clause (1) or (2) that is a part of standard medical treatment of a patient.

From Both the Civil and Criminal Codes
Civil: Minnesota Statutes Section 148A.01, Subd. 2, 4, 5, 6 and 8
Criminal: Minnesota Statutes Section 609.341, Subd. 16, 17, 18, 19 and 20

"Emotionally dependent" means that the nature of the patient's or former patient's emotional condition and the nature of the treatment provided by the psychotherapist are such that the psychotherapist knows or has reason to believe that the patient or former patient is unable to withhold consent to sexual contact by the psychotherapist.

"Patient" means a person who seeks or obtains psychotherapy.

"Psychotherapist" means a physician, psychologist, nurse, chemical dependency counselor, social worker, member of the clergy, or other person, whether or not licensed by the state, who performs or purports to perform psychotherapy.

"Psychotherapy" means the professional treatment, assessment, or counseling of a mental or emotional illness, symptom, or condition.

"Therapeutic deception" means a representation by a psychotherapist that sexual contact with the psychotherapist is consistent with or part of the patient's or former patient's treatment.

Appendix B-1

MINNESOTA DEPARTMENT OF CORRECTIONS
Former Employers Information Request

Please provide the information requested below on employers who employed you as a physician, psychologist, psychiatrist, nurse, chemical dependency counselor, social worker, member of the clergy, or in some other capacity in which you performed psychotherapy (as defined in Minnesota Statutes Chapter 148A) or any form of counseling during the past five years.

Employer's Name: _____

Address: _____

Phone Number: _____

Supervisor's Name: _____

Your Title: _____

Dates of Employment: From _____ to _____

==========

Employer's Name: _____

Address: _____

Phone Number: _____

Supervisor's Name: _____

Your Title: _____

Dates of Employment: From _____ to _____

==========

Employer's Name: _____

Address: _____

Phone Number: _____

Supervisor's Name: _____

Your Title: _____

Dates of Employment: From _____ to _____

Appendix B-1

Employer's Name: _____

Address: _____

Phone Number: _____

Supervisor's Name: _____

Your Title: _____

Dates of Employment: From _____ to _____

==========

Employer's Name: _____

Address: _____

Phone Number: _____

Supervisor's Name: _____

Your Title: _____

Dates of Employment: From _____ to _____

==========

Employer's Name: _____

Address: _____

Phone Number: _____

Supervisor's Name: _____

Your Title: _____

Dates of Employment: From _____ to _____

IF THERE ARE ADDITIONAL EMPLOYERS, PLEASE LIST THEM ON AN ATTACHMENT.

Appendix B-1

MINNESOTA DEPARTMENT OF CORRECTIONS
Authorization to Release Information

To be completed by applicant. A separate and originally signed form for each former employer listed on CR-00527 01d must be provided.

To: _____
(former employer)

I, _____, hereby authorize and grant my informed consent to permit you to release and make available to the State of Minnesota and/or its agents and/or representatives data classified as private or confidential which concerns me and which may be in your possession. The data which I authorize to be released concerns the relationship between ""psychotherapists" and "patients" and/or "former patients" as defined by Minnesota Statutes Chapter 148A. I understand that the purpose of permitting the State of Minnesota and/or its agents and/or representatives to have access to this information is to comply with Minnesota Statutes Chapter 148A and to determine my suitability for employment. I further understand that this information may subsequently be used for other purposes relating to my possible employment including, but not limited to, verification of my records and analysis by consultants who may review my suitability for employment.

This authorization shall be valid for a period of one year, but I reserve the right to at any time prior to that expiration cancel the written authorization by providing written notice to the State of Minnesota or to you of that fact.

_____ _____
Applicant's Signature Date

_____ _____
Printed Full Name Social Security Number*

_____
Telephone Number**

* Your social security number is requested to distinguish you from all other applicants, and you are not legally obliged to provide it. If you furnish your social security number, it will be sent to your former employer(s) as the Minnesota Department of Corrections acts in compliance with Minnesota Statutes Chapter 148A.

** Your telephone number is requested in order to provide former employers a way to contact you regarding this release of information form. You are not legally obligated to provide your telephone number.

CR-00527-01e (7/87)

MINNESOTA DEPARTMENT OF CORRECTIONS
Personnel Office

DETAILED INSTRUCTIONS: Implementation of Policy on Sexual Exploitation of Clients
(Supplement to Management Memo
Volume 11, Number 3 - July 1, 1987)

INTRODUCTION

Effective August 1, 1986, Minnesota Statutes Chapter 148A established three conditions under which employers may be held liable for damages to clients who are sexually exploited by counselors and therapists in their employ. First, if an employer knows or has reason to know that a psychotherapist has engaged in or requested sexual contact with a client or former client but does not take appropriate and timely action, that employer is vulnerable to a civil suit. Second, the law requires employers to check the history of applicants for jobs that involve performing psychotherapy by asking former employers about requests for or occurrences of sexual contact between the psychotherapist and clients or former clients. Third, when an employer is asked for this information about former employees the information must be given. Passage of this law was recommended to the legislature by the department's task force on sexual exploitation by counselors and therapists. In addition to the employer liability mentioned above, any individual who performs psychotherapy who sexually exploits clients is subject to civil lawsuits and/or may be charged with a felony. Minn. Stat. Sec. 609.344 and 609.345.

Because the practice of psychotherapy is not regulated by the state, the definition of a psychotherapist in the criminal and civil codes is intentionally vague so that practitioners cannot avoid liability by simply changing job titles. Consequently, some categories of department employees clearly fall within these legal definitions while others are subject to interpretation. In some cases, it is more appropriate to review an employee's activities which might constitute psychotherapy.

Due to the nature of correctional settings the potential exists for sexual exploitation of clients by staff both within and outside the context of psychotherapy. Correctional clients often have a history of exploiting others and may take advantage of department employees if given the opportunity. Regardless of the circumstances, it is the employee's responsibility to adhere to the policies of the department. The policies outlined below are intended to ensure compliance with Minnesota statutes and also include general department policies related to sexual exploitation of clients by staff.

Definitions from the criminal and civil statutes that are referred to in the following are attached (Attachment A).

(over)

1. Reporting Requirement

All employees of the department are required to report any personal knowledge of conduct by another department employee which is in violation of the provisions outlined in Management Memo Volume 11, Number 3. This report shall be made to the employee's supervisor or the appointing authority, who is responsible for reporting the suspected exploitation to any relevant authorities outside of the department. These may include reports under the Vulnerable Adults Act, child abuse laws, violations of professional licensure or institutional licensure, or criminal complaints. Internally, the existing methods of processing client complaints will be followed.

2. Authorization to Practice Psychotherapy

It has been determined that all employees of the department with the following job titles perform psychotherapy as all or part of their employment with the department: Psychologists, corrections behavior therapists, chaplains, and chemical dependency counselors. Within the department's institutional therapeutic treatment programs, institution heads will consult with program directors and then specify in writing which, if any, staff members of these programs are authorized to practice psychotherapy. The following programs fall into this category: Chemical dependency treatment, sex offender treatment, parenting programs, and the mental health unit. Appointing authorities will also specify in writing if any employees in the following categories or in any other job category are authorized to perform psychotherapy: Nurses, physicians, security caseworkers, and corrections agents. Only those employees authorized to perform psychotherapy by the appointing authority may do so. Anyone who is authorized to practice psychotherapy must be formally trained in one of the psychotherapy disciplines or be directly supervised by a professional who is so trained.

PROCEDURES

1. Hiring of Psychotherapists

a. Background check

1) All individuals who are considered for employment on or after August 1, 1986, who will perform psychotherapy as all or part of their duties, must be provided forms packet CR-00527-01 (a-e) by the appointing authority which must be completed and received in the appropriate institution or central office personnel section before the individual is hired for employment. The appointing authority may give applicants this packet of forms at any stage in the hiring process, with the understanding that all of the steps in 2) through 7) below must be completed before any applicant is hired. It may be advisable for any applicant who is being seriously considered for hiring to receive this packet early in the process. This will allow an applicant the opportunity to withdraw if he or she chooses and it may hasten the process.

2) From the time an applicant is provided the forms packet he or she must submit the completed forms to the appropriate institution or central office personnel section within five working days.

3) Upon receipt of the applicant's completed forms packet CR-00527-01 (a-e), the appropriate institution or central office personnel section has three working days to mail out form CR-00528-01 (Information Request) and form CR-00527-01e (Authorization to Release Information) to former employers who employed the applicant in work that involved any psychotherapy during the past five years. Such requests must be sent as certified mail, with return receipt requested.

4) The appropriate institution or central office personnel section is responsible for follow-up necessary to secure information from past employers. Employers outside of Minnesota are bound by the laws of their own states and may not be able to give out the requested information. Unsuccessful attempts to obtain information including prohibited release of information from other states will be documented in writing.

5) The appropriate institution or central office personnel section shall verify in writing the candidate's license status, including record of any disciplinary action taken, with the licensing authority in the event the candidate is licensed by a licensing or other regulatory board.

6) The appropriate institution or central office personnel section is responsible for completing a criminal history check on candidates to determine whether a candidate has been convicted of criminal sexual conduct (Minn. Stat. Sec. 609.342 - 609.345) or corresponding laws of other states.

7) Within 15 working days of mailing the requests for information to former employers, the appropriate institution or central office personnel section will report by phone to the appointing authority the results of these requests.

b. Results of background check

1) If any of the circumstances specified in a) through f) below are reported in writing by a former employer to be substantiated as true and as having occurred within the past five years, the candidate shall not be hired by the appointing authority. If the appointing authority believes that there are extenuating circumstances, an appeal may be made to the department's personnel director in central office.

(over)

a) The candidate has been convicted of criminal sexual conduct in violation of Minn. Stat. Sec. 609.342 - 609.345 or corresponding laws of other states.

b) The candidate has had a successful judgment entered against him or her in a civil lawsuit under Minnesota Statutes Chapter 148A or under related case law or similar laws in other states.

c) Disciplinary action related to sexual conduct with a client has been taken against the candidate by a licensing or other regulatory board in any state.

d) The candidate has been censured by a relevant professional organization for sexual conduct with clients.

e) The candidate has been disciplined, reassigned, fired, has resigned from a job, or refused to cooperate with an investigation because of sexual conduct with clients.

f) The candidate has been disciplined by or removed from any professional training program for sexual conduct with clients.

2) If information about sexual conduct that is less clear than those circumstances enumerated in a) through f) above is reported by former employers, the appointing authority will consider the civil liability and ethical responsibility of the department in hiring individuals who will perform psychotherapy as all or part of their employment. In all such cases the department's director of personnel in central office shall be consulted, and involvement of the attorney general's office should be considered.

2. Requests for Information on Former Employees

a. The appropriate central office or institution personnel section is responsible for responding to requests from other employers about past employees and sexual exploitation of clients.

b. Minnesota Statutes Chapter 148A protects employers from lawsuits for providing specific information to prospective employers regarding employees who acted as psychotherapists and were sexual with clients. The statute does not protect employers regarding other employees or clients or release of other types of information.

c. In order for the department to provide information about former employees who acted as psychotherapists who engaged in or made requests for sexual activity with clients, the following conditions must be met:

1) The request must be in writing.

2) The request must ask for information about sexual contact with clients or former clients, although it need not be phrased precisely as above.

3) There must be an authorization to release information from the former employee.

d. In the event these conditions (c. 1-3 above) are not met, the following procedures apply:

1) Require that requests be made in writing.

2) If a written request is vague, the appropriate central office or institution personnel section will respond with a notice which will include the following statement, "We have assumed that this is not a request for information under Minnesota Statutes Chapter 148A."

3) Within two working days, the appropriate central office or institution personnel section will ask the requester for a written authorization to release information from the former employee.

e. After the appropriate conditions outlined in 2. c. and d. above are met, the appropriate central office or institution personnel section, after contacting the appointing authority for all relevant information, responds using form CR-00526-01.

f. If a written report is to be enclosed with the response form, the following procedures apply:

1) The report should only contain factual information about what occurred and how it was resolved by the department. If there was no resolution, that should be clearly specified and, if possible, state the reason why it was not resolved (e.g., the employee resigned so the investigation was dropped).

2) No identifying information about any client should be included in this report.

3) Such requests for information must be responded to within seven working days.

4) The attorney general's office should be consulted if any doubt exists about what information is to be released.

attach.

Appendix B-1 ATTACHMENT A

DEFINITIONS FROM THE CIVIL AND CRIMINAL LAWS OF MINNESOTA

From the Civil Code -- Minnesota Statutes Section 148A.01:

Subd. 2. "Emotionally dependent" means that the nature of the patient's or former patient's emotional condition and the nature of the treatment provided by the psychotherapist are such that the psychotherapist knows or has reason to believe that the patient or former patient is unable to withhold consent to sexual contact by the psychotherapist.

Subd. 3. "Former patient" means a person who was given psychotherapy within two years prior to sexual contact with the psychotherapist.

Subd. 4. "Patient" means a person who seeks or obtains psychotherapy.

Subd. 5. "Psychotherapist" means a physician, psychologist, nurse, chemical dependency counselor, social worker, member of the clergy, or other person, whether or not licensed by the state, who performs or purports to perform psychotherapy.

Subd. 6. "Psychotherapy" means the professional treatment, assessment, or counseling of a mental or emotional illness, symptom, or condition.

Subd. 7. "Sexual contact" means any of the following, whether or not occurring with the consent of a patient or former patient:

(1) sexual intercourse, cunnilingus, fellatio, anal intercourse or any intrusion, however slight, into the genital or anal openings of the patient's or former patient's body by any part of the psychotherapist's body or by any object used by the psychotherapist for this purpose, or any intrusion, however slight, into the genital or anal openings of the psychotherapist's body by any part of the patient's or former patient's body or by any object used by the patient or former patient for this purpose, if agreed to by the psychotherapist;

(2) kissing of, or the intentional touching by the psychotherapist of the patient's or former patient's genital area, groin, inner thigh, buttocks, or breast or of the clothing covering any of these body parts;

(3) kissing of, or the intentional touching by the patient or former patient of the psychotherapist's genital area, groin, inner thigh, buttocks, or breast or of the clothing covering any of these body parts if the psychotherapist agrees to the kissing or intentional touching.

"Sexual contact" includes requests by the psychotherapist for conduct described in clauses (1) to (3).

"Sexual contact" does not include conduct described in clause (1) or (2) that is a part of standard medical treatment of a patient.

Subd. 8. "Therapeutic deception" means a representation by a psychotherapist that sexual contact with the psychotherapist is consistent with or part of the patient's or former patient's treatment.

(over)

From the Criminal Sexual Conduct Code* - Minnesota Statutes Section 609.341:

Subd. 11. (a) "Sexual contact" ... includes any of the following acts committed without the complainant's consent, for the purpose of satisfying the actor's sexual or aggressive impulses, except in those cases where consent is not a defense:

(i) the intentional touching by the actor of the complainant's intimate parts, or

(ii) the touching by the complainant of the actor's, the complainant's, or another's intimate parts effected by coercion or the use of a position of authority, or by inducement if the complainant is under 13 years of age or mentally impaired, or

(iii) the touching by another of the complainant's intimate parts effected by coercion or the use of a position of authority, or

(iv) in any of the cases above, of the clothing covering the immediate area of the intimate parts.

Subd. 12. "Sexual penetration" means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any intrusion however slight into the genital or anal openings of the complainant's body of any part of the actor's body or any object used by the actor for this purpose, where the act is committed without the complainant's consent, except in those cases where consent is not a defense. Emission of semen is not necessary.

Subd. 16. "Patient" means a person who seeks or obtains psychotherapeutic services.

Subd. 17. "Psychotherapist" means a physician, psychologist, nurse, chemical dependency counselor, social worker, clergy, or other person, whether or not licensed by the state, who performs or purports to perform psychotherapy.

Subd. 18. "Psychotherapy" means the professional treatment, assessment, or counseling of a mental or emotional illness, symptom, or condition.

Subd. 19. "Emotionally dependent" means that the nature of the patient's or former patient's emotional condition and the nature of the treatment provided by the psychotherapist are such that the psychotherapist knows or has reason to know that the patient or former patient is unable to withhold consent to sexual contact or sexual penetration by the psychotherapist.

Subd. 20. "Therapeutic deception" means a representation by a psychotherapist that sexual contact or sexual penetration by the psychotherapist is consistent with or part of the patient's treatment.

---

*Note: The Criminal Sexual Conduct Code does not define "former patient", thus there is no time limit placed on being considered a former patient.

FOR OTHER RELEVANT INFORMATION, CONSULT THESE TWO STATUTES.

Appendix B-1

DATE

Addressee

RE:

Dear :

The person identified above has applied for employment with the Minnesota Department of Corrections in a job classification designated as psychotherapist or which involves the provision of psychotherapy. We are in need of specific information about this applicant before we can complete the screening process.

On August 1, 1986, Minnesota Statutes Chapter 148A went into effect. Definitions from that law are printed on the reverse side of form CR-00528-01 which is enclosed. Employers must ask former employers if they have knowledge of sexual conduct with a patient or former patient by job applicants who may be hired to perform psychotherapy. The statute imposes civil liability on employers who fail to comply. Employers are also liable if they receive a written request for such information and do not answer. Employers who comply with this statute in good faith are not subject to civil suit in Minnesota or to action by a Minnesota state licensing board. Please note that we include a signed Authorization for Release of Information from the applicant, which also relieves you of any liability for providing such information in good faith.

Therefore, we are asking you to complete the enclosed form and return it within seven working days to us. This inquiry should <u>not</u> be construed as any suspicion of misconduct on the part of the applicant. If you do not respond within seven working days, we will assume that you have no such information; however, this will probably not protect you from civil liability. If you provide written material, please do not include any identifying information about clients.

Please feel free to contact me if you have any questions. Thank you for your cooperation.

Sincerely,

Personnel Director

Enclosures: Information Request (CR-00528-01)
Release Authorization (CR-00527-01e)

Appendix B-1

MINNESOTA DEPARTMENT OF CORRECTIONS
Information Request

Name of applicant: _____

Employer: _____

Employed from: _____ To: _____ Still employed? _____ Yes _____ No

Positions while employed: _____

_____

_____ We have no record of a substantiated claim against the person named above of "sexual contact" as described in Minnesota Statutes Chapter 148A.

_____ We do have record of such contact:

_____ A written report on the matter is enclosed.

_____ We have no written reports on the matter.

Whom may we contact for further information on this matter?

Name: _____

Title: _____

Phone: _____

Address: _____

_____

_____

Person completing form:

Name: _____

Title: _____

Date: _____

Definitions of terms used in Minnesota Statutes Chapter 148A are printed on the reverse side of this form.

PLEASE RETURN WITHIN SEVEN WORKING DAYS. THANK YOU.

CR-528-01 (7/87)

Appendix B-1

DEFINITIONS

Minnesota Statutes Section 148A.01, Subd. 5 defines "psychotherapist" as "a physician, psychologist, nurse, chemical dependency counselor, social worker, member of the clergy, or other person ... who performs or purports to perform ... treatment, assessment, or counseling of a mental or emotional illness, symptoms, or condition." In short, a very broad range of people and activities are included. Any past work of a human services nature is of interest.

From the Civil Code -- Minnesota Statutes Section 148A.01:

Subd. 3. "Former patient" means a person who was given psychotherapy within two years prior to sexual contact with the psychotherapist.

Subd. 7. "Sexual contact" means any of the following, whether or not occurring with the consent of a patient or former patient:

(1) sexual intercourse, cunnilingus, fellatio, anal intercourse or any intrusion, however slight, into the genital or anal openings of the patient's or former patient's body by any part of the psychotherapist's body or by any object used by the psychotherapist for this purpose, or any intrusion, however slight, into the genital or anal openings of the psychotherapist's body by any part of the patient's or former patient's body or by any object used by the patient or former patient for this purpose, if agreed to by the psychotherapist;

(2) kissing of, or the intentional touching by the psychotherapist of the patient's or former patient's genital area, groin, inner thigh, buttocks, or breast or of the clothing covering any of these body parts;

(3) kissing of, or the intentional touching by the patient or former patient of the psychotherapist's genital area, groin, inner thigh, buttocks, or breast or of the clothing covering any of these body parts if the psychotherapist agrees to the kissing or intentional touching.

"Sexual contact" includes requests by the psychotherapist for conduct described in clauses (1) to (3).

"Sexual contact" does not include conduct described in clause (1) or (2) that is a part of standard medical treatment of a patient.

From Both the Civil and Criminal Codes
Civil: Minnesota Statutes Section 148A.01, Subd. 2, 4, 5, 6 and 8
Criminal: Minnesota Statutes Section 609.341, Subd. 16, 17, 18, 19 and 20

"Emotionally dependent" means that the nature of the patient's or former patient's emotional condition and the nature of the treatment provided by the psychotherapist are such that the psychotherapist knows or has reason to believe that the patient or former patient is unable to withhold consent to sexual contact by the psychotherapist.

"Patient" means a person who seeks or obtains psychotherapy.

"Psychotherapist" means a physician, psychologist, nurse, chemical dependency counselor, social worker, member of the clergy, or other person, whether or not licensed by the state, who performs or purports to perform psychotherapy.

"Psychotherapy" means the professional treatment, assessment, or counseling of a mental or emotional illness, symptom, or condition.

"Therapeutic deception" means a representation by a psychotherapist that sexual contact with the psychotherapist is consistent with or part of the patient's or former patient's treatment.

MINNESOTA DEPARTMENT OF CORRECTIONS
Information Response

Name of applicant: _____

Employer: _____

Employed from: _____ To: _____ Still employed? _____ Yes _____ No

Positions while employed: _____

_____

_____ We have no record of a substantiated claim against the person named above of "sexual contact" as described in Minnesota Statutes Chapter 148A.

_____ We do have record of such contact:

_____ A written report on the matter is enclosed.

_____ We have no written reports on the matter.

For further information contact:

Name: _____

Title: _____

Phone: _____

Address: _____

_____

_____

Person completing form:

Name: _____

Title: _____

Date: _____

Appendix B-2

RAMSEY COUNTY

COMMUNITY HUMAN SERVICES DEPARTMENT

SEXUAL EXPLOITATION PREVENTION POLICY

May 5, 1987
Revised August, 1987

Appendix B-2

The following people played a key role in the development of this policy.

SEXUAL EXPLOITATION PREVENTION TASK FORCE

Elaine Ashbaugh, County Attorney

Ann Eilbracht (Carey), CHSD Personnel

Gene Chatelaine, Mental Health Center

Tom Hustvet, CHSD Income Maintenance

Virginia Jacobson, Mental Health Center

Doug Johnson, CHSD Social Services

Leslie Kreutter, CHSD Social Services

Don Mockenhaupt, Mental Health Center

Suzanne Prass, CHSD Social Services

Virginia Reher, CHSD Social Services

Marjorie Singher, Mental Health Center

Eileen Sipple, CHSD Personnel

Dennis Walter, County Personnel

George Wilbert, Detoxification Center

TABLE OF CONTENTS

ATTACHMENTS

Appendix B-2

POLICY FOR THE PREVENTION OF SEXUAL EXPLOITATION OF CLIENTS

I. Prohibitions and Definitions

A. It is the policy of the Community Human Services department to prohibit sexual exploitation of patients/clients by psychotherapists in this department.

1. "Sexual Exploitation" consists of but is not limited to acts prohibited by Minnesota statutes and any other inappropriate physical or inappropriate verbal sexual conduct directed toward any patient/client.

2. "Sexual Contact" Subd. 7. [SEXUAL CONTACT.] "Sexual contact" means any of the following whether or not occurring with the consent of a patient/client or former patient/client:

(a) sexual intercourse, cunnilingus, fellatio, anal intercourse or any intrusion, however slight, into the genital or anal openings of the patient/client's or former patient/client's body by any part of the employee's body or by any object used by the employee for this purpose, or any intrusion, however slight, into the genital or anal openings of the employee's body by any part of the patient/client or former patient/client for this purpose, if agreed to by the employee.

(b) kissing of, or the intentional touching by the employee of the patient/client's or former patient/client's genital area, groin, inner thigh, buttocks, or breast, or of the clothing covering any of these body parts;

(c) kissing of, or the intentional touching by the patient/client or former patient/client of the employee's genital area, groin, inner thigh, buttocks, or breast, or of the clothing covering any of these body parts if the employee agrees to the kissing or intentional touching.

"Sexual contact" includes requests by the employee for conduct described in clauses (a) to (c).

"Sexual contact" does not include conduct described in clause 2(a) - 2(c) that is a part of standard medical treatment of a patient.

3. "Psychotherapists" includes persons employed by or contractors for the Community Human Services Department who are physicians, nurses, chemical dependency counselors, clergy, social workers, psychologists, or other persons whether or not licensed by the State, who perform or purport to perform psychotherapy, or who are involved in the direct care or provision of service to the patient/client (including case aides, detoxification aides, employment guidance counselors, financial workers, mental health workers, occupational instructors, housing coordinators, shelter home coordinators, occupational therapists, program specialists, residential counselors, nursing assistants, behavior analysts, and program directors).

4. "Patient/Client". A patient/client is a person who seeks or receives services from a psychotherapist who is employed by the Community Human Services Department. Any family member or other person residing in the same household with the patient/client is also included in this definition.

5. "Psychotherapy" is the professional treatment, assessment, or counseling of a mental or emotional illness, symptom or condition.

6. "Substantiated" means proved to the satisfaction of the investigating team.

7. "Unable to Substantiate" means a report which cannot be substantiated or disproved to the satisfaction of the investigating team.

8. "False" means disproved to the satisfaction of the investigating team.

9. "Therapeutic deception" means a representation by a psychotherapist that sexual contact or sexual penetration by the psychotherapist is consistent with or part of the patient's treatment.

10. "Emotionally dependent" means that the nature of the patient's or former patient's emotional condition and the nature of the treatment provided by the psychotherapist are such that the psychotherapist knows or has reason to know that the patient or former patient is unable to withhold consent to sexual contact or sexual penetration by the psychotherapist.

B. Length of Time. For those specifically identified in the Minnesota Sexual Exploitation Law (physicians, nurses, clergy, psychologists, chemical dependency counselors and social workers) sexual contact is prohibited during the time that the employee and patient/client are involved in a professional agency relationship and for two years after the case has been officially and administratively closed with no professional contact between the employee and patient/client.

Under the Minnesota Criminal Sexual Conduct Law, a psychotherapist can be charged with criminal sexual conduct if the sexual contact occurred in the therapy session, by means of therapeutic deception and/or if the patient or former patient is emotionally dependent upon the therapist. The Statute of Limitations places a three year limit on charging adults and a seven year limit on charging minors.

C. Other Affected Employees. Any employee who, by classification definition, has power over a patient/client shall also abide by these policies. While Chapter 148A of the Minnesota statues does not specifically identify these positions when limiting employee rights to association, it would be exceedingly difficult to prove he/she did not use this position authority to exploit the patient/client should a sexual exploitation complaint be lodged. For this reason, sexual contact between the above named employees and a patient/client is prohibited during the time the employee and the patient/client are involved in a professional agency relationship and for six months after the case has been officially and administratively closed with no professional contact between the employee and patient/client.

D. It is the policy of the Community Human Services Department to enforce existing child abuse (Minnesota statute 625.55) and vulnerable adult (Minnesota statue 625.557) statutes.

E. Any employee who engages in sexual exploitation of patients/clients will be subject to discipline including termination of employment whether or not criminal prosecution takes place.

II. Internal Investigative Procedures

A. When the Community Human Services Department receives a complaint of attempted or actual sexual contact by an employee with a patient/client, the complaint shall be routed to the Director of Community Human Services Department. A complaint can be reported by the patient/client who claims to have been exploited, or by another concerned party. Any Community Human Services Department employee who believes another employee is sexually exploiting a patient/client must report this to the suspected employee's supervisor and the Director of Community Human Services Department (or his/her designee). When necessary, the employee must also report the alleged offense under the Vulnerable Adults or Child Abuse Statutes. In such a case, the investigating teams will work cooperatively wherever possible.

B. The investigation shall be completed as soon as possible. The supervisor will immediately secure the patient/client records and if necessary, make certified copies of relevant documents.

The supervisor, with the assistance of a consultant will meet with the complainant to gather data. The supervisor and the consultant will inform the complainant of his/her rights to report the alleged offense to the police. They will also inform the complainant how the information he/she provides will be used, who will have access to the information, and what the possible affects may be.

The intent of the meeting is to ascertain the exact nature of the allegations. Information gathered should include:

1) What occurred, in detail;

2) When the alleged incident(s) occurred;

3) Where the alleged incident(s) occurred;

4) How often the alleged incident(s) occurred;

5) Who witnessed the incident(s) or is aware of the incident(s) occurrence.

6) Other data (diaries, hotel records, gifts, etc.)

C. The supervisor and the investigator will then meet with the employee who allegedly sexually exploited the patient/client. The employee shall be informed of the allegations and shall be informed of the possible outcomes of the investigation. The employee shall then be questioned as to his/her perception of the situation and what has occurred. Questions shall relate to the details that were suggested during the interview with the complainant.

D. All identified witnesses will be interviewed and shall be informed of the possible outcomes of the investigation. To the extent possible, only those employees who need to know, or who have information to provide, should be involved in any investigative interview or discussion. All of the above interviews will be taped, with the permission of the participants.

E. The investigator will submit a report to the Director of the Community Human Services Department (or his/her designee). The report will include a summary of the complaint, a description of the investigation, copies of the interview reports, and the findings of fact. These findings will include a conclusion of facts as either:

1. Substantiated (or admitted)

2. Unable to be Substantiated (or unclear), or

3. False

III. Disciplinary Actions:

A. If the investigating team finds preliminary evidence to support the complaint as valid, the employee accused of sexually exploiting the client may be suspended until the investigation is completed (but not to exceed 30 days).

B. If the investigating team concludes that the complaint is substantiated, this finding will be cause for termination from his/her position at Ramsey County Community Human Services Department. The findings of the investigation and disciplinary action will become part of the employee's personnel file as well as in a central file maintained by the Director of the Community Human Services Department.

C. If the investigating team concludes that the complaint is unable to be substantiated, the immediate supervisor will decide whether any disciplinary action, change in duties, further evaluation of employee, supervisory adjustment, and or closer monitoring is warranted. If the employee returns to work, he/she will receive full backpay. The findings of the investigation will be kept in a separate file from the employee's personnel file and will be kept in a central file maintained by the Director of the Community Human Services Department.

D. If the investigating team concludes that the complaint was false, the employee will return to work with full pay reinstated. The findings of the investigation will be kept in a central file maintained by the Director of the Community Human Services Department.

E. The investigative file will contain both private and confidential information. Private information can be read by the subject of the data, the subject's authorized representative, the director of the Community Human Services Department and his/her designees. Confidential information is **not** accessible to the subject of the complaint or the subject of the data.

Any and all information within the investigative file regarding the complainant, other than the specifics of the complaint, shall be confidential. Such confidential information (e.g., name, address, client status, investigator assessment, etc.) willbe stamped "confidential" in red print. All such documents will be placed within an envelope also stamped "confidential" in red print and placed within the file. Whenever someone, besides the investigator, requests to read the file, the confidential envelope will be removed and left within the central file cabinet.

IV. Proposed Procedures for Requesting and Providing Information Sexual Exploitation (M.S. 148A)

A. Hiring Process

1. When an applicant arrives for an interview for a position covered by the statute, the person is given:

(a) A copy of the "Applicant Advisory" to read and sign.

(b) A form on which to provide information on all relevant employers in the last five (5) years; and

(c) A release of information authorization form to complete.

2. The personnel representative retains these materials.

3. When a determination has been made as to whom an offer of employment may be extended, an investigation will be made of credentials, licenses, references, etc. Copies of the sexual exploitation inquiry letter will be sent to all necessary employers and licensing boards by the personnel representative.

B. Responding to Informational Requests

1. All requests for information from other employers shoul be directed to the personnel representative.

2. The personnel representative will refer to agency records and consult with management in the division(s) where the individuals or was employed.

3. If there is no knowledge of any occurrences of sexual contact as defined in M.S. 148A, both the personnel representative and the appropriate divisional staff member will so indicate and sign the inquiry form.

4. If the personnel representative finds reason to believe there has been an occurrence, he/she will consult with the department head and county attorney before responding.

5. Only investigations of complaints or reports which concluded with a determination of "substantiated" will be reported to inquiring employers. Other instances will be reported as "no knowledge of occurrences" of sexual contact between the employee or former employee and his or her patients or former patients.

V. Client Bill of Rights Addendum

A. Patient/Client Guidelines for Evaluating Human Services Experiences.

1. Employees who assist you to access or provide you with human services should act professionally, should properly use their authority and knowledge, and treat you with respect, care and dignity.

2. It is appropriate for these employees to clearly explain office practices (regarding eligibility determination, appointments, etc.), to devote their skills to your concerns, to promote any sources of positive change, and to maintain your confidence.

3. It is **not** appropriate for these employees to become your personal friend, to spend alot of time telling you about their personal problems or feelings, or to suggest any mutual activity that makes you uncomfortable.

4. It is not appropriate for these employees to make erotic comments, touch you sexually, or have **ANY** sexual contact with you, in or out of these offices, **with** or **without** your consent. You have a right not to be sexually approached or exploited by any employee who provides human services in the Community Human Services Departments.

B. The Community Human Services Department sincerely encourages you to report any inappropriate physical or verbal sexual conduct directed toward you to the agency Department Director, Thomas J. Fashingbauer, 298-4613.

C. You also have the right to report such conduct to an attorney, and/or legal authorities including the police, any state regulatory bodies as well as ethic committees of any professional organizations to which employees may belong.

1. For psychiatrists - The State Board of Medical Examiners, 2700 University Avenue, St. Paul, Minnesota 55114 (642-0538).

2. For psychologists - Board of Psychology, 2700 University Avenue, Suite 101, St. Paul, Minnesota 55114 (642-0587).

3. For nurses - Board of Nursing, 2700 University Avenue, St. Paul, Minnesota 55114 (642-0550).

D. You have the right to report such conduct to professional organizations' ethic committees where appropriate.

1. For psychiatrists - The Minnesota Psychiatric Society, Attention: Ethics Committee, 1770 Colvin Avenue, St. Paul, Minnesota 55116 (698-1971).

2. For psychologists - The Ethics Committee of the Minnesota Psychological Association, 1349 Penn Avenue North, Minneapolis, Minnesota 55411, Attention: Dr. Seymour Gross, (348-4625).

3. For social workers - The Minnesota Chapter of National Association of Social Workers, 614 Portland Avenue, St. Paul, Minnesota 55102, (293-1935).

4. For chemical dependency counselors, the Institute of Chemical Dependency Professionals, P.O. Box 16366, St. Paul, Minnesota 55116 (227-7584).

E. If you are sexually exploited or the recipient of any inappropriate physical or verbal sexual conduct by an employee of this agency, you have the right to be assisted in securing services from another employee in this agency or services from another county.

F. You have a right to ask the Community Human Services Department personnel manager if any sexual complaints have ever been substantiated against your worker.

G. You have a right to your own sexual preference.

/mk
psec
8/25/87

ATTACHMENTS

Appendix B-2

APPLICANT ADVISORY

The position for which you are a candidate is covered by the definition of "psychotherapist" as defined by Minnesota Statute 148A, Chapter 372. A summary of M.S. 148A entitled, "Action For Sexual Exploitation: Psychotherapists", is provided for your review. A psychotherapist is defined as "a physician, psychologist, nurse, chemical dependency counselor, social worker, member of the clergy, or other person whether or not licensed by the state who performs or purports to perform psychotherapy." Psychotherapy is defined as "professional treatment, assessment, or counseling of a mental or emotional illness, symptom, or condition." A patient is "a person who seeks or obtains psychotherapy" and a former patient is "a person who was given psychotherapy within two years prior to sexual contact with the psychotherapist."

A patient or former patient may bring legal action against a psychotherapist if sexual contact or requests for sexual contact occurred during the period the patient was receiving psychotherapy from the psychotherapist or after the patient received psychotherapy if the former patient was emotionally dependent on the psychotherapist or if the sexual contact or request for sexual contact occurred by means of therapeutic deception. The statute defines emotionally dependent to mean that "the nature of the patient's or former patient's emotional condition and the nature of the treatment provided by the psychotherapist are such that the psychotherapist knows or has reason to believe that the patient or former patient is unable to withhold consent to sexual contact by the psychotherapist." The statute defines therapeutic deception to mean "a representation by a psychotherapist that sexual contact with the psychotherapist is consistent with or part of the patient's or former patient's treatment."

In order to avoid liability under M.S. 148A, the Ramsey County Community Human Services department will make inquiries of employers who have employed applicants as psychotherapists within the past five years. The Community Human Services Department will ask the current and former employers if they have any knowledge of requests for, or occurrences of, sexual contact between the applicant "psychotherapist" and any of his/her patients or former patients. Such inquiries will be made prior to an offer of employment.

I have read and understand the above advisory and the summary of M.S. 148A, and I will provide the Ramsey County Community Human Services Department with the names, addresses, and telephone numbers of employers for whom I have worked in the past five years as a psychotherapist as defined in M.S. 148A. I further understand that failure to sign this advisory and provide the required information about current and previous employers will result in my name being removed from consideration for employment with the Ramsey County Community Human Services department as a psychotherapist as defined in M.S. 148A.

Signature of Appplicant	Date	Social Security Number

*Your social security number is requested only to distinguish you from all other applicants and you are not legally obliged to provide it.

(PRINT ON LETTERHEAD)

Attention:

Re:

Dear Employer:

A current or former employee of yours, named above, is a candidate for Ramsey County employment in a position which falls under the definition of "psychotherapist" as defined by Minnesota Statute 148A, Chapter 372. A summary of M.S. 148A, entitled, "Action For Sexual Exploitation: Psychotherapists," is enclosed for your review. The statute requires us to inquire of all employers who have employed this candidate as a "psychotherapist" within the last five (5) years, concerning the occurrence of sexual contacts by the psychotherapist with patients or former patients of the psychotherapist.

In order to comply with this law, we ask that you provide us with the information required on the enclosed Psychotherapist Background Information Form. Please return the signed and completed form as soon as possible. Inasmuch as we cannot complete the hiring process until this information is received, we will greatly appreciate your prompt response.

The above named individual has signed a release form authorizing you to release the requested information. A copy of that release is enclosed.

If you have any questions about the process, please contact me.

Thank you for your cooperation.

Sincerely,

Personnel Representative

Enclosure

ltr1
8/7/87

Appendix B-2

AUTHORIZATION AND RELEASE

TO: _____

_____

I hereby authorize and grant my informed consent to permit you to release to, and make available to, the Ramsey County Community Human Services Department data which concerns me and which may be in your possession. The data which I authorize you to release is any information you may have about any occurrence of sexual contact between any patient or former patient and me, as defined by M.S. 148A. I understand that the purpose of permitting the Ramsey County Community Human Services Department to have access to this information is to comply with M.S. 148A and to determine my suitability for employment.

I understand that I have the right to cancel the written authorization by providing written notice to the Ramsey County Community Human Services Department or to you of that fact.

_____ _____

Applicant's Signature Date

_____ _____

Printed Full Name Social Security Number*

*Your social security number is requested only to further identify you and you are not legally obliged to provide it.

/mk
gar
8/20/87

PSYCHOTHERAPIST BACKGROUND INFORMATION FORM

This form is Ramsey County's request for information pursuant to M.S. 148A, a law covering sexual exploitation by psychotherapists.

Applicant's Name:_____

Social Security #:_____

Employer's Name:_____

Address:_____ State:_____ Zip:_____

We request the following information on the individual listed above.

Please return this by _____.

Dates of Employment: _____ to _____.

Position/Title while employed: _____.

Check **One**:

☐ This organization has no knowledge of the above-named person having "sexual contact" with patients or former patients as defined in M.S. 148A.

☐ This organization does have knowledge of the above-named person having "sexual contact" with patients or former patients, as defined in M.S. 148A. (Please explain below. Use additional paper if necessary.)

Name of person completing this form: _____

Title:_____ Telephone:_____

Signature:_____ Date:_____

Please return to: Community Human Services Department
Personnel Office
160 E. Kellogg Boulevard, #890
Saint Paul, Minnesota 55101

pbi
8/7/87

Appendix B-3

ADMINISTRATIVE POLICIES, PROCEDURES AND FORMS ON SEXUAL EXPLOITATION

WALK-IN COUNSELING CENTER
MINNEAPOLIS, MINNESOTA

REVISED DECEMBER, 1986

Appendix B-3

Re: _____

Dear Personnel Director:

The person named above is applying to be a volunteer counselor at our Center. We are in need of specific information before we can complete the screening process.

On August 1, 1986, Minnesota Statute 148A went into effect. That law imposes liability on a current employer of a psychotherapist if that employer fails to inquire of the therapist's other employers about sexual contact between the therapist and clients or former clients. Since our volunteers perform job duties comparable to paid positions, we are bound by the Statute.

The definition of what constitutes sexual contact is on the back of this sheet. Please note that the definition includes requesting sexual contact with a client as well as actually **making** sexual contact.

We are liable if we do not seek such information, whether or not we have reason to believe sexual contact has occurred. Past and other current employers are also liable if they (a) know of the occurrence of sexual contact; (b) receive a specific written request about whether sexual contact has ever occurred; and (c) fail or refuse to disclose the requested information. Conversely, employers who in good faith comply are not subject to civil suit or to action by any Minnesota state licensing board.

We therefore are asking you to complete the enclosed form and return it as quickly as possible. Please note that we include a signed form from the applicant releasing you from any liability should you provide information in good faith about areas like past sexual contact with clients or former clients.

Please feel free to contact me if you have any questions. Thanks for your cooperation.

Very truly yours,

Ray M. Conroe, Ph.D.
Licensed Consulting Psychologist
Clinic Director

Enclosed: -Return envelope
-Signed "Statement of Applicant"
-Form to be returned

Appendix B-3

MINNESOTA STATUTES
CHAPTER 148A

Section 1. [148A.01]. [Definitions.] in part reads:

Subd. 7. **Sexual Contact.** "Sexual Contact" means any of the following, whether or not occurring with the consent of a patient or former patient:

(1) Sexual intercourse, cunnilingus, fellatio, anal intercourse or any intrusion, however slight, into the genital or anal openings of the patient's or former patient's body by any part of the psychotherapist's body or by any object used by the psychotherapist for this purpose, or any intrusion, however slight, into the genital or anal openings of the psychotherapist's body by any part of the patient's or former patient's body or by any object used by the patient or former patient for this purpose, if agreed to by the psychotherapist;
(2) kissing of, or the intentional touching by the psychotherapist of the patient's or former patient's genital area, groin, inner thigh, buttocks, or breast or of the clothing covering any of these body parts;
(3) kissing of, or the intentional touching by the patient or former patient of the psychotherapist's genital area, groin, inner thigh, buttocks, or breast or of the clothing covering any of these body parts if the psychotherapist agrees to the kissing or intentional touching.

"Sexual contact" includes requests by the psychotherapist for conduct described in clauses (1) to (3).

"Sexual contact" does not include conduct described in clause (1) or (2) that is a part of standard medical treatment of a patient.

NAME OF PSYCHOTHERAPIST*: _____

EMPLOYER: _____

ADDRESS: _____

EMPLOYED FROM: _____ TO: _____

STILL EMPLOYED: _____ YES _____ NO

POSITIONS WHILE EMPLOYED: _____

_____

***NOTE:** The law defines "psychotherapist" as a "physician, psychologist, nurse, chemical dependency counselor, social worker, member of the clergy, or other person...who performs or purports to perform...treatment, assessment, or counseling of a mental or emotional illness, symptoms, or condition." In short, a very broad range of people and activities are included. Any past work of a human services nature is of interest.

_____ We have **no** record or knowledge of sexual contact as described in the statute.

_____ We **do** have record or knowledge of such contact.

_____ A written report on the matter is enclosed.

_____ We have no written reports on the matter.

Who may we contact for further information on this matter?

NAME: _____

TITLE: _____

TELEPHONE: _____

ADDRESS: _____

_____

PERSON COMPLETING FORM:

NAME: _____
(Please Print)

SIGNATURE: _____

TITLE: _____

DATE: _____

Please return to Ray Conroe, Clinic Director of Walk-In Counseling Center, in the enclosed envelope.

(Rev. 12/86)

WALK-IN COUNSELING CENTER
2421 Chicago Avenue South
Minneapolis, MN 55404
870-0565/0566/0574

COUNSELOR/SUPERVISOR VOLUNTEER APPLICATION

(Return to Clinic Director, Ray Conroe)

DATE _____

NAME _____ SEX _____

ADDRESS _____ ZIP _____

PHONE (Office)_____ (Home) _____

CURRENT EMPLOYMENT _____
(Agency/Company) (Position/Title)

****

1. PAST WICC INVOLVEMENT

   a. Have you ever <u>volunteered</u> at WICC previously? Yes _____ No _____
   (If "yes", please indicate information under 6a.)

   b. Have you ever <u>applied</u> at WICC previously, but not volunteered?

   Yes _____ No _____ (If "yes", please attach an explanation. Include date of application and reasons for not having volunteered.)

2. DEGREES HELD AND/OR EXPECTED

Institution	Major Field	Degree	Year

3. LICENSURE STATUS

   a. Have you ever been licensed or certified? Yes _____ No _____
   b. Type (e.g. Licensed Psychologist, ACSW) _____

   _____

   State Where Held _____

   Expiration Date _____

   Areas of Competency or Professional Practice for which Licensed/ Certified _____

   _____

   | | Check if you hold more than one licensure or certification and list on the back of the last page.

Appendix B-3

Page 2 (Licensure Status continued)

c. Has disciplinary action of any sort ever been taken against you by a licensing board, professional association, or educational/ training institution? No _____ Yes _____

d. Are there complaints pending against you before any of the above named bodies? No _____ Yes _____

e. Have you ever had a civil suit brought against you relative to your professional work or is any such action pending? No _____ Yes _____

Note: IF YOU HAVE ANSWERED "YES" TO 3c, d, OR e, PLEASE ATTACH AN EXPLANATION.

4. TRAINING AND CLINICALLY RELEVANT EXPERIENCE

Practicum Placement, Internship and other Supervised Clinical Experience

Agency (include client populations and treatment modalities)	Dates	Approximate Hours

5. RELEVANT JOB EXPERIENCE

a. Current & Past Employment in Mental Health Related Settings (List most recent first.)

Name of Agency & Description (Job Titles, Setting, Duties & Dates

Page 3 (Relevant Job Experience continued)

b. Have you ever been asked to resign or been terminated by a training program or employer? No _____ Yes _____ (If "yes", attach an explanation.)

c. Experience as Clinical Supervisor

Description (Setting, Type of People Supervised, Client Population, Treatment Modalities)	Approximate Hours

NOTE: In accordance with Minnesota Statute 148A., we are obliged to contact your employers over the last five years and ask whether they have knowledge of your having sexual contact with clients. Complete the attached yellow sheet. Please note that paid internships are considered a form of employment.

6. GENERAL INFORMATION

a. Relevant Present and Past Volunteer Work

PROGRAM	ACTIVITIES	DATES

b. Areas of Special Expertise (e.g. sexual abuse counseling, chemical dependency counseling, sign language, foreign language)

_____

_____

_____

_____

Appendix B-3

7. EXPECTATIONS REGARDING WICC

Why do you want to volunteer at WICC? How did you learn of/become acquainted with WICC? What do you expect from this experience?

_____

_____

_____

_____

8. REFERENCES

Give the names, agency/institution affiliations and phone numbers of 3 people who are familiar with or who have supervised your clinical work within the last 5 years.

Name	Agency/Institution	Phone

9. AVAILABILITY TO VOLUNTEER AT WICC:

___Counselor: Does crisis intervention, short-term (10 sessions or less) counseling, referral, and follow-up.

___Supervisor: Oversees and is responsible for team functioning, reviews therapeutic work, leads case conference, and does some counseling and referral.

Note: Monday and Wednesday afternoon teams meet once a week and Friday afternoon teams once every-other-week, 12:45 - 5:00 p.m. Evening teams meet Monday, Tuesday, Wednesday, and Thursday (once every-other-week) 6:45 - 11:00 p.m. Return sessions are often necessary on intervening weeks.

10. CONSULTATION/TRAINING VOLUNTEER OPPORTUNITY -Contact Jeanette Milgrom, Director of Consultation and Training.

11. PRIVATE PRACTICE REFERRALS - WICC volunteers in private practice who wish to receive WICC referrals may be eligible for listing in the rollodex on the receptionist's desk. For further information, contact Ray Conroe, Clinic Director.

PLEASE SEE "STATEMENT OF APPLICANT" ON FOLLOWING PAGE.

STATEMENT OF APPLICANT: (Please ready this carefully before signing.)

All information submitted by me in this application is true to the best of my knowledge. I understand that any significant misstatement in, or omission from, this application may be cause for denial of appointment as a volunteer or cause for dismissal from the volunteer staff.

By applying for appointment to the volunteer staff of WICC, I acknowledge that I have the responsibility to read the "Ethical Guidelines at Walk-In Counseling Center" and other WICC rules and regulations. I agree to act in accordance with these ethical guidelines and any other rules or regulations adopted by WICC.

I authorize the Walk-In Counseling Center, its staff and representatives to consult with persons or institutions with which I have been associated and with others, including past and present employers, who may have information bearing on my professional competence, character, and ethical qualifications. I release from liability all representatives of WICC for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications. I also release from any liability all individuals and organizations who provide information to WICC in good faith and without malice concerning my professional competence, ethics, character, and other qualifications.

I understand and agree that I will notify WICC of any changes in my job or training status, licensure, censure, or sanction by professional bodies, or any other information relating to my ability to perform as a volunteer at WICC.

_____ _____

Name (Please print or type) Date

_____

Signature

Appendix B-3

WALK-IN COUNSELING CENTER
2421 CHICAGO AVENUE SOUTH
MINNEAPOLIS, MN 55404

Volunteer
Applicant _____
(Name)

MN Law (Statutes 148A., effective 8-1-86) requires WICC to make written inquiry to past employers in the mental health field regarding psychotherapists' possible sexual misconduct with clients.

Please list below all current and past employment in the mental health field (part-time, temporary & full-time) and all paid internships (including post-doctorals) during the past 5 years. (List chronologically, most recent first, etc.)

_____ Not applicable. I have had no employment or paid internships in the last 5 years. _____
(Signature)

EMPLOYER(S): (Current or most recent first)		Office Use Only:				
Name & Mailing Address	Phone Number Dates of Employment Position/Job Title	Date Letter Sent	Returned	Date Follow-up Letter Sent	Returned	

ATTACH SHEET IF ADDITIONAL LISTINGS

How To Obtain Additional Resources

Materials Published by the Minnesota Task Force on Sexual Exploitation by Counselors and Therapists

C-1a. It's Never O.K.: Sexual Exploitation by Counselors and Therapists - A brochure for consumers of counseling and therapy services. In a brief format, this pamphlet covers: a description of unacceptable behavior on the part of counselors, other types of inappropriate actions that often precede sexual exploitation, tips on choosing a counselor, common reactions of clients who have been victimized, and options to pursue in seeking help. Published, September, 1987.

C-1b. It's Never O.K.: A Handbook for Victims and Victim Advocates by Counselors and Therapists - A 36 page booklet designed to affirm the experiences of victims and to outline the options for seeking help. Material on the following subjects is included: definitions of sexual exploitation, warning signs in the behavior of the counselor, common emotional reactions of clients who have been victimized, answers to frequently asked questions, information for significant others, suggestions for how to choose a counselor, and a sample "Client's Bill of Rights." Published, May, 1988.

C-1c. It's Never O.K.: A Handbook for Professionals on Sexual Exploitation by Counselors and Therapists - A large volume of material on three subjects: therapeutic issues encountered in working with sexually exploited clients, with therapist-perpetrators, and in providing clinical supervision; administrative issues faced in preventing sexual exploitation and in coping with the problem once it has occurred; and educational and clinical issues to be covered by institutions that train counselors and therapists. The book also contains a description of the creation and accomplishments of the task force; copies of Minnesota laws on sexual exploitation; and a reprint of the Task Force's 1985 Legislative Report, now out of print as a separate document. Published, September, 1988.

For information on how to obtain these materials, write to:

Minnesota Program for Victims of Sexual Assault
Minnesota Department of Corrections
300 Bigelow Building
450 North Syndicate
St. Paul, Minnesota 55104

Annotated Bibliography of Literature on Sexual Exploitation

An annotated bibliography of mental health, legal, and public media literature. Essential for anyone doing research on this topic. The bibliography is periodically updated.

Ordering Information:

Lerman, Hannah. Sexual Intimacies Between Psychotherapists and Patients. 1986. Division of Psychotherapy, American Psychological Association, 3602 East Campbell, Phoenix, Arizona 85018.

$13.00 per copy - Can be ordered by telephone - 602/956-0494.

Walk-In Counseling Center Manual on Intervention and Prevention of Psychotherapists Sexual Involvement with Clients

This volume is based on 15 years of clinical and consultative work with well over 1,000 cases of client/therapist sexual involvement. It provides practice-oriented guidelines and a state-of-the-art overview of:

*Interviewing and assessing the victim
*Short-term structured support groups for victims
*One day workshops for victims
*Advocacy and complaint options
*Processing sessions involving client and therapist
*The post-therapy termination relationship
*Assessment of the therapist and the development of rehabilitation plans
*Administrative safeguards to limit the risk of this conduct
*Supervision issues, before and after
*The Minnesota and Wisconsin state task forces, their organization, impact, and some new data on the problem
*The new criminal and civil statutes

Ordering Information:

Psychotherapists' Sexual Involvement With Clients: Intervention and Prevention. Edited by Gary Schoener, Jeanette Milgrom, MSW, John Gonsiorek, Ph.D., Ellen Luepker, MSW, & Ray Conroe, Ph.D.

Walk-In Counseling Center
Attention: Manual
2421 Chicago Avenue South
Minneapolis, Minnesota 55404

Minnesota Interfaith Committee on Sexual Exploitation by Clergy

The Minnesota Interfaith Committee on Sexual Exploitation by Clergy was established as a subgroup of the Minnesota Task Force on Sexual Exploitation by Counselors and Therapists in 1984. It was brought into being by this legislative task force for the purpose of assisting denominational leaders as they seek to respond to the problem of sexual exploitation by clergy. With the passage of legislation that specifically includes clergy among the professional counselors who are subject to criminal and civil suits, it has become increasingly important for the church to respond in some definite way.

The Interfaith Committee is composed of laity and clergy representing a variety of Protestant denominations, the Catholic community, and the Jewish community. Many of the committee members are counselors by profession, either in church settings, community mental health centers, or in private practice. Some of the members are parish pastors. One is a former denominational executive. All are active church people who are concerned for the church's ministry of counseling.

A document is being prepared that specifically addresses sexual exploitation by clergy. Ordering information is listed below.

Ordering Information:

Contact: The Reverend Doctor John Martinson
Chair of the MN Interfaith Committee
Abbott Northwestern Counseling Center
2545 Chicago Avenue South
Minneapolis, Minnesota 55404

Additionally, committee members may be available as resources and can also be reached through Dr. Martinson.

TASK FORCE ON SEXUAL EXPLOITATION BY COUNSELORS AND THERAPISTS

REPORT TO THE MINNESOTA LEGISLATURE
FEBRUARY 1985

WRITTEN BY

BARBARA E. SANDERSON, COORDINATOR

TASK FORCE ON SEXUAL EXPLOITATION
BY COUNSELORS AND THERAPISTS
MINNESOTA PROGRAM FOR VICTIMS OF SEXUAL ASSAULT
MINNESOTA DEPARTMENT OF CORRECTIONS
300 BIGELOW BUILDING
450 NORTH SYNDICATE AVENUE
ST. PAUL, MINNESOTA 55104
612-642-0256

ACKNOWLEDGEMENTS

TASK FORCE ON SEXUAL EXPLOITATION EXPLOITAITON
BY COUNSELORS AND THERAPISTS

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Unit Supervisor
Central Minnesota Mental
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St. Cloud

Dorothy Bernstein
Psychiatrist
Member, Board of Medical
Examiners
Minneapolis

Jane Boyajian
Unitarian Clergyperson
Consultant in Ethics and
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Josephier Brown
Chemical Dependency Counselor
Former Executive Director
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Alice Hudson
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Aitkin

Connie Levi*
Minnesota State Representative
Dellwood

Nancy Malmon, Chairperson
Member, Board of Nursing
Minneapolis

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Minnesota State Senator
Minneapolis

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Law School
Minneapolis

Raymond Schmitz
Olmsted County Attorney
Rochester

Chris Servaty
Psychologist
Sexual Violence Center
Minneapolis

* Ex officio member
** Replaced Dorothy Bernstein

WORK GROUP MEMBERS

The task force would like to express its thanks to the following professionals who served on its five work groups and gave so generously of their time, energy, and expertise:

Elmo Agrimson
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American Lutheran Church
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St. Paul

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MN Program for Victims of Sexual Assault
MN Dept. of Corrections
St. Paul

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Jewish Family & Children's Service
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Sexual Violence Center
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Abbott-Northwestern Hospital
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Dependecies Institute of MN
New Brighton

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MN Program for Victims of
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MN Department of Corrections
St. Paul

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Campus Assistance Center
University of Minnesota
Minneapolis

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Social Worker/Psychologist
Greenspon Associates
Minneapolis

Inez Wagner
Executive Director
Aid to Victims of
Sexual Assault
Duluth

ADDITIONAL RESOURCE PEOPLE

The task force, work groups, and staff of this project would like to give a special thank you to the following people:

- For her inspiration and insight

  Noel Larson
  Social Worker/Psychologist
  Clinical Administrator
  Meta Resources
  St. Paul

- For their pioneering work with clients exploited by therapists and for their extensive input into this project

  Ellen Luepker
  Social Worker
  Family and Children's Service
  Minneapolis

  Gary Schoener
  Executive Director
  Walk-In Counseling Center
  Minneapolis

- For sharing her views on the problem and the recommendations

  Sharon Satterfield
  Psychiatrist
  Director
  Program in Human Sexuality
  Medical School
  University of Minnesota
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- For their assistance in understanding current civil, criminal, and administrative practices and in preparing the recommendations in these areas

  Jack Breviu
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  M. Sue Wilson
  Attorney
  Wilson and Pomerene
  Minneapolis

- For their sharing of valuable information and personal experiences

  The 40 people who testified at the public hearing and others who contacted the task force.

STAFF ASSISTANCE IN PRODUCTION OF THE REPORT

The task force and coordinator would like to thank the following Minnesota Department of Corrections staff members:

- For guidance, support and editing assistance

Dottie Bellinger
Assistant Director
Minnesota Program for
Victims of Sexual Assault

Dan O'Brien
Assistant to the Commissioner
of Corrections

Tom Lawson
Director
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Peggy Specktor*
Director
Minnesota Program for
Victims of Sexual Assault

Bruce McManus
Deputy Commissioner
Community Services

- For many patient hours spent at the computer preparing this report for publication

Nancy Haram
Secretary
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- For technical and editorial consultation

Sue Aumer
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* Portions of the "Overview of the Problem" section of this document were drawn from an unpublished paper by Peggy Specktor, entitled "Sexual Exploitation by Therapists: Perspectives, Problems and Public Policy", written for the Education for Reflective Leadership seminar at the Humphrey Institute of Public Affairs, University of Minnesota, Minneapolis, 1983.

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SUMMARY OF THE REPORT

BACKGROUND INFORMATION

The 1984 Minnesota legislature mandated the Commissioner of Corrections to form the Task Force on Sexual Exploitation by Counselors and Therapists. After an extensive call for applicants, the task force was constituted with a broad base of representation from professional organizations, regulatory agencies, the legal community, agencies and individuals involved in counseling and therapy services, appropriate state agencies, women's and men's organizations, mental health advocacy organizations, consumers, and geographic regions of Minnesota. Approximately 60 professionals and members of the public worked directly on this project. Additionally, testimony was provided by 40 people at a public hearing that was covered extensively in the media.

This group was instructed to report to the 1985 session of the legislature on a variety of issues related to the problem, including creation of a statewide education plan and recommendations for criminal, civil, and regulatory changes. This document is that report.

Sexual exploitation of clients is a widespread problem among counseling professionals. In self-report studies, as many as 17% of the responding therapists have admitted to sexual contact with patients during therapy or within three months following termination. Eighty percent of these therapists have been sexual with multiple clients. It is estimated that the actual incidence of sexual exploitation is much higher.

The long-term damage to sexually exploited clients is often extensive. In addition to not receiving help with their original problems, these victims have a high rate of psychiatric hospitalization, depression, shame, suicidal feelings and attempts, and other serious psychological consequences. They also experience decreased trust in other people and develop sexual problems, which lead to marital discord and broken relationships. People close to the exploited client and the abusing therapist also frequently require treatment as a result of the exploitation.

Therapists who sexually exploit their clients fall into several diagnostic categories. Most of them suffer from character disorders which include a lack of any feelings of remorse. This makes treatment of these abusers very difficult and the prognosis for their recovery exceptionally poor.

The remedies available to sexually exploited clients are usable in only a small percentage of the cases. If the therapist is employed, there may be a complaint procedure available within the agency. If the therapist belongs to a professional organization which has a prohibition against sexual contact with clients, the client may file a complaint; however, sanctions available to these organizations are very limited.

Other legal options for sexually exploited clients are also limited. In order to prosecute under the criminal statutes, the client must be forcibly assaulted, as defined by the current criminal sexual conduct code, be a minor, or mentally or physically incapacitated. Most cases of therapist-client sexual exploitation do not fall within these bounds.

The civil statutes contain no mention of the issue, so suits brought under common law must prove liability. In addition, since most malpractice insurance policies in Minnesota do not cover sexual exploitation of clients, it is pointless for clients to sue in most cases.

If the therapist is licensed by the state, the client may complain to the appropriate regulatory board and the therapist may face a variety of sanctions related directly to the practice of therapy, ranging from restriction of practice to revocation of the license. The only therapists currently regulated by the state are physicians, including psychiatrists; psychologists; and nurses. There are many other counselors who are not licensed and who, therefore, have no consequences related to their practice when they sexually exploit clients. There is currently no mechanism in Minnesota to prevent anyone from practicing psychotherapy.

RECOMMENDATIONS

Statewide Education Plan

A general plan for educating professionals who must work with the problems of sexual exploitation of clients includes recommendations that:

- The state develop models of policies and procedures related to sexual exploitation for use by professionals;
- The state collect, create, and disseminate information on the problems of sexual exploitation to professionals;
- The state design and implement training seminars on the problems of sexual exploitation for professionals; and

- The state develop a manual on sexual exploitation by counselors and therapists to be used by all concerned professionals.

Specific plans for educating special groups are targeted for:

- Faculty of institutions that train counselors and therapists;
- Practicing counselors and therapists;
- Employers and clinical supervisors of counselors and therapists;
- Members of professional organizations; and
- Private and public participants in the administrative, civil, and criminal complaint processes.

A general plan for educating the public on the problems of sexual exploitation of clients includes recommendations that:

- The state develop a brochure on sexual exploitation of clients for the public;
- The state provide information for media coverage on sexual exploitation of clients;
- The state write an addition for Client's Bills of rights that would define and prohibit sexual exploitation in therapy;
- The state design a handbook for victims of sexual exploitation and their advocates; and
- The state utilize the existing sexual assault network to provide information, crisis intervention, advocacy and referral to victims of sexual exploitation by therapists.

Specific educational plans are targeted for:

- The general public and clients; and
- Victims and victim advocates.

Criminal, Civil and Administrative Law Changes

It is recommended that the following be added to the criminal statutes:

- A clear definition of who is considered to be a psychotherapist;
- Inclusion of sexual exploitation of clients in the third and fourth degree criminal sexual conduct codes; and
- Rules of evidence in sexual exploitation cases similar to those in other sexual abuse cases.

It is recommended that the following be added to the civil statutes:

- A clear definition of who is considered to be a psychotherapist;
- A cause of action for sexual exploitation of clients;
- Employer liability in such cases;
- A requirement that malpractice policies in Minnesota cover sexual exploitation cases;
- Extension of the statute of limitations in appropriate cases; and
- Professional reporting requirements.

In the administrative statutes, it is recommended that changes to current regulatory boards include:

- A statutory prohibition of sexual exploitation of clients;
- A mandate that each client of a licensee of the boards receive a client bill of rights that includes a definition and prohibition of sexual exploitation;
- Inclusion on each board's ethics panel of at least one psychotherapist and one public member; and
- Standardization of investigative and disciplinary procedures across all of the boards.

In terms of currently unregulated therapists, it is recommended that:

- The legislature adopt policies that create consequences for all psychotherapists and sources of redress for all of their clients that relate directly to the practice of psychotherapy, including the authority to prohibit offenders from practicing; and

- The state continue in a more timely manner its current process of reviewing licensure applications submitted by counseling groups.

Due to the constraints of the separation of church and state, it is recommended that:

- In lieu of state regulation, religious institutions work together in an ecumenical effort to deal with the problem of sexual exploitation of clients by the counseling clergy; and

- That the state cooperate with any such effort.

Implementation

In order to implement the suggestions contained in this report, it is recommended that:

- Adequate staffing be provided to work with the task force and to carry out the recommendations of this report;

- This effort be carried out by the Department of Corrections, which has housed the Minnesota Program for Victims of Sexual Assault for the past ten years;

- The task force continue for another year to complete its work; and

- The legislature express its concern for clients who have been sexually exploited by therapists in Minnesota by funding this project.

BACKGROUND INFORMATION

SECTION ONE:

OVERVIEW OF THE PROBLEM OF SEXUAL EXPLOITATION BY COUNSELORS AND THERAPISTS

There are many aspects to the complex problem of sexual exploitation of clients by therapists. This section of the report presents an overview of the problem, beginning with a clarification of terms. Next, the research on the prevalence of sexual exploitation of clients is reviewed. Then the effects of victimization upon the clients are described, as are the characteristics of exploitive therapists. Finally, the remedies currently available in Minnesota to sexually exploited clients are enumerated, along with obstacles to reporting.

DEFINITIONS

The terms used to discuss sexual exploitation by counselors and therapists are often ambiguous and thus may become part of the problem. In order to eliminate this potential source of confusion within this report, the following terms will be used with these meanings:

> Psychotherapist, Counselor or Therapist - any physician, psychologist, nurse, social worker, chemical dependency counselor, members of the clergy, or other person whether or not licensed by the State of Minnesota who renders or purports to render psychotherapy, counseling, or other assessment or treatment of or involving any mental or emotional illness, symptom, or condition.
>
> Client or Patient - any person who receives the services of a psychotherapist, counselor or therapist.
>
> Sexual Exploitation - any sexual or romantic contact between client and therapist, which may include, but not be limited to, the following: intercourse, kissing, touching breasts or genitals in a sexual manner by either client or therapist, dating, or verbal suggestions of sexual involvement by the therapist.

PREVALENCE AND DYNAMICS

The taboo against sexual relations between therapists and clients is strong. The Hippocratic oath instructs against "The seduction of patients bound or free." Freud clearly stated that conventional morality and professional dignity make a sexual relationship

unacceptable. The American Psychiatric Association, the American Psychological Association, the National Association of Social Workers and other professional mental health organizations condemn the practice. And yet it happens.

Dr. William Masters said that if only 25% of the women who came to him claiming they have slept with previous therapists are being truthful, the issue is overwhelming (Lamberti, 1981). A study by Kardener, Fuller and Mensh (1973), reported that of the 46% of psychiatrists sampled who responded to their survey, 10% reported having engaged in erotic behavior with clients, 5% to the point of intercourse. This study was replicated by Holroyd and Brodsky (1977) with psychologists. With a 70% return of inquiries, they found that 5.5% of male and 0.6% of female licensed Ph.D. psychologists admitted to sexual intercourse with clients. Of this group, 80% had intercourse with more than one patient, with an average of 5.3 clients each. An additional 9.0% of male psychologists and 1.0% of female psychologists reported other erotic contact with clients. This study also found that within three months of therapy termination, 7.2% of males and 0.6% of females had intercourse with clients. In total, 17.1% of male and 2.0% of female psychologists who responded had some form of sexual contact with clients, either during therapy or within the three following months.

A study of a large drug abuse treatment system, funded by the Drug Abuse Council in 1974, documented widespread exploitation of women, including the use of coercive tactics to bring about sex between clients and counselors (Ponsor, Soler, and Abod, 1976). The best estimates are that one in five psychotherapists will be sexually intimate with her/his patients (Zelen and Butler, 1980).

There is increasing evidence that psychotherapists are aware of the problem of sexual involvement within their own professions. A study conducted by Grunebaum, Nadelson and Macht in 1976 found that 50% of the psychiatrists in their sample knew of specific instances of sexual involvement between client and therapist, but most had not reported these cases to any official body.

A recent study conducted by the Task Force on Sexual Intimacy Between Psychotherapists and Patients of the California State Psychological Association revealed that 57% of the responding psychologists reported that they had been consulted informally by other psychologists who were concerned about their own sexual involvement with clients (Bouhoutsos, 1982).

When a therapist engages in any kind of sexual contact with a patient, the therapist is taking advantage of his or her superior position. In 1974, Kardener drew the parallel between therapist-client sexual involvement and incest. He compares the parent as a caretaker of the child, with the therapist as

caretaker of the clients. When sexual intimacy occurs in the therapeutic situation, the patient is denied healing, support and adequate caretaking (Zelen and Butler, 1980).

In many ways, the therapist-client relationship often replicates the parent-child relationship. When it is used constructively, this can be a powerful and healing mechanism. The interpersonal boundaries that are appropriate and healthy between a parent and a child are very similar to the ethical interpersonal boundaries that promote a healing, therapeutic relationship in counseling. Nielsen (1984) has described the breakdown of such boundaries that leads to abuse. Among them are: role reversals, emotional enmeshment, voyeurism, and sexual talk and touch. These boundary violations happen in therapy when counselors put their own needs and wishes ahead of the good of the clients; discuss their own problems with the clients; and fail to keep an appropriate emotional distance from their clients' problems. They also occur when the therapist asks for more explicit sexual information than is necessary to help the client or when they talk with or touch the client in a sexual manner.

White (1978) has applied similar concepts to organizational problems. He asserts that failure to maintain appropriate professional boundaries within counseling organizations can create a climate of "organizational incest", which may result in the sexual exploitation of clients. Among the problems which may contribute to this destructive environment are: the system being closed to outside scrutiny and ideas; the staff using work colleagues for their entire support system and using work as a place to solve personal problems; and inappropriate sexual relationships between people at different levels in the organization (e.g., supervisor-supervisee).

While a small percentage of psychotherapists still believe that there may be some benefits to clients as a result of sexual relationships with their therapists, there is no scientific evidence to support this claim (Hare-Mustin, 1974). Sometimes psychotherapists contend that the sexual contact was permissible because the therapist was in love with the patient. Yet, Edelwich and Brodsky (1982) point out that sexual involvement with a client is always a failure of therapy. The problem is one of a misuse of power and failure to respect appropriate interpersonal boundaries between professional and client.

Locally, in the last ten years Walk-In Counseling Center in Minneapolis has assisted more than 350 clients who were sexually exploited by former therapists. They have worked with Minneapolis Family and Children's Service to help these clients recover, and both organizations have provided national leadership and consultation on the problems of sexually exploited clients.

EFFECTS OF SEXUAL EXPLOITATION ON THE VICTIMS

Little scientific data is available on the effects of sexually abusive behavior on a client. However, studies by Belote (1974), and D'Addario (1977), strongly indicate that the long term effects of such behavior is detrimental to the patients, and in some cases it is devastating.

Clinical observations reported in 1983 by Schoener, Milgrom and Gonsiorek, and in 1984 by Luepker and Retsch-Bogart, resulted in a description of the common experiences of the client who is sexually involved with a therapist. Their clients suffered from intense feelings of guilt and shame, anger at the violation of trust, fear of reprisals and rejection, low self-esteem, depression, and grief over the loss of the therapeutic relationship. Furthermore, these clients had received no valid treatment for the problems that originally brought them to therapy.

More recently, Bouhoutsos, Holroyd, Lerman, Forer, and Greenberg, (1983) reported data regarding the nature and effects of sexual intimacy between psychotherapists and patients. While this study only had a 16% return rate, its findings are still enlightening. In California, 318 psychologists reported treating 559 patients who had been sexually exploited by a former therapist. This study found that 90% of these patients had subsequent ill effects. The patient's personalities were adversely affected in 34% of the cases. This included increased depression, loss of motivation, impaired social adjustment, significant emotional disturbance, suicidal feelings or behavior, and increased drug or alcohol use. Patients also experienced an increased mistrust of the opposite sex, negative impact on marriage and family, and impaired sexual relationships. Twenty-six percent of the patients were reported to have worsened sexual, marital or intimate relationships. Eleven percent of the cases were hospitalized and 1% committed suicide.

In their clinical work with 27 victims of therapist-client sexual exploitation at the Minneapolis Family and Children's Service, Luepker and Retsch-Bogart (1984) found that 14% of these clients had required psychiatric hospitalization after the onset of sexual activity with their therapists. An additional 22% had been psychiatrically hospitalized prior to such involvement. The clinical impression of these authors was that this high rate of hospitalization was the only characteristic that distinguished these clients from their general agency client population.

While clients who are sexually exploited are the primary victims of their therapists, there are also potential secondary victims. The spouses or significant others of the primary victims, their children, parents, friends and co-workers may be indirectly but seriously affected by the sexual exploitation. It is common for broken marriages and relationships to follow revelation of the sexual exploitation. Additionally, colleagues, family and friends of the exploiting therapist may also experience adverse results, as tertiary victims (Milgrom, 1981).

THE SEXUALLY EXPLOITIVE THERAPIST

While there are no scientific studies that reveal the causes of sexually exploitive behavior by therapists, interviews with admitted abusers and clinical observations provide some insight. Butler and Zelen (1977) interviewed 20 therapists who admitted to sexual contact with their clients. Ninety percent of these subjects reported being vulnerable, needy or lonely at the time when the sexual contact occurred. During unsatisfying marriages, recent separations or divorces, some of these therapists used their clients to gratify their own needs.

In his work with over 350 cases of therapist-client sexual exploitation, Schoener (Task Force Minutes, September 25, 1984) has detailed five levels of disturbance on the part of offending therapists:

1. Episodic behavior - The offender engages in an isolated instance of bad judgment or loss of control. These offenders are usually remorseful and have a good prognosis for rehabilitation, but represent a small proportion of the total number of cases.

2. Neurotic - The offender often engages clients in a slow seduction that substitutes for a social life for the therapist. Prognosis for rehabilitation is variable.

3. Compulsive character disorder - The offender engages in repetitive, compulsive acting out. Many sexually exploitive therapists fall into this category and prognosis for recovery is very poor, as with many other character disordered people who have entrenched patterns of acting out behavior.

4. Narcissistic character disorders - The offender is grandiose, thinking that he or she knows what is best for people, even despite blatant evidence to the contrary; uses people without feeling any remorse; may be a cult-like leader with a devoted, protective following; is systematically exploitive, which may also involve financial exploitation. Many sexually exploitive therapists fall into this category and the prognosis for their rehabilitation is extremely poor.

5. Overtly psychotic - The offender suffers from a long-term, serious emotional disturbance. Only a few sexually exploitive therapists fall into this category and the prognosis for recovery is highly variable.

REMEDIES CURRENTLY AVAILABLE IN MINNESOTA TO SEXUALLY EXPLOITED CLIENTS

Clients who are sexually exploited by their therapists may have several remedies available to them. These remedies may exist through employers of the therapist, professional organizations to which the therapist belongs, or through the state. If the therapist is employed by an agency or institution, the exploited client may be able to file a complaint with the employer. However, many employers do not have policies which prohibit or punish sexual contact with clients and may have no formal grievance procedure for clients to follow. Many therapists who sexually exploit clients are self-employed and work alone.

If the therapist belongs to a professional organization that covers the practice of psychotherapy, the exploited client may be able to file a complaint with that organization. As with employers, some organizations do not have policies which prohibit or punish sexual contact with clients, and they may have no formal grievance procedure for clients to follow. Furthermore, therapists are not required to belong to professional organizations and many of them do not choose to join. Even professional organizations, which have a well-developed procedure for client complaints like that of the National Association of Social Workers, can only impose limited sanctions against offending members. Expulsion from the organization and public denunciation are usually the most extreme consequences.

Through the State of Minnesota, there are three possible sources of remedy: criminal, civil, and administrative. Currently, in order to prosecute under the criminal statutes, a sexually exploited client must be forcibly assaulted, as defined by the current criminal sexual conduct code, be a minor, or mentally or physically incapacitated. This covers only a small percentage of cases.

Civil remedies for sexual exploitation by therapists currently fall within the realm of common law, making the question of liability of the therapist and his or her employer an issue in every case. Malpractice is the most common cause of action and source of damage awards, but most malpractice insurance policies written in Minnesota do not cover sexual exploitation of clients.

Administrative remedies are available when the therapist is licensed by the state; however, the only counselors licensed in Minnesota are physicians (including psychiatrists), psychologists, and nurses. Remedies include suspension or revocation of the therapist's license, but there are no consistent policies and procedures for investigation or discipline of licensed professionals. The practice of all other psychotherapists is unregulated by the state. Even if a therapist's license is revoked, that therapist may still continue to practice psychotherapy because he or she will then fall into the category of the unregulated.

OBSTACLES TO REPORTING SEXUAL EXPLOITATION BY COUNSELORS AND THERAPISTS

Both clients and concerned colleagues face a number of problems in reporting instances of sexual exploitation by therapists. For clients, the problems may begin with a lack of information. Many clients are unaware that a therapist's behavior is unethical and/or illegal. Secondly, many clients do not have knowledge of the resources available to them or are intimidated by the complicated procedures involved in taking action against an exploitive therapist. Reporting is also hampered because clients are fearful that they will not be believed or that they will be blamed for provoking the sexual abuse. They may also fear the reaction of friends or loved ones. Finally, the investigative procedure is difficult for some clients. If action is pursued with licensure boards or ethics committees, the client must be willing to be cross-examined, to spend considerable time, and to face reliving painful experiences. A civil suit, criminal action, or courtroom appeal of a loss of license also involves time, money and threatens public exposure (Schoener, Milgrom, and Gonsiorek, 1983; and Luepker and Retsch-Bogart, 1980). Due to all of these reasons, only a small percentage of sexually exploited clients take any sort of action against offending therapists (Bouhoutsos, 1982).

Concerned colleagues face a different set of problems. Currently, only psychologists are required to report sexual exploitation of clients by other psychologists. There are tremendous risks involved for therapists who consider reporting their colleagues, including the fear of libel suits, fear of retaliation by other therapists, loss of referrals, and violating clients' rights to confidentiality and privacy. Finally, there has been a tradition of not speaking negatively of professional colleagues, which has resulted in therapists keeping silent when they know of sexual exploitation of clients.

(References for the above section are located in Appendix D.)

SECTION TWO:

HISTORY OF THE TASK FORCE ON SEXUAL EXPLOITATION BY COUNSELORS AND THERAPISTS

ESTABLISHMENT OF THE TASK FORCE

The 1984 Minnesota Legislature mandated the Commissioner of Corrections to establish a task force to study the problems of sexual exploitation by counselors and therapists. Laws of Minnesota, 1984, Chapter 631, charged this task force to:

- Develop a statewide plan to educate clients, potential clients, counselors and therapists, their employers and training institutions, and the general public on the issues surrounding sexual exploitation by counselors and therapists;

- Study the need for regulation of all professionals engaging in therapy and counseling and the need to improve rules and procedures of regulatory agencies in addressing complaints involving sexual exploitation by counselors and therapists;

- Explore changes in the civil and criminal codes as they relate to sexual exploitation; and

- Develop recommendations to the legislature on the above-mentioned topics.

(See Appendix A for a copy of this law.)

In June 1984, the Commissioner of Corrections widely publicized the call for task force applicants through the Secretary of State's Office, the press, and with an extensive mailing. Broadly based representation on the task force was sought, including representatives from professional organizations, regulatory agencies, the legal community, agencies and individuals involved in counseling or therapy services, appropriate state agencies, women's organizations, mental health advocacy organizations, men's organizations, and consumers. Approximately 90 helping professionals and members of the public responded. Eighteen members and six ex officio members were selected to represent the constituencies mandated by the legislature and the various geographic regions of Minnesota.

In August, the Commissioner of Corrections appointed the Coordinator and named the Chairperson of the task force.

THE WORK OF THE TASK FORCE

At its first meeting in September, the task force organized into five topical work groups to accomplish the necessary research and to make action recommendations to the task force. These groups were: Public Education, Criminal and Civil Statutes, Victim Issues, Professional Regulations, and Professional Education. (See Appendix B for a description of the work groups' activities.)

Additional members were added to each work group to give more people an opportunity to participate in the process, to gain additional expertise, and to share the enormous work load. Approximately 60 people contributed directly to the work of the task force. Included in this group were: victims of sexual exploitation by therapists, psychiatrists, psychologists, social workers, members of the clergy, chemical dependency counselors, nurses, marriage and family counselors, victim advocates, representatives of appropriate state agencies and licensing boards, criminal justice professionals, attorneys, legislators, and representatives of professional organizations. (See Appendix C for a list of all task force and work group members.)

In October and November, the work groups and the task force spent several full days meeting to study the various sexual exploitation issues. As a part of this process, they invited input from area professionals who have worked with the problem, including: therapists for exploited clients and abusing therapists; victim advocates; attorneys for complaining clients, accused therapists, and the state; staff and members of state regulatory boards; and representatives of professional organizations who have policies and procedures for regulating the sexually exploitive behavior of their members.

To gather further information from informed professionals and firsthand testimony from victims, the task force held a public hearing on November 12, 1984. The hearing was publicized through press releases and a mailing to 2,000 agencies, organizations, and individuals. Forty people gave 11 hours of testimony, transcribed by court reporters to a 483 page document. The media carried extensive coverage of this hearing resulting in many more calls and letters to the task force.

In late November, during a 12 hour work session, the work groups formulated their specific proposals. The task force spent the next two months debating and revising these ideas, before making this final report in February, 1985.

RECOMMENDATIONS

SECTION ONE:

STATEWIDE EDUCATION PLAN

The law which created the Task Force on Sexual Exploitation by Counselors and Therapists mandates the formulation of a statewide education plan for the public, clients, counselors and therapists, employers, and training institutions. As the task force examined the problem and heard testimony from those affected by it, the importance of a multifaceted educational program was apparent. Because there may be denial and lack of remorse on the part of therapists who sexually exploit their patients, it is essential that colleagues and employers be able to recognize the problem and know how to handle it. It is also important that the public become knowledgeable as they approach therapy, so that they know what is and is not acceptable behavior from their therapists and what their rights are as clients. Additionally, it is important that those persons who are responsible for processing administrative, civil, and criminal complaints understand the issues and the dilemmas faced by both the victimized clients and the accused therapists. Therefore, the following recommendations are made for a statewide educational plan.

PROFESSIONAL EDUCATION

In order to educate the wide variety of professionals who need to know about sexual exploitation by therapists and how to deal with it, it is recommended that the state develop a general professional education plan, the details of which will be tailored to meet the needs of the individual categories of professionals. Recommendations for the overall plan and the specific issues for each group follow.

I. GENERAL RECOMMENDATIONS FOR PROFESSIONAL EDUCATION

It is recommended that:

A. The state develop models of policies and procedures related to sexual exploitation for use by professionals.

B. The state collect, create, and disseminate information on the problems of sexual exploitation to professionals.

C. The state design and implement training seminars on the problems of sexual exploitation for professionals.

D. The state develop a manual on sexual exploitation by counselors and therapists to be used by all concerned professionals.

This manual would include:

1. The nature and scope of sexual exploitation by therapists;
2. Ethical implications of sexual exploitation by therapists;
3. Legal implications of sexual exploitation by therapists;
4. Description of the causes that lead a therapist to becoming sexually exploitive, and the symptoms of such therapists;
5. Strategies for dealing with feelings of sexual attraction in the therapeutic relationship;
6. Strategies for clinical supervisors to use in coping with potential and actual sexual exploitation of clients;
7. Strategies for educational institutions to use in preventing the sexual exploitation of clients;
8. The responsibility of the employer to clients, therapists, and the community;
9. Reactions of clients to sexual exploitation and how to help them emotionally;
10. Strategies for helping clients deal with the process of filing a sexual exploitation complaint;
11. Private and public remedies and how to accomplish them;
12. Organizational patterns that contribute to the problem;
13. Impact of sexual exploitation on colleagues;
14. Models of policies and procedures to deal with sexual exploitation; and
15. Strategies for dealing with sexual exploitation cases involving the clergy.

II. RECOMMENDATIONS FOR SPECIFIC PROFESSIONAL GROUPS

A. Educating Faculty of Institutions That Train Counselors and Therapists

Universities, colleges, and other training organizations are the initial contact for many persons entering the helping professions. These institutions serve a gatekeeping function in that they have some control over who is allowed entry into their professions. They are also the student's first exposure to the ethical standards of the profession, both through what is explicitly taught and the examples modeled by the faculty. Additionally, these educational programs provide an opportunity for advanced counselors to learn the skills essential to becoming supervisors. These individuals should be trained to recognize and handle potential and actual sexual exploitation problems among their supervisees. Therefore, it is recommended that:

1. **The state develop guidelines and/or models concerning sexual exploitation for training institutions.**

   These models and/or guidelines would include:

   a. Entrance and exit screening to identify students whose personality characteristics might put them at risk to sexually exploit clients;
   b. Supervision of student interns covering the issues of sexual attraction, sexual exploitation, and setting and keeping appropriate interpersonal boundaries with clients; and
   c. Ethical standards for professors that forbid sexual exploitation of students and supervisees, so that a learning atmosphere is created that nurtures ethical professional behavior and the keeping of appropriate interpersonal boundaries.

2. **The state develop guidelines and/or models for coursework in the area of sexual exploitation of clients.**

   These models and/or guidelines would include:

   a. The nature and scope of the problem of sexual exploitation;
   b. The use of power and need for appropriate interpersonal boundaries between therapist and client as they relate to sexual exploitation;

c. Techniques for supervising others when issues related to sexual exploitation arise;
d. Recognizing and helping clients who have been sexually exploited by other therapists;
e. Ethical issues regarding sexual exploitation of clients for therapists, their colleagues, and employers; and
f. Legal issues regarding sexual exploitation of clients for therapists, their colleagues, and employees.

3. **The state offer consultation to the faculty of training institutions on the subject of sexual exploitation.**

This consultation would cover:

a. The nature and scope of the problem of sexual exploitation of clients;
b. Professional ethical standards relating to the sexual exploitation of clients, students, and supervisors;
c. The role and responsibility of training institutions in preventing therapist-client sexual exploitation; and
d. Adoption and implementation of the guidelines and/or models developed above.

4. **The state distribute the manual on sexual exploitation and other relevant information to educational institutions.**

B. Educating Practicing Counselors and Therapists

Many counselors and therapists who have successfully completed their educational programs have had little or no exposure to the ethical and practical problems of sexual exploitation. Other psychotherapists have had no formal counseling education. Therefore, it is recommended that:

1. **The state distribute the manual on sexual exploitation and other relevant materials to practicing counselors and therapists.**

2. **The state design and implement a series of regional training seminars for practicing counselors and therapists.**

These seminars would include:

a. The nature and scope of the problem of sexual exploitation of clients;

b. Ethical and legal issues of sexual exploitation;
c. Strategies for dealing with sexual attraction to clients;
d. Appropriate interpersonal boundaries with clients and how to keep them;
e. Techniques for recognizing and working with clients who have been sexually exploited by other therapists;
f. Identifying and eliminating organizational patterns conducive to sexual exploitation, including the sexual exploitation of supervisees; and
g. Techniques for recognizing and working with therapists who have sexually exploited their clients.

C. Educating Employers and Clinical Supervisors of Counselors and Therapists

Employers whose agencies include counseling have a primary responsibility to the clients they serve. They are legally and ethically responsible for the professional conduct of the therapists they employ. Additionally, quality clinical supervision is an important element in prevention and handling of sexual exploitation. Many employers and clinical supervisors have had little or no opportunity to educate themselves on the issues of sexual exploitation and their responsibilities when such occasions arise. Therefore, it is recommended that:

1. The state develop guidelines and/or models on the problems of sexual exploitation of clients for employers of counselors and therapists.

   These guidelines and/or models would include:

   a. Ethical responsibilities of agencies in regard to sexual exploitation of clients;
   b. Legal responsibilities of agencies in regard to sexual exploitation of clients;
   c. Hiring and firing practices related to sexual exploitation of clients;
   d. Sexual exploitation policies and complaint and disciplinary procedures;
   e. Effective supervision on sexual exploitation issues;
   f. Staff education on sexual exploitation of clients; and
   g. Organizational patterns that foster sexual exploitation of clients and how to prevent and handle them.

2. The state design and implement a series of regional training seminars on the problems of sexual exploitation of clients for the employers of therapists.

   These seminars would include:

   a. The nature and scope of the problem of sexual exploitation of clients;
   b. Ethical responsibilities to clients in regard to sexual exploitation;
   c. Legal responsibilities to clients in regard to sexual exploitation;
   d. Techniques for checking the backgrounds of potential therapists to avoid hiring potentially sexually exploitive therapists;
   e. Techniques for identifying current therapists at risk for sexual exploitation;
   f. The importance and nature of adequate clinical supervision on the sexual exploitation issues;
   g. The necessity for and nature of an adequate screening process for clinical supervisors;
   h. Models for establishing a written policy prohibiting sexual contact with clients that make it grounds for dismissal;
   i. Models for establishing a client complaint procedure;
   j. Models for establishing within the work setting an investigative procedure for client complaints of sexual exploitation and a disciplinary process for offenders;
   k. Models for establishing an agency ethics review committee;
   l. Models for staff education on the subject;
   m. Techniques for identifying and eliminating organizational patterns conducive to sexual exploitation, including the sexual exploitation of supervisees; and
   n. Strategies for responding to requests for employment recommendations for sexually exploitive therapists.

3. The state compile and maintain a list of professionals who have the expertise and ability to help organizations which experienced difficulty with the problems of sexual exploitation or which seek consultation to prevent such problems.

4. The state create and distribute clinical supervision guidelines for supervisors on the problem of sexual exploitation.

5. The state design and implement a series of regional training seminars for clinical supervisors on the problems connected with sexual exploitation of clients.

   These seminars would include:

   a. The nature and scope of the problem of sexual exploitation of clients;
   b. Power and interpersonal boundary issues of sexual exploitation of clients and supervisees;
   c. Strategies to help supervisees deal with their sexual attraction to clients;
   d. Techniques to help supervisees create and maintain appropriate interpersonal boundaries with clients;
   e. Techniques to help supervisees recognize and work with clients who have been sexually exploited by other therapists;
   f. Techniques to recognize and help supervisees who have sexually exploited clients;
   g. Strategies for identifying and eliminating organizational patterns conducive to sexual exploitation, including the sexual exploitation of supervisees;
   h. Ethical concerns related to sexual exploitation of clients; and
   i. Legal concerns related to sexual exploitation of clients.

D. Educating Members of Professional Organizations

Many counselors and therapists belong to professional organizations which have the potential to foster high ethical standards among their membership. Currently, the approaches of such organizations to the problem of sexual exploitation by their members vary widely, ranging from no mention of such issues in their codes of ethics to standards calling for public censure and expulsion of offenders from the organization. One of the things that makes membership in some organizations attractive is that it includes the right to purchase relatively inexpensive malpractice insurance. It is recommended that:

1. The state develop guidelines and/or models for professional organizations on the handling of problems of sexual exploitation of clients.

   These guidelines and/or models would include:

a. A model section for a code of ethics prohibiting sexual exploitation of clients;
b. A model investigative and disciplinary procedure for sexual exploitation cases that includes a time line;
c. Guidelines for establishing membership criteria which address sexual exploitation concerns; and
d. A model for on-going membership education which addresses sexual exploitation issues.

2. The state work cooperatively with professional organizations to develop a plan to disseminate the manual on the problems of sexual exploitation and other relevant materials to all professionals who may be concerned with the problem.

3. The state create and implement a statewide seminar for members of professional organizations on the problems of sexual exploitation of clients.

This seminar would include:

a. The nature and scope of the problem of sexual exploitation, including information about exploitive therapists and the experiences of victimized clients;
b. The development of a written code of ethics that includes a specific prohibition of sexual exploitation of clients;
c. The creation of procedures which enforce the code of ethics that include a clear-cut disciplinary procedure and time line that is fair to both complaining clients and accused therapists and protects their confidentiality;
d. The establishment of criteria for membership that support an ethical professional environment;
e. The provision for ongoing ethical and practical education for members around the issues of sexual exploitation; and
f. The identification and elimination of organizational patterns conducive to sexual exploitation, including the sexual exploitation of supervisees.

4. The state maintain ongoing contact with professional organizations on sexual exploitation issues.

This would be done through:

a. Consultation with individual organizations;
b. Providing articles and announcements for organizational newsletters; and

c. Providing a speaker's bureau for organizational meetings.

E. Educating Private and Public Participants in the Administrative, Civil and Criminal Complaint Processes

When a client makes a formal complaint against a therapist for sexual exploitation, the complaining client and the accused therapist must deal with many individuals who have the power to make the process humane and fair. These individuals include private or public attorneys, members of the regulatory boards and their staffs, investigators, law enforcement officers, judges, and others. Many of these participants in the legal process have had little or no opportunity to educate themselves on the issues of sexual exploitation and so, inadvertently, make the process more difficult for the parties involved. Currently, there are only a very few private attorneys who have handled client sexual exploitation. Changes in the criminal, civil, and administrative statutes and procedures will also necessitate education of those people entrusted with carrying out these processes. Therefore, it is recommended that:

1. The state distribute educational materials on the problems of sexual exploitation of clients to professionals involved in the legal process.

   These materials would include:

   a. A manual on sexual exploitation for all concerned professionals; and
   b. A synopsis of the relevant laws and cases.

2. The state design and implement seminars on the problems of sexual exploitation of clients for professional groups involved in the administrative, civil and criminal complaint processes.

   These seminars would include:

   a. The nature and scope of the problem of sexual exploitation;
   b. The experiences of the accused therapists and the complaining clients, and how to make the process humane and fair for both; and
   c. Application of statutory and case laws to the problem.

3. The state create and maintain a network among attorneys working on related administrative, civil, and criminal cases, and compile and maintain a referral list available to the public.

PUBLIC EDUCATION

In order to educate the public about therapy and the potential dangers of sexual exploitation, it is recommended that the state develop a wide range of materials to convey the necessary information to the public. An overview of the general recommendations is presented, followed by specific suggestions for the general public and victims.

I. GENERAL RECOMMENDATIONS FOR PUBLIC EDUCATION

It is recommended that:

A. The state develop a brochure on sexual exploitation of clients for the public.

B. The state provide information for media coverage on sexual exploitation of clients.

C. The state write an addition for client's bills of rights that would define and prohibit sexual exploitation in therapy.

D. The state design a handbook for victims of sexual exploitation and their advocates.

E. The state utilize the existing sexual assault network to provide information, crisis intervention, advocacy and referral to victims of sexual exploitation by therapists.

II. RECOMMENDATIONS FOR SPECIFIC PUBLIC GROUPS

A. Educating the General Public and Clients

A recent study released by the National Institute of Mental Health found that one out of every five people in the United States has a treatable mental illness. All of these people are therapy candidates and this does not include the people who are not ill, but seek therapy as a way to enrich some aspect of their lives. Many of the client victims of sexual exploitation who have communicated their stories to the task force indicated that two powerful forces contributed to their sexual exploitation by their therapists. One was that they sought help at one of the most vulnerable moments in their lives. The other was that they did not know what to expect in therapy; they trusted that the therapist knew what he/she was doing. Thus, it seems important to educate the general public to become good consumers of therapy. Also, many people who are not in counseling themselves know someone who is and are in a position to offer information and wisdom. Therefore, it is recommended that:

1. The state publish and make available to the public a brochure on the problems of sexual exploitation of clients.

   This brochure would include:

   a. A definition of sexual exploitation of clients;
   b. A statement that it is the therapist's responsibility to refrain from sexual involvement with the client under all circumstances;
   c. A statement that it is the client's right to ask questions about anything that happens in therapy and to consult a third party about any concerns;
   d. A statement that sexual contact between therapist and client is considered unethical professional behavior, and that it is not considered to be therapeutic and may have long-lasting destructive consequences for the client;
   e. A statement that it is unethical for a therapist to terminate therapy for the purpose of initiating sexual contact with the client and that the negative consequences to the client may be long-lasting;
   f. A statement that clients have a right to be fully informed of the therapist's qualifications to practice, including training, credentials, and years of experience;
   g. A statement that clients have a right to be fully informed regarding the therapist's areas of specialization and limitations;
   h. A statement that clients should have access to a client's bill of rights;
   i. A strategy for choosing a therapist in a way that minimizes the risk of sexual exploitation; and
   j. Procedures for finding help with sexual exploitation experiences.

2. The state communicate information about sexual exploitation of clients to the public in a variety of other ways through the media.

   This would include:

   a. News releases;
   b. Public service announcements on radio and television; and
   c. Other information in the electronic and print media.

3. The state create and make available to the general public, clients, counselors, and therapists a client's bill of rights on the sexual exploitation of clients.

This document would include:

a. A definition of sexual exploitation of clients;
b. A statement that counselors and therapists are prohibited from having sexual contact or romantic involvement with their clients; and that in all circumstances it is the counselors' responsibility to see that this does not happen;
c. The procedure for reporting a violation; and
d. The procedure for obtaining advocacy for reporting a violation and referral for supportive services.

B. Educating Victims and Victim Advocates

Victims of sexually exploitive therapists need a great deal of assistance. Many entered therapy in a very vulnerable state and risked putting their trust in a counselor. When a therapist exploits his or her power and violates that trust relationship, the damage can be immense and long-lasting. Significant others, family members and friends of the victim, and other clients of the exploited therapist, may also be greatly affected by the sexual exploitation and may be considered secondary victims. When a victim or a secondary victim seeks help in dealing with that sexual exploitation, there is a great deal of complex information that needs to be communicated sensitively and clearly to that person. Therefore, it is recommended that:

1. The state create and disseminate a handbook for victims of sexual exploitation and their advocates.

   The handbook would include:

   a. Legal and layperson's definitions of sexual exploitation;
   b. The client's bill of rights;
   c. Options for reporting and how to do each one;
   d. Confidentiality considerations in dealing with reporting procedures, the media, family and friends, other clients, the agency, the professional community and others;
   e. Common reactions of primary and secondary victims and fictional accounts of both; and
   f. The places and means to get advocacy, support, treatment and referral.

2. The state provide information on sexual exploitation and referral to local resources to anyone who requests help.

3. The state establish a client advocacy model and provide training to the existing sexual assault centers to assist them in providing crisis information, referral, and advocacy for victims of sexual exploitation by counselors and therapists.

4. The state create and maintain a network among psychotherapists who provide counseling to victims of sexual exploitation and compile and maintain a referral list available to the public.

Reprint of 1985 Legislative Report by the Task Force on Sexual Exploitation By Counselors and Therapists

SECTION TWO:

CRIMINAL, CIVIL AND ADMINISTRATIVE REMEDIES

In Minnesota, there are three potential avenues of legal remedies to take against sexually exploitive counselors and therapists: criminal, civil and administrative. The abused client may choose to pursue any or all of these legal actions that apply. In order to prosecute under the criminal statutes, the client must be forcibly assaulted, as defined by the current criminal sexual conduct code, be a minor, or mentally or physically incapacitated. Most cases of therapist-client sexual exploitation do not fall within these bounds.

In the civil realm, current causes of action fall within common law, rather than statutory law. Malpractice is a possible cause of action; however, most professional liability insurance policies do not currently cover sexual exploitation. Consequently, financial damages are not usually available to the exploited client and lawyers are reluctant to take such cases. One case has been tried under the consumer fraud laws, but the remedies available in this area are very limited.

Administrative remedies are available when the therapist is licensed by the state; however, the only counselors licensed in Minnesota are physicians (including psychiatrists), psychologists, and nurses. These remedies range from conditional licensing to suspension or revocation of the license or registration. They serve to protect the state and the public in general, but offer no compensation to the individual client. In addition, there is currently no mechanism to keep abusing therapists from practicing counseling. While these remedies provide some help to some victims, the existing statutes need to be expanded and clarified to adequately protect the public from sexually exploitive therapists and to make the process more equitable for accused counselors. Therefore, the following recommendations are made:

I. RECOMMENDATIONS FOR CHANGES IN THE CRIMINAL STATUTES

Research and testimony from psychotherapy professionals and from victims indicated that the damage done to clients sexually exploited by their therapists can be extensive and long-lasting. Consequently, the following recommendations expand the criminal code to include those injured individuals not currently covered. These recommendations seek to clarify the problem and to better ensure protection of the privacy of the client, so that more victims might be willing to risk prosecuting. It is recommended that the following changes be made in the criminal statutes.

(For the proposed wording of these statutory changes, see Appendix E.)

A. New Definitions

Since there are many people who are performing the functions that constitute counseling and therapy, clear definitions of who is to be covered by these statutes are necessary. Additionally, sexually exploitive therapists often lead their victims to believe that the sexual contact is a beneficial part of their treatment. Thus, it is recommended that the following definitions be added to the criminal code:

1. Psychotherapist - counselors and therapists, defined by a list of occupations and by services performed;
2. Patient - clients who seek or obtain services; and
3. Deception - using false claims to obtain sexual contact.

B. Additions to Third and Fourth Degree Criminal Sexual Conduct

Third degree criminal sexual conduct currently involves sexual penetration under any of the following circumstances: the victim is a minor, mentally defective, mentally incapacitated, or physically helpless; the perpetrator uses force or coercion over any victim or authority over a minor. The present Minnesota Sentencing Guidelines recommend a presumptive sentence duration of 18-97 months imprisonment for a conviction, depending upon the offender's criminal history and the specific circumstances of the crime.

Fourth degree criminal sexual conduct is currently like third degree, except that it involves sexual contact. The present sentencing guidelines recommend a presumptive sentence duration of 12-65 months imprisonment for a conviction, depending upon the offender's criminal history and the specific circumstances of the crime.

Many psychotherapists attempt to avoid their responsibility to their patients by ending treatment in order to become sexually involved. Testimony from professional experts and victims indicates that these clients may be as seriously injured by this form of sexual exploitation as those who are exploited during therapy.

Under current law, a complainant must prove lack of consent. In many of the cases of therapist-client exploitation, it is the client's vulnerability, dependency, and trust in the therapist that results in what is misconstrued as consent.

It is recommended that the following be added to both the third and fourth degree criminal sexual conduct code:

1. Deception may not be used to accomplish sexual contact;
2. A psychotherapist may not engage in sexual contact with a current patient;
3. A psychotherapist may not engage in sexual contact with a former patient within six months of the last day of providing services; and
4. Consent of the patient to sexual contact may not be used as a defense by the psychotherapist.

C. Additions to the Admissibility of Evidence in All Criminal Sexual Conduct Cases Involving Sexual Exploitation of Clients

Testimony from psychotherapy professionals and research in the field has indicated that accusations of sexual exploitation by clients are usually not fabricated or a misinterpretation on the client's part. In cases of alleged therapist-client sexual exploitation, it often comes down to a question of the patient's word against the psychotherapist's word, and the issue of the patient's personal or medical history is frequently raised to discredit the patient's accusations. Thus, it is recommended that the following be added to the criminal sexual conduct statute and to the rules of evidence promulgated by the Minnesota Supreme Court:

1. Evidence of the patient's personal or medical history not be admissible except when it is the accused therapist's defense that the patient has fabricated the story.

2. Evidence of the patient's personal or medical history must be admitted in the following manner:

   a. The accused therapist must request a hearing prior to the trial;
   b. The judge must determine whether the value of the patient's history outweighs its prejudicial value;
   c. The judge may allow only those parts of the patient's history to be admitted as evidence that expert testimony has determined to be directly related to the issue of fabrication;
   d. The judge must make a specific order detailing exactly what portion of the patient's history may be admitted as evidence and nothing else may be introduced; and

e. Violation of the terms of the judge's order shall result in a mistrial, which will not prevent a retrial of the accused therapist.

II. RECOMMENDATIONS FOR CHANGES IN THE CIVIL STATUTES

Victims of sexual exploitation by therapists and those professionals who have helped them to recover from their experiences report that taking civil action can be confusing, traumatic, and possibly fruitless. Because there are no statutory prohibitions of sexually exploitive behavior by counselors and therapists, each case must establish the liability of the therapist and any employer of that therapist. In most cases there is no malpractice insurance coverage of the exploitation; consequently, it is difficult or impossible to recover damages. Currently, only psychologists are mandated to report such abuse. The statute of limitations has often expired before the client even recognizes the abuse as such. The proposals in this section are designed to bring clarity and consistency to the civil statues in this area. It is recommended that the following changes be made in the civil statutes. (For the proposed wording of these statutory changes, see Appendix F.)

A. New Definition

Since there are many people who are performing the functions that constitute counseling and therapy, clear definitions of who is to be covered by these statutes are necessary. Thus, it is recommended that the following definition be added to the civil code:

> Psychotherapist - counselors and therapists, defined by a list of occupations and by services performed.

B. Cause of Action

Current causes of action for sexual exploitation cases are not statutory, but are only a part of common law; consequently, liability must be proven in each case and interpretation of the common law is made on a case by case basis. Statutory provision for a cause of action would create clarity and uniformity in the law, eliminate the need to establish liability in each case, and establish a legislative policy against sexual exploitation by counselors and therapists. It would have the additional advantages of simplifying litigation and encouraging settlement of cases, all of which would be cost effective for the state. Thus, it is recommended that the following be added to the civil code:

A cause of action for wrongful sexual contact between psychotherapist and patient be created, in cases where physical, mental or emotional injury has occurred for the patient or anyone else.

C. Employer Liability

With the exercise of care and good judgment, employers have the power to lessen the possibility of sexual exploitation of clients in their agencies. Making employers liable would encourage them to take more responsibility in this area. The current standard in common law is that the client must prove that the therapist's employer should have been able to reasonably foresee that the therapist would be sexually exploitive. The proposed statutory change would establish that the act of employing a therapist would constitute the forseeability of sexual exploitation. Thus, it is recommended that the following additions be made to the civil code:

1. That employers be held liable for the same damages as therapists within their employ; and

2. That sexual contact must occur within the scope of employment: arising out of the psychotherapy, occurring during the therapy session, or occurring on the premises.

D. Professional Liability Insurance

A recent Minnesota Supreme Court interpretation indicates that some malpractice insurance policies in Minnesota do not currently cover sexual contact by psychotherapists. Many such policies, particularly those written in the past few years, specify that they do not cover sexual exploitation. This means that the likelihood of a client collecting civil damages is very small; consequently, lawyers are very reluctant to take sexual exploitation cases. Thus, it is recommended that the following be added to the civil statutes:

That all professional liability insurance policies covering psychotherapists in Minnesota must cover sexual contact between therapist and client.

E. Statute of Limitations

The nature of the damage in sexual exploitation cases often results in a client not recognizing the victimization until years later. In other cases, the therapist uses his or her power to manipulate, coerce, or threaten the patient into not reporting. Thus, it is recommended that the following be added to the civil statutes:

That the statute of limitations be extended in cases of sexual exploitation by psychotherapists when the client is unable to complain for a period of time due to the effects of the sexual contact or due to any threats, instructions or statements from the sexually exploitive therapist.

F. Punitive Liability

The purpose of punitive damages is to punish someone for outrageous conduct and to make them an example so that others will be deterred from similar behavior. Actual damages only compensate the victim for expenses or losses incurred and pain and suffering experienced. The only way to increase damage awards beyond the actual damages is to allow for punitive damages. In many instances of therapist sexual exploitation, the breach of trust and misuse of power is an outrageous act. It is also believed that punitive damage awards might deter other offenders. Thus, it is recommended that the following be added to the civil code:

That punitive damages may be awarded to the sexually exploited client.

G. Reporting Requirements

Mandatory reporting of sexual exploitation by colleagues was one of the concepts most extensively explored by the task force. The dilemmas faced in resolving this issue have to do with confidentiality and deciding who is most important to protect. There are several groups to be considered: the complaining clients, the public in general, the accused therapists, the employers of the accused therapists, and those who would be doing the reporting. It seems impossible to devise a plan that protects the confidentiality and interests of everyone.

In particular, there is often a conflict between the immediate welfare of injured clients and the public in general. Therapeutically, a client who has been sexually exploited by a former therapist may not be ready to report and may feel abused anew if someone else reveals his or her identity. It seems that the decision to report should be within the control of the abused client. On the other hand, if the abuse is never reported, the abusing therapist is free to exploit other members of the public. So, the question is, how to balance protection of the public with respect for the confidentiality of the exploited client.

For the accused therapists and their employers, the dilemmas are somewhat different. A therapist who is accused anonymously has no opportunity to face his or her accusers and consequently no opportunity to prove him/herself innocent, raising serious due process questions. Even though it is rare for false accusations of sexual exploitation to be made, they do occur occasionally. On the other hand, it is often difficult to prove a case against a sexually exploitive therapist without corroborating testimony from other victims. Third party reporting makes it possible for investigators to locate, through reporting therapists or employers, other victims who often will then change their minds and report. Employers of psychotherapists who are accused of sexual exploitation may find themselves in conflict between protecting the confidentiality of the abused client and protecting themselves from further liability by not reporting. In some cases, the confidentiality rights of the client may prevent employers from dismissing the offending therapist because of due process considerations.

Those psychotherapists who discover sexual exploitation by their colleagues may also find themselves confronted with a dilemma. If they learned this information from a client, then, in reporting, they run the risk of losing the trust of that client. Since most sexually exploited clients who return to therapy have a very difficult time trusting another therapist, this could be a serious problem and might even prevent some clients from seeking help to deal with their exploitation experiences.

The task force believes that there are no simple solutions to these complex issues and that they warrant further monitoring, research, and study. For now, the task force has attempted to balance the above considerations by recommending that the following changes be made in the civil code:

1. That when a psychotherapist or an employer of a psychotherapist discovers that a patient has been sexually exploited by a therapist, if he or she has access to that patient, he or she must inform the patient that such acts by the therapist are a violation of the law and ask for the patient's consent to use his or her name in reporting the incident; and

2. That if the client consents to have his or her name used, then the psychotherapist or employer must report the conduct to the appropriate regulatory board or agency;

3. That if the client declines to have his or her name used, the psychotherapist or employer is encouraged, but not required, to report the incident, naming the therapist, but not the client, to the appropriate regulatory board or agency;

4. That no client may be charged or held liable for any cost incurred by any psychotherapist or employer of a psychotherapist in the course of investigating any claim of sexual contact between a psychotherapist and a client;

5. That psychotherapists or employers who report such behavior in good faith will be immune from any civil or criminal liability.

6. That violations of these provisions would constitute a misdemeanor; and

7. That the Attorney General, in consultation with the Commissioner of Corrections, shall determine where these reports will be made.

III. RECOMMENDATIONS FOR CHANGES IN THE ADMINISTRATIVE STATUTES

Administrative statutes are the only sources of regulation of the actual rights and responsibilities of the practice of psychotherapy. Documented cases of therapist-client sexual exploitation in Minnesota have indicated that both regulated and unregulated therapists attempt to take sexual advantage of their clients. The current state of regulation in Minnesota appears to contribute to the problem. Physicians (including psychiatrists), psychologists and nurses are the only counselors licensed by the state. Licensure and registration do not necessarily imply training or competency in the practice of psychotherapy.

Everyone else who is a psychotherapist is unregulated. Furthermore, there is nothing in Minnesota statutes to prevent an offending therapist from continuing to practice. If a psychiatrist, psychologist, or nurse has his or her license revoked, then they fall into the unregulated group and may continue to practice, as long as they do not use any regulated title. They do usually lose the chance to collect third party payments from clients' medical insurance policies, which may result in the loss of some clients for those professionals when they lose their licenses. The current boards are reluctant to revoke licenses because they want to continue to monitor the behavior of offending therapists; however, there is little or no evidence to indicate that this monitoring is effective in protecting the public. In some cases, complaining clients have experienced difficulty in getting a timely response or satisfaction from the boards. Additionally, enforcement is inconsistent and there is even disagreement about what constitutes the burden of proof in disciplinary cases.

Despite these problems with the currently regulated groups, it seems clear that the state needs to assume some form of responsibility for the many psychotherapists who are currently practicing and unregulated. As the task force investigated these issues, it became clear that there are no simple solutions to these problems. Also, regulation by itself is no panacea, but must be accompanied by an active education program in order to be effective. The recommendations below reflect the desire of the task force to improve current regulatory procedures and to address the reality that so many counselors in the state are unregulated.

Another problem exists in state licensed institutions that deal with psychotherapy patients. Current provision for employees of such agencies do not adequately prohibit sexual exploitation of patients or make it grounds for dismissal.

It is recommended that the following changes be made in the administrative statutes:

A. REGULATORY BOARDS

1. Statutory Prohibition of Sexual Exploitation

Currently, not all of the boards have an explicit statutory prohibition against sexual exploitation of clients. Thus, it is recommended that the following be added to the administrative code:

> That the statutes covering all current and future regulatory boards shall contain a specific prohibition against sexual exploitation of psychotherapy clients.

2. Client's Bill of Rights

Many exploited clients testified that they did not know what was appropriate therapist behavior when they entered counseling. They suggested that each therapist be required to provide such information to each client. In many cases, this information could be inserted in existing bills of rights. Thus, it is recommended that the following be added to the administrative code:

> That any psychotherapist licensed, registered or otherwise regulated by an administrative body of the State of Minnesota be required to give each current and new client a copy of a client's bill of rights which includes a specific definition of and prohibition against sexual exploitation of clients.

3. Ethics Panels

At present, not all boards have a psychotherapist member, so that standards of ethical practice may not be adequately represented. Thus, it is recommended that the following be added to the administrative code:

a. That in consideration of cases of sexual exploitation by psychotherapists, all board ethics panels contain, at a minimum, one psychotherapist and one public member; and
b. That in the case of the Medical Board of Examiners, the psychotherapist be a psychiatrist.

4. Investigative and Disciplinary Procedures

Currently, complaining clients and accused therapists have a wide variety of often frustrating experiences with the existing boards. For clients, this adds to the emotional trauma of the original exploitation and, in many cases, appears to lead to a reluctance to complain. For therapists, it often means having their careers disrupted for two or more years. Disciplinary action is inconsistent, and it is possible that remorseful therapists are punished more severely than habitual offenders who are well defended. Attorneys representing the state, the complaining clients, and the accused therapists report that the standard for the burden of proof in cases related to the regulatory boards is unclear. Many argue that acceptance of the preponderance of the evidence as the standard of proof would allow the state the greatest leeway in prosecuting cases and thus in protecting the public. Other states, such as Wisconsin, publicize the cases where disciplinary action is taken, providing opportunities for members of the public to protect themselves from offending therapists. In Minnesota, this is usually not done, except for the Board of Psychology. Thus, it is recommended that the following be added to the administrative code.

a. That the Attorney General's office create a single standard of procedure for investigating complaints of sexual exploitation by therapists, including the following:

   i. A clear, consistent time line;
   ii. A provision for exceptional cases, with a requirement that these be well-documented and clearly explained to both client and therapist; and
   iii. The Attorney General's office and the boards make every effort to protect the identity of the client and the identity of the therapist until proven guilty.

b. That disciplinary actions of the boards on sexual exploitation by therapists be consistent and include the following:

   i. Procedures for the first offense:
      a. As a rule, the license or registration of the person be suspended for a minimum of one year;
      b. Exceptions be documented;

c. Psychotherapeutic treatment by a therapist, approved by the board, be mandatory before reinstatement of the license or registration and that a second therapist, approved by the board, evaluate the disciplined therapist's competency to practice without abusing clients before such reinstatement; and

d. A period of supervised probation following reinstatement.

ii. Procedures for subsequent offenses

a. License or registration be permanently revoked.

b. The boards have no discretionary power to waive this penalty.

iii. Burden of proof

Be clarified to be the preponderance of the evidence.

c. That the boards actively publicize their disciplinary actions by detailed press releases.

B. INSTITUTIONS AND AGENCIES LICENSED BY THE STATE AND PROVIDING PSYCHOTHERAPY

At present there are a variety of institutions that are licensed by state agencies to provide inpatient and outpatient mental health services, including psychotherapy. This would include, but not be limited to, mental hospitals, chemical dependency treatment centers, and halfway houses. Patients of such institutions and agencies are very vulnerable to sexual exploitation by psychotherapists and any other staff who have access to them. The Vulnerable Adults Act mandates that some institutions adequately provide for the well-being of their clients, including protecting them against sexual exploitation. What does not exist is a statutory mandate that would create job-related consequences for those who sexually exploit patients in state licensed institutions, including making it grounds for dismissal. Thus, the following recommendations are made for changes in the administrative code:

1. That all employees in state licensed institutions and agencies must refrain from sexual contact with patients, and that violation may result in dismissal.

2. That each such institution or agency be mandated to develop accompanying policies that include:

a. A code of ethics that defines and prohibits sexual exploitation of patients;
b. Staff education on sexual exploitation of patients;
c. Adequate supervision that deals with potential sexual exploitation of patients;
d. Investigative and disciplinary procedures for sexual exploitation cases;
e. Hiring procedures that reduce the possibility of sexual exploitation of clients;
f. Firing policies for sexual exploitation cases; and
g. A patient's bill of rights that includes a definition and prohibition of sexual exploitation of patients by employees.

C. REGULATING THE UNREGULATED

In testimony from victims and from those professionals who have helped them cope with their experiences, it was made clear that much of the sexual exploitation is being done by psychotherapists whose practice is not regulated by any state agency. This means that the only constraints on their practice are criminal and civil remedies and the current laws contain no provision for most of these cases. Many clients reported their horror upon discovering that the state of Minnesota has so little control over such potentially damaging behavior. Also, there is currently no way to keep anyone from practicing psychotherapy in Minnesota. Thus, the following recommendations are made for the regulation of the unregulated:

1. General Recommendations for Regulation

The task force made extensive but unsuccessful efforts to identify specific recommendations that would solve the problems related to sexual exploitation by unregulated psychotherapists. Thus, it is suggested that the legislature determine and adopt policies which incorporate the following general recommendations:

a. All psychotherapists must have consequences for sexual exploitation of clients that are directly related to their practice of psychotherapy and include the possibility of being prohibited from practicing psychotherapy in any form; and
b. All sexually exploited psychotherapy clients must have a source of redress with the state that relates directly to their psychotherapists' practice of psychotherapy.

2. The Licensure Process

Currently, several occupational groups (including social workers, chemical dependency practitioners, marriage and family therapists, and professional counselors) are seeking to be licensed by the state. Acknowledging that regulation, including licensure, is a possible source of prevention and remedy for sexual exploitation of psychotherapy clients, it is recommended that:

> The state continue in its review process of the counseling groups seeking state licensure in a more timely manner.

3. The Special Case of the Clergy

Members of the clergy are sought out for both psychological and spiritual counseling, affording them the opportunity for great power and influence with their counselees. The cases of sexual exploitation by clergy handled by Walk-In Counseling Center and described by victims at the public hearing of the task force indicate the importance of a organized approach to the problem within the clergy. Also, as trusted advisors to whom many people turn in times of crisis, and who are often the continuing resource throughout the life of a counselee, the clergy are in a position to provide support to members of their congregations who have been sexually exploited by other counselors.

A number of clergymen from several denominations testified at the public hearing about the problem of sexual exploitation among their profession. Among the suggestions made for increasing accountability within their ranks was the establishment of an interfaith effort for the development of guidelines and procedures for use in dealing constructively with ministers and congregation members who have experienced sexual exploitation.

Since the separation of church and state is constitutionally guaranteed, it is unlikely that the state will mandate administrative regulation of the practice of counseling by the clergy, except in their civil functions. Therefore, it is recommended that:

a. Religious institutions work together in an ecumenical collaboration to create ecclesiastical and professional policies prohibiting sexual exploitation of counselees and to implement clear and consistent disciplinary policies in such cases; and

b. The state cooperate with and offer assistance, training and materials to religious institutions and any ecumenical collaboration in responding to the problem of sexual exploitation of clients.

SECTION THREE:

IMPLEMENTATION

I. STAFFING

Many of the recommendations contained in this report will require extensive staff support to carry them out. Therefore, it is recommended that:

> Adequate staffing be added to implement this work.

II. IMPLEMENTING AGENCY

The task force and two temporary halftime staff members are currently a part of the Minnesota Program for Victims of Sexual Assault, a program of the Minnesota Department of Corrections. The Minnesota Program for Victims of Sexual Assault has successfully provided statewide services on other forms of sexual assault and sexual abuse for the past ten years. Therefore, it is recommended that:

> The staff to implement this project, except where otherwise specified in the report, be housed in the Department of Corrections.

III. THE TASK FORCE

While the Task Force on Sexual Exploitation has accomplished a great deal in its first five months of existence, there are still many objectives to be reached. Some are issues that the task force did not have time to address before its report was due and others consist of implementing and monitoring its recommendations. Therefore, it is recommended that:

> The Task Force on Sexual Exploitation continue for one year with its work as an advisory board to the Department of Corrections.

A. The work of the on-going task force would include:

1. Assist with the implementation of the recommendations of this report;

2. Encourage research in Minnesota on the incidence of sexual exploitation of clients in various professional groups and on the effectiveness of preventive and remedial programs and policies;

3. Monitor and encourage communication among the state agencies responsible for providing services and remedies for sexual exploitation of clients;

4. Encourage the reporting of instances of sexual exploitation of clients and the fair and expeditious handling of those cases;

5. Work with the legislature to identify and make recommendations on currently unaddressed issues involving the sexual exploitation of clients;

6. Coordinate the efforts of the state to reduce the incidence of sexual exploitation by counselors and therapists; and

7. Work with other states to establish a national communication system so that sexually exploitive therapists cannot escape the consequences of their actions by moving from state to state.

B. The Commissioner of Corrections shall determine the membership of the task force in accordance with the criteria set forth in the Laws of Minnesota, 1984, Chapter 631.

IV. FUNDING

In order for the State of Minnesota to underscore its commitment to dealing with the problems of sexual exploitation of clients in this state, it is recommended that:

The legislature appropriate adequate funds for the task force, staffing, materials, and other resources needed to carry out the recommendations of this report.

APPENDICES

APPENDIX A

Chapter No. 631
Laws of Minnesota, 1984

relating to occupations and professions; establishing a task force to study the problem of sexual exploitation by counselors and therapists.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. (TASK FORCE ON SEXUAL EXPLOITATION BY PSYCHOTHERAPISTS.)

Subdivision 1. (CREATION; MEMBERSHIP.) The commissioner of corrections shall appoint a task force to study the problem of sexual exploitation by counselors and therapists. The task force shall consist of not more than 18 members who are broadly representative of the state, including representatives of professional organizations, board of medical examiners, board of psychology, and board of nursing, agencies and individuals offering counseling or therapy services, the legal community, appropriate state agencies, women's organizations, and consumers. The terms, compensation, and removal of members are as provided in section 15.059.

Sub. 2. (STATE-WIDE PLAN.) The task force shall develop a statewide plan to:

(1) educate the public about the nature and scope of sexual exploitation by counselors and therapists;

(2) educate counselors and therapists, their employers, and training institutions about the consequences of and methods of preventing unethical conduct; and

(3) educate clients and potential clients about their rights, ways to select nonabusive counselors and therapists, and remedies for sexual exploitation by a counselor or therapist.

Sub. 3. (RECOMMENDATIONS.) Based on its findings, the task force shall make recommendations to the legislature by February 1, 1985, on:

(1) the need for a bill of rights for counseling and therapy clients;

(2) the need to improve the procedures and rules of regulatory agencies to minimize trauma for complainants and standardize penalties;

(3) the advisability of prohibiting information concerning the previous sexual conduct of a client or former client in proceedings of regulatory agencies;

(4) the need to create a felony offense for sexual exploitation by a counselor or therapist;

(5) the need for increasing damage awards in civil suits involving sexual exploitation by counselors or therapists;

(6) the need to require rules of professional conduct that prohibit sexual contact with clients and patients and require reporting of known violations;

(7) the need for regulation of all professionals engaging in therapy and counseling; and

(8) the need for other actions to address the problem of sexual exploitation by counselors and therapists.

Subd. 4. (EXPIRATION.) The task force expires on July 1, 1985.

Sec. 2. (EFFECTIVE DATE.)

Section 1 is effective the day following final enactment.

APPENDIX B

WORK GROUP DESCRIPTIONS

Task Force on Sexual Exploitation by Counselors and Therapists

PROFESSIONAL EDUCATION

This group will address the legislative mandate to develop a state-wide plan to educate counselors and therapists, their employers, and training institutions about the consequences and methods of preventing unethical conduct. It also examined the need for such educational plans for clinical supervisors, professional organizations, professional participants in the legal process, and the clergy.

PUBLIC EDUCATION

This group addressed the legislative mandate to develop a state-wide plan to educate the public, including clients and potential clients, about the nature and scope of sexual exploitation by counselors and therapists. It also examined possible sources of interference with such education.

VICTIM ISSUES

This group addressed the legislative mandates to: examine the need for a bill of rights for counseling and therapy clients; examine the need to improve the procedures and rules of regulatory agencies to minimize trauma for complainants; and standardize penalties.

CRIMINAL AND CIVIL STATUTES

This group addressed the legislative mandates to examine the need to create a felony offense for sexual exploitation by a counselor or therapist and to examine the need for increasing damage awards in civil suits involving sexual exploitation by counselors or therapists. It also examined the advisability of prohibiting information concerning the previous sexual conduct of a client in testimony in civil suits against sexually exploitive counselors and therapists and examined the need to extend the statute of limitations in criminal and civil cases involving sexual exploitation by a counselor or therapist.

PROFESSIONAL REGULATIONS

This group addressed the legislative mandates to: examine the need for regulation of all professionals engaging in therapy and counseling; examine the need to require rules of professional conduct that prohibit sexual contact with clients and patients and require reporting known violations. It also examined the impact of current regulations.

APPENDIX C

TASK FORCE AND WORK GROUP MEMBERS

PUBLIC EDUCATION

*DAVID BARAGA
*KATHY DENMAN
*ALICE HUDSON
*JEANETTE MILGROM
REBECCA BIDERMAN
NANCY BIELE
MARIA BROWN
DONNA FISCHER
STEPHEN PINSKY

CRIMINAL & CIVIL STATUTES

*JILL RUZICKA
*RAYMOND SCHMITZ
JOHN AUSTIN
CAROLEN BAILEY
BARBARA DOHERTY
PHILIP GETTS
JAMES KERR

VICTIM ISSUES

*AUTUMN COLE
*PATRICIA McDONOUGH
*CHRIS SERVATY
DARLENE DOMMEL
CAROLYN HALLIDAY
RICHARD LUNDY
GAYL MADIGAN
JOHN MARTINSON
CRAIG NAKKEN
SONDRA SMALLEY

LEGISLATIVE MEMBERS

**SENATOR DONNA PETERSON
**REPRESENTATIVE LEE GREENFIELD
**REPRESENTATIVE CONNIE LEVI

***(Replaced DOROTHY BERNSTEIN)

PROFESSIONAL EDUCATION

*JANE BOYAJIAN
*MARY HARTMANN***
**TRUDY DUNHAM
JOSEPH DALY
VALLI KANUHA
KENNETH PIERRE
MIMI SANDS
MINNA SHAPIRO
PEGGY SPECKTOR
INEZ WAGNER
ANN STEFANSON WIENS

PROFESSIONAL REGULATIONS

*JOSEPHIER BROWN
*SHIRLEY CORRIGAN
*JOHN GONSIOREK
*LEAH HOROWITZ
*CARL MARQUIT
*ROSEMARY MARTIN
**CHARLES McCAFFERTY
**NORMAN HANSON
ELMO AGRIMSON
DOTTIE BELLINGER
EUGENE BURKE
DANIEL CAIN
LYNNE LOCKIE
LUDWIG SPOLYAR

CHAIRPERSON OF THE TASK FORCE

*NANCY MAIMON

COORDINATOR OF THE TASK FORCE

BARBARA SANDERSON

*TASK FORCE MEMBERS
**EX-OFFICIO TASK FORCE MEMBERS

APPENDIX D

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APPENDIX E

RECOMMENDED WORDING FOR CHANGES IN CRIMINAL STATUTES

609.341 DEFINITIONS

Subd. 16. "Psychotherapist" means any physician, psychologist, nurse, social worker, chemical dependency counselor, clergy or other person whether or not licensed by the State of Minnesota who renders or purports to render psychotherapy, counseling, or other assessment or treatment of or involving any mental or emotional illness, symptom or condition.

Subd. 17. "Patient" means any person who seeks or obtains psychotherapeutic services.

Subd. 18. "Deception" means the making of a false or fraudulent representation concerning a cure, treatment or professional identity or relationship for the purpose of obtaining sexual intercourse or contact.

609.344 CRIMINAL SEXUAL CONDUCT IN THE THIRD DEGREE

(c) The actor uses force, coercion, or deception to accomplish the sexual penetration or

(e) The actor is a psychotherapist and engages in sexual penetration with his patient, in a prosecution under this clause Consent shall not be a defense.

(f) The actor is a psychotherapist and engages in sexual penetration with a former patient within six months after the last day upon which the actor provided psychotherapeutic services, in a prosecution under this clause Consent shall not be a defense.

609.345 CRIMINAL SEXUAL CONDUCT IN THE FOURTH DEGREE

(c) The actor uses force, coercion, or deception to accomplish the sexual contact or

(e) The actor is a psychotherapist and engages in sexual contact with his patient, in a prosecution under this clause Consent shall not be a defense.

(f) The actor is a psychotherapist and engages in sexual contact with a former patient within six months after the last day upon which the actor provided psychotherapeutic services, in a prosecution under this clause Consent shall not be a defense.

609.347 EVIDENCE

Subd.6. In a prosecution under 609.342 to 609.346 involving a psychotherapist and patient, evidence of the patient's personal or medical history shall not be admissible except where fabrication by the complainant is the defense and

(1) The actor requests a hearing prior to the commencement of the trial.

(2) The court at such hearing determines that the probative value of such history outweighs the prejudicial value thereof.

(3) In determining the above, the court shall consider only specific examples of conduct of the complainant which are determined by the court upon expert testimony to be related directly to the issue of fabrication.

(4) The court shall make a specific order detailing the information to be admitted and no other information may be introduced.

(5) Violation of the terms of such order shall be a mistrial which shall not prevent the retrial of the actor.

APPENDIX F

RECOMMENDED WORDING FOR CHANGES IN THE CIVIL STATUTES

A BILL FOR AN ACT

relating to psychiatrists, psychologists, and psychotherapists; establishing a cause of action; requiring insurance coverage; defining the statute of limitations, amending Minnesota Statutes section 541.07

BE ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. (DEFINITIONS.) For the purposes of this Act, the following terms shall have the following meanings.

Subd.1. "Psychotherapist" means any physician, psychologist, nurse, social worker, chemical dependency counselor, clergy, or other person whether or not licensed by the State of Minnesota who renders or purports to render psychotherapy, counseling, or other assessment or treatment of or involving any mental or emotional illness, symptom, or condition.

Subd.2. "Person" means any natural person, corporation, partnership, or other entity.

Section 2. (CAUSE OF ACTION FOR WRONGFUL SEXUAL CONTACT.) From and after the effective date of this Act, any person who suffers directly or indirectly physical, mental or emotional injury of any kind caused by, resulting from, or arising out of sexual contact with a psychotherapist who is rendering or has rendered to that person psychotherapy, counseling, or other assessment or treatment of or

involving any mental or emotional illness, symptom, or condition shall have a civil cause of action against the psychotherapist for all damages resulting from, arising out of, or caused by such sexual contact.

Section 3. (LIABILITY OF EMPLOYER.)

Subd.1. Any person who employs or hires a psychotherapist, whether as an agent, employee, independent contractor, or otherwise, for the primary or incidental purpose of rendering psychotherapy, psychoanalysis, counseling, or other treatment of any mental or emotional illness, symptom, or condition, shall be liable to the same extent as any such psychotherapist for damages as provided in section 2 above so long as the sexual contact occurred within the psychotherapist's scope of employment.

Subd.2. For the purpose of this section, the sexual contact shall be deemed to have occurred within the psychotherapist's scope of employment if it arose out of psychotherapy rendered to the plaintiff at least in part during a regularly scheduled therapy or treatment session or on premises regularly used by the psychotherapist for the rendering of psychotherapy.

Section 4. (INSURANCE COVERAGE REQUIRED.) No policy of professional liability insurance intended to afford or provide coverage for any psychotherapist as defined in section 1 of this Act who is practicing in this state on or after the effective date of this Act shall exclude or fail to provide coverage for damages resulting from, arising out of, or caused by sexual contact of any kind between a patient or client and a psychotherapist who is a named insured.

Section 5. (EXPENSES OF INVESTIGATION NOT TO BE CHARGED TO PATIENT.) No patient may be charged or held liable for any charge, cost, or expense incurred for any purpose whatsoever by any psychotherapist or employer of a psychotherapist in the course of investigating any claim of sexual contact between a psychotherapist and a patient.

Section 6. Minnesota Statutes (1984) Chapter 541 shall be amended by adding a new section to read as follows:

Subd.1. (Period of Limitation for Unlawful Sexual Contact). In the case of an action for wrongful sexual contact against a physician, psychologist, nurse, social worker, chemical dependency counselor, clergy, or other person whether or not licensed by the State of Minnesota who renders or purports to render psychotherapy, psychoanalysis, counseling, or other treatment of any mental or emotional illness, symptom, or condition, the applicable period of limitation shall be suspended during any period when the plaintiff is unable, as the direct and proximate result of (1) the wrongful sexual contact or (2) any written or verbal threat, instructions, or statements from the defendant, to commence and prosecute the cause of action.

Subd.2. Any act which exists on the effective date of this action and is not otherwise barred shall be subject to this section.

Section 6. Minnesota Statutes (1984) Section 549.20 is amended by adding a new subdivision to read as follows:

Subd.4. (Punitive Damages). Nothing in this section shall be deemed to limit or affect the right of any person to recover punitive or exemplary damages for wrongful sexual contact with a physician, psychologist, nurse, social worker, chemical dependency counselor, clergy, or other person who renders or purports to render psychotherapy, psychoanalysis, counseling, or other treatment of any mental or emotional illness, symptom, or condition, and nothing in this section shall be deemed to affect or limit the right of any person to seek punitive or exemplary damages from any master or principal whose employee, independent contractor or other agent is found to have engaged in wrongful sexual conduct within the scope of his or her employment by the principal or master.

626.599 REPORTING OF SEXUAL ABUSE BY THERAPISTS

Subd.1. (Public Policy). The Legislature hereby declares that the public policy of this state is to protect persons who have sought or obtained the services of a therapist from sexual exploitation by such therapist.

Subd.2. (Definitions). As used in this section, the following terms have the meaning given them unless the specific content indicates otherwise:

(a) Patient - as defined in 609.341.

(b) Psychotherapist - as defined in 609.341.

(c) Employer - any person who employes or hires a psychotherapist, whether as an agent, employee, independent contractor or otherwise, for the primary purpose of rendering psychotherapy, psychoanalysis, counseling, or other treatment of any mental or emotional illness, symptom or condition.

Subd.3. (Notice to Patient). Any psychotherapist or employer of a psychotherapist who learns that a patient has been subjected to any acts that would constitute a violation of MSA Statutes 609.344 (e) or (f) or 699.345 (e) or (f) shall immediately advise the patient that such acts may give rise to a civil cause of action for damages against the psychotherapist who committed the act and his or her employer, and, if proved beyond a reasonable doubt, constitute a gross misdemeanor. In providing such notice to the patient, the psychotherapist shall also inform the patient that if the acts in question are reported to any regulatory agency or board that the patient has the right to consent to the use of his or her name in any such report. The psychotherapist shall also inform the patient that the acts in question may be reported in any event but that neither the patient's name nor any other identifying information about the patient shall be set forth in any such report.

Subd.4. (Duty to Report). If the patient consents to the use of his or her name in the report specified in Subd. 3, the psychotherapist or employer of a psychotherapist who learns that a patient has been subjected to any acts that would constitute a violation of MSA Statutes 609.344 (e) or (f) or 699.345 (e) or (f) shall report in writing any such act to the

appropriate regulatory board or agency. If the patient refuses to consent to the use of his or her name in such report, the psychotherapist or employer of a psychotherapist who learns that a patient has been subjected to any acts that would constitute a violation of MSA Statutes 609.344 (e) or (f) or 699.345 (e) or (f) may report the acts in question but shall not state the patient's name or set forth any other identifying information about the patient.

Subd.5. (Contents of Report). In any report submitted pursuant to Subd. 4, the person submitting the report shall state identity of the person who committed the acts in question, the nature of the conduct, the place or places where it occurred, and the dates upon which the conduct occurred.

Subd.6. (Violation a Misdemeanor). Any person who willfully violates any provision of this section shall be guilty of a misdemeanor.

Subd.7. (Immunity from Liability). No person who in good faith makes any report pursuant to this section shall be held liable for any civil damages or criminal penalty as the result of making any such report.

Subd.8. (Agency to Receive Report). The Attorney General, in consultation with the Commissioner of Corrections, shall by rule and regulation designate the agency, board, or commission, as the case may be, to receive the reports required by this section.