NEWSPAPER COVERAGE OF INSTITUTE ON "EROTICISM IN THERAPY"
84th Annual Minnesota Social Service Assn. Conference
11AM-4PM, Monday March 21, 1977 Dyckman Hotel, Minneapolis

Developed and sponsored by: Walk-In Counseling Center Inc.

Coordinated by: Gary Schoener, Jeanette Milgrom

Program: "Delineating the Problem"--John Grace, Administrative Fellow, U. of Minnesota

"Handling Erotic Feelings in Therapy"--Minna Shapiro,ACSW, Dir. of Family & Child Treatment, Family and Children's Service, Mpls.

Vern Devine, Ph.D., Senior Clinical Psychologist, Henn. Co. Medical Center

"Working Therapeutically With Women Who Have Been Sexually Involved With Their Psychotherapists"-- Jeanette Milgrom, MSW, Community Coordinator & Gary Schoener, Licensed Psychologist, Executive Director, both of the Walk-In Counseling Ctr.

"Ethical-Legal Sanctions"--Gary Schoener

John A. Breviu, Special Asst. Attorney General, State of Minnesota

Phillip Getts, Attorney, Firm of Dayton, Herman & Graham

COVERAGE IN THE ST. PAUL PIONEER PRESS--THREE ARTICLE SERIES BY CAROL LACEY, Thurs. March 24, Friday March 25, and Saturday March 26, 1977

St. Paul Pioneer Press
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Thurs., Mar. 24, '77
FAMILY LIFE

Erotic contact during therapy may harm patient, therapist

(First of a three-part series)

By CAROL LACEY
Staff Writer

Janet had left her husband. She was incredibly depressed. She had been seeing a therapist before, but now she felt the need to see him two or three times a week.

During their sessions together the therapist used to stare at her, to flirt with her. About all they talked about was sex. He'd tease her, "Don't think you can get out of here without a hug and a kiss."

She found it a real ego boost to think of him as her lover.

When the relationship moved in that direction, things didn't work out well. Still, he needed her. He even helped set a place for her . . . and the two of them when they could get together.

Janet became increasingly dissatisfied. The relationship wasn't getting anywhere. Most of their friends were his former patients. And, she found he was lying to her.

She felt helpless, with nowhere to turn. Still she kept seeing him.

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Therapy: Erotic contact not

Continued from Page 10

For patients like Janet, being "turned on" in therapy can be a real ripoff. Not only does it easily lead therapist and client into a damaging relationship, but, sexual intentions blot out any prospects that therapy is going on.

That was the conclusion drawn by leaders and participants in an institute on eroticism and therapy held as part of the Minnesota Social Service Association annual meeting in Minneapolis. The three-day conference concluded Wednesday.

The professionals from Walk-In Counseling Center, Minneapolis, and other agencies, made it clear that they were not talking about those types of therapy situations where the client is seeking help for specific sexual problems, situations where sex surrogates or overt sexual activity may be on element of therapy.

What they're talking about is the therapy session where clients come in for professional help with personal problems. In such a setting the possibility of sexual encounters most likely doesn't even cross the client's mind — and certainly is not usually expected as part of the therapy routine.

It may happen in the first meeting, or it may build up gradually over a long period of time. However, what develops is specific, unmistakable activity with sexual intentions. Whether it's hugging and kissing, heavy petting, or whether it leads into bed, erotic contact hurts both patient and therapist, workshop participants agreed.

There's no evidence which links erotic behavior to a particular therapeutic theory — Gestalt, behavior modification, Fruedian, whatever, according to John Grace, administrative fellow in the University of Minnesota school of social work.

In some of the contemporary approaches, there may be a lot of touching, even hugging. When this happens without sexual intentions, it can be a real help for the patient, workshop participants agreed.

Freudian approaches using transference techniques may result in the patient mistaking growing positive feelings of a good therapeutic relationship for "being in love" with the therapist.

Whatever the approach, it is important for the therapist to realize what is happening and to keep it within the boundaries of a healthy therapeutic relationship, participants said.

If there are any sexual overtones, no matter how subtle, they will be picked up and the future of the therapy will be jeopardized, if not destroyed.

But there do seem to be two distinct types of therapists who try to turn their patients on, according to Grace.

"First," he said, "there is the cult figure who regularly and systematically instigates erotic contacts with cleints as part of 'proper psychotherapy.'"

"Clients are often encouraged or intimidated into erotic behaviors by the therapist's obvious social status and presumed professional competence," he said.

The other type of therapist, he continued, is the "depressed, lonely professional who acts out behaviorally."

"A number of case studies," he noted, "indicated therapists were experiencing marital problems prior to or during their sexual liasons with clients."

The most common situation involves a woman client and male therapist, Grace indicated.

Researchers aren't clear why this is the most common pattern. It may be because of the low number of female therapists or of the relative number of women and men in therapy.

Perhaps more important is the extreme vulnerability of the woman client and the towering authority with which the therapist possesses her.

In a landmark study that has gained national acclaim, Betsy Belote of the California Institute of Psychology developed a typical client profile.

From interviews and psychological testing of 25 women who had erotic contacts with their male psychotherapists she drew a typical female client profile. She found the majority were in "awe of their therapists" and felt "helpless and emotionally dependent" upon them.

They were unmarried, separated and living alone. They were unemployed either as students, or as housewives and mothers. They had attended college or had graduated from college and were an average of 16½ years younger than their therapists.

They were above average in physical attractiveness and conventional and feminine in their grooming and dress.

"They sought therapy because they were depressed and did not know where else to turn," Belote reported. "They were nonorgasmic with their therapists and in all other sexual relationships . . . and felt that having sex with their therapists meant that they were very 'special' and that this was a validation of their self worth."

Such subjects fit the criteria for masochistic behavior and "hysterical personality" which are surprisingly close to the traditional definition of "healthy femininity" in our society, according to Belote. And that makes sexual intimacy between female clients and male therapists all the more debilitating.

Local professionals see the types of personalities and backgrounds as more diverse than Belote.

"A good many clients we see are typically open to exploitation of various kinds," agreed Martha Hughes, counselor at the Walk-In Counseling Center. "It relates to the kind of self-concept they have . . . but it doesn't excuse the therapist in any way from exploiting them."

Until recently, such activities were considered bizarre and so rare that they were hardly worth considering.

However, while reporting of erotic incident is still uncommon and while those studies that do exist aren't completely reliable, evidence that gives solid clues to the nature and extent of the problem is beginning to surface.

They show that among health professionals — physicians and nurses as well as therapists — anywhere from 5 to 60 per cent engage in some sort of erotic behavior with their patients. Of these, a very low percentage — from 2 to 5 per cent — actually engage in sexual intercourse.

And, Grace continued, at least one fifth of these health professionals believe such activity may be helpful to their patients.

He didn't take the problem seriously at first because it seemed so sensational. "The sense of absurdity . . . the thought that these women must be fabricating this . . . is one of the hardest things to overcome," he said.

"But it's real," he said, "and it's serious."

(Friday Pioneer Press: Reactions to the problem.)

advised

Sex with therapist no cure for patient

(Second of a three-part series)

By CAROL LACEY
Staff Writer

No matter how good it may seem at the time, sexual contacts between therapist and client end up as a bummer for them both.

That was the consensus of participants in an institute on eroticism in therapy at the Minnesota Social Service Association conference in Minneapolis this week.

"As far as I'm concerned, two consenting adults can do anything they want," said Minna Shapiro, social work supervisor with Family and Children's Service, Minneapolis.

"It's the idea of an unequal relationship that bothers me," she said. "It makes the situation almost like child molesting."

Vern Devine of Hennepin County Medical Center agreed, and pointed out that therapists, usually male, have considerable power and authority over their clients in a counseling situation.

Once it has happened, women clients react similarly to women rape victims, observed Jeanette Milgrom, community coordinator of the Walk-In Counseling Center and co-leader of a support group for victims of therapists' assaults.

The first reaction, she said, is guilt and shame. "Women wonder what might happen to the therapist and his family, what might happen to their own family," she said.

"Much of the guilt centers on feelings of having been seductive," she continued, "having screwed up the therapist's life, having enticed the therapist to 'cheat' on his wife."

"Some clients are almost obsessed with feelings of responsibility, and totally ignore that the therapist, as a professional, is supposedly in charge of the treatment and guided by a code of ethics," Milgrom said.

Also, she added, some of the guilt and shame comes because women have been enticed into sexual behavior they generally have not condoned.

Then, particularly if the woman has stopped seeing her therapist, she may feel a deep sense of grief, Milgrom continued.

"Some entered therapy looking for a parent, thought they'd found it, only to become incestuously involved with their newly found parent," she said.

More commonly, the grief is over the loss of the "close and long-term relationship which has been thrown overboard in a few minutes."

"This grief can be as strong as the grief after death of someone close or the grief after divorce," Milgram said.

"Some clients," she said, "are unable to handle this sort of grief and refuse to separate from the therapist."

Clients also may feel angry about a variety of things. "They may be angry at the therapist whom they trusted and who betrayed them," she said. "They may be angry when they realize that no treatment was going on . . . which often is the case when there is sex involvement."

Women find themselves angered over lack of ways to judge a therapist. They feel that the therapist is able to set up all the "rules" and that his power over them continues even after therapy.

Women also fear reprecussions, Milgrom said. They are afraid someone — husband, boy friend, family or the community — will "reject them for having been involved in illicit sex."

They worry about what the therapist will do after treatment — and often for good reason, Milgrom indicated. "In some instances locally," she said, "they have been harassed by the therapist or some of his other clients. Once word has leaked out, some therapists attempt to conduct pressure campaigns against ex-clients and those assisting them. Ex-clients may be pawns in this vicious game.

"Since low self-esteem and depression are two of the most common problems which lead people to seek therapy," she continued, "It is sad when therapy adds to these problems.

"Some exploitive therapists interpret a client's unwillingness to become sexually involved as another illustration of their 'inability to love' or to 'accept love,'" Milgrom said. "The client's anxiety is interpreted as further proof of this 'neurotic' problem."

Also, she said, "the therapist often leads the women to believe he's the only one who can help her . . . and then leaves her stranded."

Out of this all comes considerable ambivalence and confusion. Even those who felt that the therapist was helpful to them find they would like to confront him to clear up confusion and settle their minds.

"Did he really care about me or was I just a sex object? Is he sick? Is he evil? Why me? What attracted him to me? Does he do this with other women? How many?" are some of the questions women need answered.

Reliable information on the psychological effects of erotic involvement for the therapist is scarce, reported John Grace, administrative fellow at the University of Minnesota school of social work.

But it can happen even to a therapist who may abhor sexual relationships between therapist and client because, at some point in his life, he becomes vulnerable.

A client keeps coming in. He finds himself happier and happier seeing this person. Therapy sessions become mutually reinforcing.

The therapist rationalizes, "What this person needs is someone who really cares."

But before he realizes it, gradually, he becomes more and more sexually involved. Only after he is in deep does he become aware of what has happened.

He feels guilty. He doesn't know what to do. He feels isolated from other professionals. He wouldn't dare talk about it to anyone.

Shapiro suggested therapists ask themselves a few questions about their practice. "Do you treat a particular client differently? Are you less confrontive with a particular client? Do you have special protective feelings toward her, do you bend the rules, take her out, suggest she continue in longer-term therapy?"

Sometimes, Shapiro observed, she has been sitting in on an interview where the worker "knew he was in trouble."

"It was expressed in ambivalence . . . talking about going out to dinner with the client," she said. "The response of the therapist was not clear . . . there were a lot of double meanings."

"Even with limited physical contact," she said, "The situation was obviously misleading and nontherapeutic."

Non-psychological issues, Grace indicated, are "more clear-cut."

Saturday Pioneer Press: Clients and therapists coming to grips with the problem.

St. Paul Pioneer Press Sat. March 26, 1977 Family Life Sect. (p.1)

Therapists confront fact of erotic feelings

(Last of a three-part series)

By CAROL LACEY
Staff Writer

"Erotic feelings . . . like other feelings . . . occur in all of us. We can't plan for the right time or place for them to occur," Minna Shapiro told colleagues in Minneapolis this week.

A social worker and supervisor with Family and Children's Service, Minneapolis, she participated in an institute on eroticism in therapy at the Minnesota Social Services Association conference.

"Erotic feelings happen in therapy," she said. "We have to face that fact . . . and then act in the best interests of the client and ourselves."

This problem is not unique to therapists. It happens to others—lawyers, dentists, even fathers.

One the reason why people have problems in dealing with this is that the culture in which they live also has problems dealing with it, pointed out Vern Devine of Hennepin County Medical Center.

"We do not comfortably accept the normality of sexual feelings," he said. "We have grown up with the notion that erotic feelings are to be associated with love.

"But," he continued, "erotic feelings are an everyday activity.

"If we recognized that these feelings existed," Devine said, "acting on them might be at a much lower incidence."

For professional therapists, it's imperative to "own up to and deal with these feelings rather than just shoving them under the rug," Shapiro said.

"It's the therapists's responsibility to know what he's about," Shapiro said. "If he's 'turned on" by a woman, he should know it and know how to handle it.

"The key," she said, "is knowing how a person can be turned on, yet control the situation so he or she is not seduced."

The therapist has the responsibility to remember that the client is "more vulnerable" than he, she said.

"Many times the client is alonely, needy person who doesn't value herself."

And, in a situation where the therapist is giving full attention and concern, it's not uncommon that good feelings should be mistaken for love.

It's completely up to the therapist, she said, to spell out clearly the "boundaries and behavior" allowable in the therapeutic situation.

"Sometimes I have found it helpful to be blunt about it," said Gary Schoener, executive director of Walk-In Counseling Center, Inc., Minneapolis.

He tells his client, "I'm really not going to get involved with you.

"Clients have to do some reality testing," Schoener said. "Once they hear you say 'no,' they can go on to other things."

If therapists can't do this on their own, they may need help, Shapiro indicated.

They may ask for transfer of the client to another therapist — although sometimes, if this is done with no discussion of the problem with the client or the next therapist, it can create severe problems for both client and therapist.

Or, the therapist might discuss the situation openly with the client and discuss alternatives to dealing with it.

Another approach is to call in another therapist and work with the client together for a time.

One solution that doesn' work at all is for therapist and client to ignore the problem and try to go on, pretending it doesn't exist.

"Whenever I encounter people in therapy who do a lot of touching — lapsitting, hugging, whatever," Devine said, "if they don't address the issue of sexual feelings, I have a great deal of skepticism about the legitimacy of what they're trying to do."

And, if male therapists are more commonly involved in this kind of activity, it is interesting to note that women therapists seem more comfortable in handling such a touchy situation, Shapiro indicated.

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Therapy: Erotic feelings a problem

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"Male therapists avoided it more," she said. "They'd try to make a quick transfer of their client . . . or look for an easy way to get around it."

What about the victims? In the past, there have been few places for women to turn. Now, however, resources such as the Walk-In Counseling Center provide individual and group counseling for women who have suffered this kind of trauma.

A new group for women who have been sexually or erotically involved with their therapist will begin there early in April.

The purpose of the group is for women to support one another and to work through their feelings related to the relationship with the therapist. Confidentiality is emphasized heavily. There is no fee for group meetings, which occur one evening per week.

Jeanette Milgrom, community coordinator of the center and co-leader of the support group, believes this approach is helpful for the women.

"In the group there are other women 'in the same boat' and they feel immediate empathy," she said.

"In this group many may come never having talked about this in their life to anyone," she said. "It's a real relief for them to discover they can talk about it . . . and the sky won't come down on them.

"As a result," Milgrom said, "it becomes easier for them to share their experience with others as appropriate."

Further, she continued, "most likely in the group there will be women in different stages of getting over their experiences. This can be comforting."

Finally, she said, it can help the self respect of individual women to find out that they're not "so dumb," that this kind of experience can happen to women who are intelligent and successful in their lives.

One of the keys to the group experience ie breaking down the authority of the therapist over the client.

"I let them know right away that sex involvement of the client and therapist is just plain wrong," Milgrom said.

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Center combats therapist-client sex

By MOLLY MacGREGOR

The relationship between patient and doctor is one traditionally characterized by trust and confidentiality. But for clients who become sexually involved with mental health therapists, that relationship takes on some emotional and legal characteristics seen more often in cases of rape.

The incidence of sexual encounter is not uncommon. And clients, like rape victims, often suffer from guilt, depression and anxiety. Also like rape victims, clients often are hesitant to take action against the therapist, even though legal and professional recourse is available.

The Walk-In Counseling Center at 2421 Chicago Av. So. has a reputation of responding to unusual problems and clients. The center first tackled this problem a year ago, when Jeanette Milgrom, a social worker and community coordinator for the center, founded a group for women who had been sexually involved with their therapists. She is now recruiting women to start a second group to meet this spring.

Sexual encounters may occur within the therapy session, or outside it, and don't necessarily include intercourse.

"We feel any erotic involvement is in the same bag psychologically as actual intercourse for the client," Milgrom said.

Although sexual encounters sometimes occur between female therapists and male clients, and between same-sex therapist/client relationships, the most common such relationship is between a male therapist and female client.

Incidence of such encounters is hard to measure, according to Milgrom. In a 1973 survey of psychiatrists, 50 percent said they know of specific incidents of erotic behavior between client and therapist, although none had reported it to a professional organization. Another ten percent said they had engaged in sexual behavior with clients, but only 5 percent reported having intercourse with clients.

"Many people assume that if a woman gets involved sexually with a therapist, it's because she has come to the therapist for help with a sexual problem. But in all the cases we know of, sex was not the problem for the woman," Milgrom said.

The most common complaints of women who go to therapists—and this is true for women who have been sexually involved with therapists—are depression and anxiety, Milgrom said.

Women who have sought help from the Walk-In Counseling Center have tended to be intelligent, attractive and well-educated. Milgrom considers the University population one of the largest single groups in which women who have been involved with their therapists may be found.

And incidences of sexual encounters between client and therapists happen to psychiatrists, psychologists, social workers, chemical dependency counselors and even clergy working as counselors, Milgrom said.

Jeanette Milgrom Photo by David Gronbeck

Milgrom uses the concept of the Freudian father-figure to describe the relationship between a male therapist and female client. Power relationships and role expectations are very different in other situations, she said.

"According to the average picture, the male therapist is 16-and-a-half years older than the woman client," Milgrom said. "He pays attention to her, listens to her, and hears all her secrets and most intimate problems.

"And the woman tends to assume that he must know what he's doing; he's studied for a long time and has a professional reputation, and besides, the woman thinks, he has that code of ethics up on the wall," Milgrom said. So a woman may not question what the therapist says, or suggests—even when it extends to sexual activity."

This attitude, Milgrom said, is both ironic and unfortunate. Sexual behavior between clients and therapists under almost any set of circumstances is frowned upon by all professional branches. And in the case of the psychiatrist, who is subject to the same legal restrictions as physicians, there is legal precedence for malpractice charges to be filed when evidence of sexual behavior between client and therapist exists.

"The first thing I tell people when they come to us is that I think sex between client and therapist is wrong in all cases. I don't care how seductive the woman feels she has been, it is simply wrong for the therapist in all cases," Milgrom said.

The Walk-In Counseling Center primarily offers emotional support for women who have come from a sexual relationship with a therapist. The center does not encourage anyone to seek legal or professional action against the former therapist, but will help any client who decides to do so.

"I won't even ask the therapist's name unless the client wants to tell me," Milgrom said. "If the client is in a deep, deep depression, which is often the case, we care only about her emotional health."

Part of the reason the center does not encourage the client to take action is because the process for legal suits and professional hearings is long and taxing on the client.

In fact, the trial itself may be the easiest part of the legal action, according to Philip Getts, a Minneapolis attorney who has worked on such cases. Before the trial, the client must submit to examination by the other side's attorney, and possibly by the other side's psychiatrists, he said.

Sexual encounters between client and therapist are as difficult to prevent as they are to discover, Milgrom said.

"You can't get references from other satisfied customers before going to the therapist," Milgrom said.

"But if women know this kind of thing happens, as least in some cases, they might not walk in as innocently," she said.