INTIMACY IN COUNSELLING: BEYOND THE BOUNDARIES OF A PROFESSIONAL RELATIONSHIP

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ABSTRACT

The concept "intimacy" in counselling is a complex though sensitive one. In this article the concept is defined and two opposing views presented about intimacy between the client and the helping professional in the counselling relationship. The effects of intimacy between clients and helping professionals are considered and some of the ethical/legal implications discussed. Finally, the author examines the reasons for the silence surrounding the phenomenon and recommendations are made to prevent misconduct.

INTRODUCTION

The professional relationship is central within all helping professions including social work. The phenomenon of sexual attraction between the helping professional and client is well researched and documented - especially in psychology and psychiatry (Edelwich & Brodsky 1982; Feldman-Summers & Jones 1984; Pope, Keith-Spiegel & Tabachnick 1986; Bouhoutsos *et al.* 1983; Borys & Pope 1989; Deaton, Illingworth & Bursztajn 1992; Gutheil & Gabbard 1992; Kagle & Giebelhausen 1994). This paper argues that this aspect needs to be openly addressed and managed in both training and supervision of social workers. Currently there seems to be a silence about it.

INTIMACY WITHIN THE PROFESSIONAL HELPING RELATIONSHIP

Sexually intimacy is generally implied in any discussion of intimacy within the counselling context (Edelwich & Brodsky 1982; Pope, Kieth-Spiegel & Tabachnick 1986; Bouhoutsos *et al.* 1983; Borys & Pope 1989; Deaton, Illingworth & Bursztajn 1992; Kagle & Giebelhausen 1994). However, there are factors that need to be taken into account when defining the term.

Bates and Brodsky (1989:130) discuss four aspects of sexual intimacy. Firstly, there "is an intention to arouse the patient sexually or to satisfy one's own needs". Sexual intimacy may include the intention to arouse the client as well as the act of sexual intercourse. Physical touching may be used to show warmth and comfort, yet this could also be interpreted as erotic or sexual. The authors claim that there is a distinct difference between the two types of touch, and that the client is frequently aware of the difference.

Secondly, there is a lack of professional judgement in recognising that the client is aroused by the helping professional. The issue is that a competent professional should be aware of the client's reactions and not miss the signs of arousal in the client.

The third aspect refers to dual relationships in which the helping professional relates to the client in several roles, i.e. the relationship has more than one purpose, e.g. as a friend, employer, teacher, family member and sexual partner (Bates & Brodsky 1989; Kagle & Giebelhausen 1994). A therapeutic relationship is meant to be one dimensional and exclusive. The helping professional offers a service and the client is the consumer. In most helping relationships with clients, the relationship is a tool for change; thus crossing boundaries will have an impact on the services rendered. The relationship is also not egalitarian as the helping professional has the

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power and authority of an expert. Thus through dual relationships the distinctive nature of the relationship that is vital in assisting the client is undermined.

The fourth aspect to defining sexual intimacies between the helping professional and client is the notion of selectivity. If a helping professional is involved with a client sexually, he/she will treat the client differentially on the basis of age, sex and attractiveness (Bates & Brodsky 1989). This question is also raised by Taylor and Wagner (1976), who challenge helping professionals who claim that the sexual intimacy is used as a therapeutic tool. The question is thus: would a helping professional have intercourse with every client who expressed the need therefor regardless of age, sex and attractiveness? What if the client was of the same sex, or considered unattractive or of an undesirable age - would the same services be rendered?

There are opposing views about the therapeutic impact of a sexual relationship between the helping professional and the client. Several authors (Hare-Mustin 1974; Stone 1976; Davidson 1977; Hays 1980; Serban 1981; Bouhoutsos *et al.* 1983; Durre 1980 cited by Pope *et al.* 1986; Feldman-Summers & Jones 1984; Gutheil & Gabbard 1992; Kagles & Giebelhausen 1994) state that sexual relations result in an anti-therapeutic relationship, i.e. it has negative effects on both the client and the therapeutic value of the service. Barnhouse (1978), writing about therapist-client sex in a psychodynamic therapy context, asserts that therapist-client sex is detrimental for three reasons. Firstly, during the transference relationship the client engages in a parent-child relationship and therefore therapist-client sex can be experienced as having an incestuous overtone. Secondly, an important part of therapy is often interpretation and understanding of the client's sexual fantasies. Thirdly, even though it is sometimes argued that clients voluntarily and autonomously enter into sexual relationships with their therapists, Barnhouse is of the opinion that this view is invalid due to the power held by the therapist. The client is thus not in a position to refuse a sexual relationship.

Contrary to the aforementioned views, Kagle and Giebelhausen (1994) note that often the helping professional rationalises the situation as being unique and that a sexual relationship is in fact meeting the needs of the client. Bouhoutsos *et al.* (1983) state that some helping professionals believe that sexual intimacies may be beneficial, e.g. to help patients with low self-esteem, to treat sexual dysfunction, or to meet the helping professional's own need and to serve his/her own interests. Authors who allude to the belief that sexual intimacies can be beneficial include James McCartney (1966) and Martin Shepard (1971) - the latter being the author of **Love Treatment**. Both strongly disagree with the notion that the helping professional who engages in a sexually intimate relationship with a client is being exploitative. The idea has been expressed that sometimes the only way to help the client is to cross the boundaries of the professional relationship.

The contradictory views expressed may also pervade thinking about social work. This could emanate from the fact that social workers, compared to other helping professionals, are much younger when they start practising social work, and supervision does not necessarily emphasise the physical/sexual attraction between client and social worker. Often it is assumed that social workers know the boundaries of the professional relationship.

The stereotype: the powerful helping professional versus the vulnerable client

The scenario that comes to mind when talking about intimacy between the helping professional and client is that of a male helping professional with authority and power who preys on the vulnerable female client. According to studies carried out in the United States (Borys & Pope 1989; Bouhoutsos *et al.* 1983; Pope *et al.* 1986) it has been found that a significantly higher number of male helping professionals are sexually involved with female clients. Usually their

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"victims" are younger clients compared with the number of female helping professionals who become involved with male clients (Borys & Pope 1989; Bouhoutsos *et al.* 1983; Pope *et al.* 1986). Bates and Brodsky (1989) even offer a profile of the male helping professional who would become involved with clients. Usually the helping professional would be middle-aged, his own love relationship is unsatisfactory, his caseload would primarily consist of female clients, his "victims" are usually younger than he is, he is lonely and also professionally isolated, he tends to be highly manipulative of the client, he makes the client feel needed, he is not necessarily attractive but has a charismatic aura and a good working reputation. Rutter (1989) in his article "Sex in the Forbidden Zone" focuses entirely on the male helping professional who exploits the female under his care and finds a similar profile.

Bates and Brodsky (1989) portray a helping professional who has personal problems and thus uses his authority and power to engage the unwilling client. Rutter (1989:25) explains that sexual intimacy can occur anytime when "a female entrusts important aspects of her physical, spiritual, material welfare to a male who has power over her". The author further asserts that males are unable to prevent intensely passionate feelings from becoming sexual, whereas women can hold them distinct. For males the allure of the forbidden is the central theme in sexual intimacies with clients. This is confounded by the "myth" that women must show deference to men and that the healing, nurturing and sexual powers that men attribute to women can drive men to "get the women" regardless of the violations. This explanation tends to portray male helping professionals as powerless against the immense sexual force of the female client. In contrast to the image presented of the exploitative helping professional, we get the helping professional who truly feels that he/she is in love with the client. Bates and Brodsky (1989:135) point out that this is usually found in younger helping professionals as they are inexperienced in therapy. They may not realise or have not been sufficiently trained to realise that the client is not free enough from the therapeutic setting to make "an informed and voluntary decision".

Challenging the stereotype

Although studies by Borys and Pope (1989), Bouhoutsos *et al.* (1983) and Pope *et al.* (1986) clearly demonstrate that the majority of the helping professionals who engage in sexual intimacies with their clients are male, there is no one stereotype. Pope *et al.* (1986) conducted a survey to determine the extent to which psychotherapists were attracted to clients and how they react and handle these feelings. It was found that 87% (95% of male and 76% of female) psychotherapists have been attracted to a client at one time. Only a very small minority acted on these feelings. Refraining from acting on feelings of attraction were mainly due to the following reasons: awareness of unethical conduct and unprofessional practice; it was counter-therapeutic and exploitative; against their own values; therapist in a committed relationship; and fear of censure/loss of reputation. The majority (63%) of the therapists felt uncomfortable, anxious and guilty about their feelings, especially the younger ones – i.e. below the age of 35 years. Just over half sought supervision or consultation in response to their feelings. Thus one must bear in mind that attraction to clients is a prevalent experience amongst both male and female helping professionals.

The seducing client

In contrast to the explanation that sexual intimacies are initiated by the helping professional is the concept of "seduction" of the helping professional. Edelwich and Brodsky (1982) explain this notion. These authors' argument, similar to that of Gutheil and Gabbard's (1992), is that there is no clear-cut explanation for the sexual intimacies that occur and they assert that the dynamics of seduction are complicated. The initiation and maintenance of sexual intimacies may stem from

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both the helping professional and the client in a tangled and entwined manner, in which the cause cannot be easily attributed to either party. Edelwich and Brodsky (1982) give a breakdown of forms of seductive behaviour of the client: fantasy, preference for helping professional of one sex or the other; edited self-presentation; voyeurism in helping professional's personal life, extracurricular contacts, verbal exhibition, body language and spoken invitation. The authors also list and explain the reasons for clients seducing their therapists, e.g. to gratify sexual desire, to divert attention from treatment issues, to bribe or manipulate, to establish an unholy alliance in conjoint therapy, to compromise the therapist's position, to gain status among peers, to gain strength by bonding with a stronger person, and to gain attention and gratification through the use of accustomed strategies. Helping professionals may do sexually provocative things which do not stem from the desire to manipulate or exploit, but from "normal human feelings and insufficient training and experience" (Edelwich & Brodsky 1982:30). These include the following: being attracted to clients, ambiguous communication, voyeurism and over-identification. The authors also acknowledge there are situations in which clients are sexually exploited, but one must not neglect those situations in which the clients act seductively, believing this is the desire of the helping professional, and who draw wrong conclusions when the helping professional is behaving inappropriately.

For Finney (1975) the seduction by a client could emanate from an unconscious expression of anger/hostility towards the counsellor. Or it could even be an attempt to equalise the power imbalance in the professional relationship.

Bates and Brodsky (1989) and Rutter (1989) mention a non-sexual value as to why women clients may comply. The therapeutic relationship becomes important in their lives and a great need for the approval of the helping professional develops. Cultural factors in women's upbringing could steer them to complying with the sexual desires of powerful men.

One can therefore see that the issue of helping professional and client sexual intimacies are fraught with different viewpoints and understandings. As much as there is desire to do so, one cannot conclude that either clients or the helping professional cause this phenomenon. However, there are ethical considerations as to who should take responsibility.

CONSEQUENCES OF SEXUAL RELATIONS IN THE THERAPEUTIC RELATIONSHIP

Clients may experience mistrust and anger towards therapists after there has been a sexual relationship (Feldman-Summers & Jones 1984). Durre cited by Pope *et al.* (1986) and Gutheil and Gabbard (1992) state that the potential for successful therapy is doomed. Bouhoutsos *et al.* (1983) found that clients were hesitant to seek further help and had an inability to trust.

The effects have been compared to those of rape, incest or child abuse (Kagel & Giebelhausen 1994). Clients feel abandoned and mistreated (Chesler 1972, cited by Feldman-Summers & Jones 1984). According to Rutter (1989), the clients will be injured due to the power situation which is inherent in the helping professional-client relationship. Clients may be too injured to find happiness and may succumb to playing the role of the victim in subsequent relationships. Durre (1980) cited by Pope *et al.* (1986) notes the detrimental effects that have been found in clients who have survived a sexually intimate experience with a helping professional. The consequences include attempted suicide, severe depression, mental hospitalisations and separation/divorce from spouses. Women report that they have been fired or have left their job due to ineffectual working habits which stem from depression, continual crying, anger and anxiety as consequence of the sexually intimate experience with their helping professional.

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Bouhoutsos *et al.* (1983) found that 90% of the clients who had engaged in a sexually intimate experience with their helping professional were "damaged". This study notes the same effects of the experience as those noted by Durre (1980 cited by Pope *et al.* 1986). Pope *et al.* (1986) refer to this response as the "therapist-patient sex syndrome", which is similar to the rape response syndrome, reaction to incest or child abuse or battering, and post-traumatic stress disorder.

Bouhoutsos *et al.* (1983) further found that the effects of the sexual intimacy were worse when the intimacy had been initiated by the helping professional. Feldman-Summers and Jones (1984) found that the impact of the intimacy was worse when the client had experienced prior sexual victimisation as this made him/her more vulnerable. Another aggravating factor was that of the helping professional being married.

Gutheil and Gabbard (1992) question the actions of the helping professional, especially if the client had been a traumatised victim. They point out that there are also helping professionals who feel exploited and question whether the actual harm comes from "cessation trauma", i.e. the negative effects of the discontinuation of the relationship and not the relationship itself. The realisation that what was once thought of as a genuinely special relationship was false and mere exploitation can be devastating to a client. Despite Gutheil and Gabbard's (1992) challenges of the typical view of the client victim, they do not subscribe to the view that sexual intimacy with the client is beneficial.

Taylor and Wagner (1976) assert that in all relationships fantasies and expectations occur, but they are often distorted. The positive and negative effect of the relationship depends on how closely the fantasy resembles reality.

As mentioned earlier, there is a persistent minority that argue in favour of the beneficial therapeutic effects of sexual intimacy, e.g. McCartney and Shepard (cited by Pope *et al.* 1986). There is a frustration with the boundaries between the helping professional and the client.

ETHICAL CONSIDERATIONS

The National Association of Social Workers' Code of Ethics states that "The social worker should under no circumstances engage in sexual activities with clients" (NASW: 5 quoted in Kagle and Giebelhausen 1994). The same opinion is expressed by the American Psychological Association and contained in the Principles of Medical Ethics (Bates & Brodsky 1989; Feldman-Summers & Jones 1984). Borys and Pope (1989) state that the Ethical Principles of Psychology require the psychologist to act in such a way as to avoid the impairment of his/her own professional judgement and to avoid increasing the risk of the exploitation of clients. Sexual intimacies with clients are therefore unethical.

Steere (1984:xii), writing in the South African context, expresses the same views for psychologists when she says the purpose of professional ethics is to "assure the public of certain basic levels of expertise and protection". The South African Council for Social Work in its code of conduct [5(b)] states that a social worker must "maintain a professional relationship with the client". This broad statement could be interpreted to mean that a sexual relationship with a client is not permissible.

In Borys and Pope's (1989) study of the beliefs and practices of helping professionals the vast majority believed that under most conditions sexual and non-sexual dual relationships were unethical. The reasons are summarised by Kagle and Giebelhausen (1994) in their assertion that the therapeutic relationship is distinctive in three ways. Firstly, clients put confidence in the helping professional who has special knowledge, expertise and authority. This results in unequal power and responsibility. Secondly, in the therapeutic context the client is vulnerable, needs help

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and is willing to share, while the helping professional has influence. Finally, there is the issue of transference and counter-transference. The therapeutic context encourages the projection of unconscious needs and repetition of significant relationships. Crossing the boundary of a therapeutic relationship will undermine its distinctive nature. Outside of the therapeutic relationship the helping professional is no longer held in check by professional values. Taylor and Wagner (1976) state that sexual contact forces roles to change and therapy ceases. They question whether a helping professional can remain professionally objective under such circumstances. Gutheil and Gabbard (1992) state that regardless of any subjective feeling of the client that sexual intimacy with the helping professional will be beneficial or not harmful, ethically it is exploitation and cannot be justified clinically.

When looking at the legal implications of sexual misconduct, one has to note the issues surrounding its criminalisation. There are a number of dilemmas that surround the criminalisation of helping professional-client sex (Deaton, Illingworth & Bursztajn 1992). The following questions have been put forward: What constitutes *consent* to a sexual relationship within a helping professional-client relationship? Is the client by definition unable to give consent, as this may be coerced or misguided? Does the client have sufficient autonomy to give consent and to engage in moral reasoning? If a client can, how will we know consent is given? How much value should be placed on consent anyway? Should consent be a defence to a criminal charge of misconduct? If yes – what does this consent look like? If no – then how long is consent not relevant for? What exactly is the helping professional-client relationship? Does it change? Does it end? If so, how will we know? What is the nature of power in the relationship? What kind of power? Can a client ever yield power? What about the rights to privacy? The right to free association? Are the consequences of criminalisation good? Will criminal penalties be a deterrent? Do they include prison? Rehabilitation? Will forced rehabilitation work? What about compensation? These questions are put forward in an attempt to respond to the phenomenon at hand. In the Unites States of America sexual intimacy between client and helping professional has been ground for legal action (Bates & Brodsky 1989; Kagle & Giebelhausen 1994).

Taylor and Wagner (1976) state that it is not enough to simply state that sexual intimacy between helping professional and clients is unethical. It is important to provide assistance in dealing with it. By acknowledging the existence of such a phenomenon one can deal with it rationally and professionally.

INTIMACY: THE "UNSPOKEN" PHENOMENON

The phenomenon of sexual intimacy in counselling is not spoken about freely - neither amongst clients nor helping professionals nor even those who educate the helping professionals. The reasons why clients do not come forward and report such incidents could include the following:

- They do not realise that the helping professional-client sexual relationship/intimacy is unethical (Berliner 1989);
- Clients are uninformed about the procedure (Kagle & Giebelhausen 1994);
- In cases of power issues, the helping professional may hold the client's future in their hands in terms of being able to influence the client's physical, psychological, spiritual, economic and intellectual well-being (Rutter 1989); and
- Clients keep quiet because of the mistrust created by the experience of sexual intimacy with the helping professional (Feldman-Summer & Jones 1984).

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The silence around the subject extends to the helping professionals as well. A number of reasons are offered for this. Schultz-Ross, Goldman and Gutheil (1992) argue that since the focus on the psychiatric dyads has lessened or has been lost, there is less emphasis on the helping professional. There has been a change in the concept of illness and the helping professional-client relationship. The change has been from a situation where both the helping professional and the client journey from a shared resolution of differences to a situation where the focus is on a disease-based model where the patient assumes the traditional role of the medically sick. This means more focus on the patient/client and less on the helping professional. The fallibility of the helping professional is less acknowledged. The feelings of the helping professional used to be important as a diagnostic tool and in shaping treatment. Now, with less emphasis on these feelings, the helping professional will not explore his/her own feelings and is more likely to act on his/her feelings without realising it. This may lead to sexual misconduct. Schultz-Ross *et al.* (1992) state that the situation is aggravated by the fact there has been a move away from understanding motives in terms of sexuality. Understanding these two issues may not necessarily prevent sexual misconduct, but may provide supervisors with warning signs.

Rutter (1989) offers another reason for the silence around the issue of sexual misconduct. He states that male helping professionals often look away from their colleagues' sexual exploitation as men all have an inner wish to engage in such behaviour. Most male helping professionals behave ethically, but see those who do not as surrogates for the rest, the rest who are hoping that it may happen to them. This leads to what Rutter (1989) terms "men's mutual conspiracy" which perpetuates the silence around sexual misconduct.

Some authors attribute the silence around the phenomenon to lack of awareness on the part of the helping professionals; lack of sufficient education and training with regard to sexual intimacies with clients; inability to deal with feelings; and lack of systematic research to get a fuller understanding on the phenomenon (Borys & Pope 1989; Kagle & Giebelhausen 1994; Pope *et al.* 1986). Pope *et al.* (1986) also mention that sexual misconduct has been taboo. This has resulted in helping professionals suppressing the natural friendliness/interest in clients and thus becoming stilted and unnatural. It has meant that helping professionals have punished clients for sexual feelings by harmfully misdiagnosing them. It has resulted in the helping professional blaming clients for their sexual feelings. The taboo on attraction has influenced the choice of client that the helping professional would be willing to take on. Attractive clients are being avoided. It has also been found that helping professionals have reacted with anxiety, guilt, embarrassment and verbal avoidance when clients discuss sexual material. Finally, the taboo around the topic has meant that research has been neglected, as no one is willing to talk about the issue.

Research has also been difficult, as clients are not freely available due to their right to confidentiality (Bouhoutsos *et al.* 1983). The research of Gutheil and Gabbard (1982) attempts to deconstruct the politically correct scenario of sexual misconduct by stating that there is a world-wide longing for simple answers. The resistance to complex and realistic analysis of the situation is reflected in the amount and type of research that has been done.

The above-mentioned factors have meant that the education that helping professionals have received about sexual attraction to clients has been lacking in substance and barely adequate (Pope *et al.* 1986).

In South Africa social workers, in both public and non-governmental welfare organisations, are facing many constraints - including the "luxury" of supervision. The complexity of attraction or

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intimacy between client and social worker is often a source of frustration for social workers, which they try and deal with on their own.

RECOMMENDATIONS

The author concurs with others who have made the following recommendations in an attempt to prevent sexual misconduct amongst helping professionals and break the silence around the phenomenon:

- It is necessary to provide undergraduates, graduates and continuing educational programmes with information around sexual attraction to clients, the risks of exploitation and the dynamics of the relationship (Kagel & Giebelhausen 1994; Pope *et al.* 1986). Training must provide students with the knowledge of professional ethics and facilitate the development of ethical judgement. Berliner (1989) states that the study of ethics must make up a significant part of the curriculum - thus meaning that it is not limited to a special lecture, but is integrated into all education and practice (Borys & Pope 1989; Pope *et al.* 1986).
- All programmes offered must be based on research-based literature – hence there is a need for more research to be initiated (Borys & Pope 1989; Pope *et al.* 1986).
- There is a need for clear institutional standards that are written, operationally defined, monitored and enforced (Borys & Pope 1989);
- Each student and helping professional must make a personal commitment to the ethics or else the code is pointless (Berliner 1989). Pope *et al.* (1986) point out that personal ethics and regard for client welfare seem to be more compelling than helping professionals' fear of negative consequences. Personal commitment should therefore be encouraged and built upon.
- Attention should be given to the subject during supervision, which will allow the helping professional to explore his/her personal responses (Kagel & Giebelhausen 1994). Educational settings in general must allow students to acknowledge, explore and discuss feelings of sexual attraction to clients (Pope *et al.* 1986);
- Discouraging helping professionals should not be done in terms of abstract sounding issues of "dual relationships" and "sexual misconduct". First-hand accounts may be useful to make the issue real (Borys & Pope 1989);
- It is imperative to provide all clients with information about their rights and to give information about complaints procedures (Kagel & Giebelhausen 1994; Pope *et al.* 1986);
- The reporting of sexual misconduct and dual relationships should be encouraged (Kagel & Giebelhausen 1994); and
- Helping professionals who have had sexual contact with their clients should be encouraged to seek help and confront the problem (Kagel & Giebelhausen 1994; Pope *et al.* 1986).

CONCLUSION

There are many issues that surround the phenomenon of the sexual misconduct of the helping professional. This appears to stem from a lack of training regarding attraction to clients. All that has been stated in general applies also to the social work profession and points to the need for supervision of practitioners. Social workers' education must also acknowledge and explore issues of attraction to clients. The attraction seems to be a prevalent phenomenon, though acting on the feelings less so. Are we as social workers equipped to deal with the feelings that we might

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experience as human beings and that we may evoke in our clients? This process starts with education and learning to be comfortable with our own sexuality and also with the sexuality of those to whom we offer our services. To be fully effective social workers we must be able to face sexual issues in others and ourselves without feeling guilty, anxious, uncomfortable or overwhelmed.

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