

THE RELATIONSHIP BETWEEN PROFESSIONAL SEXUAL BOUNDARY VIOLATION
AND SEX ADDICTION: AN EXPLORATORY STUDY OF POST-TREATMENT AND
RETROSPECTIVE PRE-TREATMENT DISPOSITIONS

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Dissertation Prepared for the Degree of
DOCTOR OF PHILOSOPHY

UNIVERSITY OF NORTH TEXAS

December 2011

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Menassa, Bret Michael. The Relationship between Professional Sexual Boundary Violation and Sex Addiction: An Exploratory Study of Post-Treatment and Retrospective Pre-Treatment Dispositions. Doctor of Philosophy (Counseling), December 2011, 275 pp., 38 tables, 18 figures, references, 218 titles.

In this exploratory study, 35 male professionals who had successfully completed residential sex addiction treatment were surveyed. Respondents' median age was 47.5, and reported ethnicities were White (89%), Asian, (9%) and Hispanic (2%). Prior to intake, 17 respondents had reportedly violated sexual boundaries with patients, clients, or staff (BV group) and 18 reportedly had not (NBV group). Respondents completed a demographic information form and two validated instruments: (a) Sexual Symptom Assessment Scale (S-SAS), measuring symptom severity of Compulsive Sexual Behavior (CSB); and (b) Boundary Violation Index (BVI), assessing frequency of risk factors for Sexual Boundary Violation (SBV).

Respondents reported a very large decrease in CSB symptom severity over time (partial $\eta^2 = .856$), change that was statistically equal for respondents in the BV and NBV groups. Furthermore, respondents reported a large decrease in SBV risk over time (partial $\eta^2 = .620$); however, the BV group reported a greater decrease in SBV risk than the NBV group (partial $\eta^2 = .221$). Reductions in both CSB symptoms and SBV risk were stable over time, up to five years post discharge. CSB symptoms and SBV risk were not correlated at retrospective pre-treatment, but for practical purposes, were moderately correlated at post treatment ($r = 0.386$, $n = 25$, $p = 0.057$). Although not significant, correlation at pre-treatment was more than twice as strong for the BV group than for the NBV group. Days of Treatment was a meaningful, although non-significant, contributor to decreases in CSB symptom severity ($\beta = -.323$). Similarly, Days of Treatment ($\beta = -.785$), Counseling ($\beta = -.303$), Recovery Support ($\beta = -.292$), and Continuing

Education ($\beta = -.259$) were meaningful, although non-significant, contributors to decrease in SBV risk. At study participation, 77.1% of respondents had reportedly retained their professional licenses, although 15.4% reported having received a new licensing board complaint. Clinical and professional implications, limitations, and areas for future research are discussed.

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ACKNOWLEDGEMENTS

This document would not have been possible without the contributions of several individuals. Thanks to Ron Arrington for taking a chance on this project, and to Si Invath and Corey Ward for their patient and detailed work. Additionally, I am grateful for the support and encouragement of my mentor, Dr. Jan Holden, who accepted the challenge of helping a beginning researcher conduct a study that quickly became much more complex than initially envisioned. Jan is one of the few people—and actually may be the only person other than myself and perhaps immediate family—who will ever read this document cover to cover. I began actually to pity her while I was writing Chapter 4! Dr. Holden’s guidance, scrupulous editorial contributions, and periodic infusions of humor and hope throughout the entire arduous process were invaluable.

I am grateful for the support of my wife, Beverly Neu Menassa, herself a mental health counselor and college educator, for her encouragement and support not only over the two years I worked on this dissertation but throughout the entire eight years I spent in graduate school. Beverly sacrificed a tremendous amount and took on an increased workload while I was in school, working only part-time. I am sure the wonderful life we have built over our 19-year marriage is due in large part to her. Likewise, I am grateful for the patience and understanding of my son, Garrett Taylor Menassa, who went two summers without our regular bike rides and trips to the swimming pool, to whom I can finally say, “I’m off the computer, now!”

Lastly, I wish to thank William Swiggart of Vanderbilt University and the Society for the Advancement of Sexual Health (SASH). Bill not only assisted me in adapting the BVI for the present context, but suggested I apply for SASH’s Student Research Grant for 2010, an award I was proud to win. SASH’s generous funding of a portion of this study is greatly appreciated.

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CHAPTER 1

INTRODUCTION

From as early as the time of the ancient Greeks, philosophers have recognized that physicians are individuals entrusted with a sacred duty: caring for the health and well-being of patients (Edelstein, Temkin, & Temkin, 1987; Moline, 1986; Suits, 2003). For example, the Hippocratic oath, commonly attributed to Hippocrates but which modern scholars now suspect was more likely authored by followers of Pythagoras, has been credited as the document that initiated and continues to inspire concepts of ethical medical practice (Edelstein, Temkin, & Temkin, 1987, Suits, 2003). Surprising though it may be to the modern reader, the 4th century B.C.E. author of the Hippocratic oath included a specific injunction against sexual contact between physician and patient. The presence of this clear prohibition in the oath suggests that some physicians have violated sexual boundaries with patients since at least classical times, a transgression that a troubling number of health professionals continue to commit more than two and a half millennia later (Federation of State Medical Boards, 2006; Gross, 2008).

The Fiduciary Relationship

Physicians are but one example of a class of persons who enter into a fiduciary relationship with persons in their care. The Hippocratic oath describes perhaps the earliest recorded conception of a fiduciary relationship; however, in modern practice, a fiduciary is typically considered to be any individual who accepts the faith and trust of other, presumably less-skilled or knowledgeable, persons (Feldman-Summers, 1989; Moline, 1986). This other person, sometimes referred to as the beneficiary, reciprocally places trust in the fiduciary to safeguard the beneficiary's health, property, money, safety, or well-being. In practical effect, then, any professional engaged for the benefit of another is assumed to be bound by a fiduciary

obligation (Black, 1990; Moline, 1986). Such professionals include but are not limited to medical, mental, and spiritual health providers; legal and other advisers; and educators (Abel, Osborn, & Warberg, 1998; Bloom, Williams, Ulwelling, & Klevit, 1999; Feldman-Summers, 1989; Gabbard, 1989).

By its very nature, the fiduciary relationship describes a condition of at least some dependence and vulnerability on the part of the beneficiary and, conversely, a position of power and influence on the part of the fiduciary (Black, 2009; Suits, 2003). These reinforcing conditions of dependence and influence contribute, ironically, to the possibility a beneficiary could be exploited by the very person approached for help (Gabbard, 1989). Therefore, implicit in the granting of the beneficiary's trust in the fiduciary is the assumption that the fiduciary is sufficiently competent to warrant it (Moline, 1986). Professional competence, when broadly conceived, can include not only the depth and variety of the professional's training and experience but also the state of the professional's personal health. For example, otherwise exceptionally qualified professionals may nevertheless find their competence compromised when in a state of physical, cognitive, or emotional impairment (Federation of State Physician Health Programs, 2005). Such impairments can place the beneficiary in jeopardy of incompetent care as surely as if he or she had sought help from an untrained amateur.

Professional Impairment

Impairment has become an increasingly frequent topic of concern among professional credentialing bodies and licensing agencies. As such, the regulating bodies of nearly all helping professions have, over the past 25 years or so, devised assessment, treatment, and disciplinary protocols to assist impaired professionals and determine when—or indeed, if—they may return to practice (Federation of State Medical Boards, 2005; Johnson, 1988; Schneldman, 1995). For

example, state medical licensing boards typically empanel a physician health program (PHP), an impaired professionals program (IPP), or another similarly named and empowered subcommittee to deal with physicians deemed too impaired to practice safely and ethically (Federation of State Physician Health Programs, 2005). Among the most common impairments addressed by PHPs and IPPs are alcohol dependence and substance addiction (Federation of State Medical Boards, 1995). Recently, however, rehabilitation specialists have begun to consider a number of behaviors as potentially addictive, as well, including gambling, eating, shopping, computer use, and perhaps most controversially, sexual activity. Consequently, the Federation of State Physician Health Programs (FSPHP) recently suggested that physicians displaying problematic degrees of such so-called addictive behaviors be, similar to their alcohol- or substance-dependent colleagues, considered impaired and potentially eligible for treatment (FSPHP, 2005).

Statement of the Problem and Study Goals

Here, then, is where the three very broad topics that have been thus far outlined—the professional fiduciary responsibility, professional impairment, and sex addiction—converge: (a) the professional’s ability to act as a loyal fiduciary, maintaining appropriate boundaries and working for only the client’s benefit, can be compromised by personal impairment; (b) such impairment, which has commonly included alcohol and substance addiction, has recently been conceived to encompass other biological and behavioral processes, including sex addiction; and (c) impairments such as these can impair the professional’s ability to set and maintain professional boundaries, putting the client at risk of incompetent—and potentially sexually exploitive—care. In other words, specialists in the field have hypothesized, instances of sexual boundary violation (SBV) in professional relationships can be conceived of as manifestations of the impairment of sex addiction, a disorder as appropriate for treatment and rehabilitation as

alcoholism or substance dependence (Blanchard, 1991, as cited in Irons & Schneider, 1994; Carnes, 1991; Celenza & Gabbard, 2003; Irons & Schneider, 1994, 1999).

Over the years, clinicians and scholars have published research and commentary on nearly every aspect of SBV, including frequency and prevalence, risk factors predicting its occurrence, deleterious victim effects, and consequences for and potential rehabilitation of transgressors. However, I found significant debate between contributors to the scholarly literature on virtually every one of these topics, including a lack of agreement on even such fundamental points as where an “appropriate” professional boundary should be set. Furthermore, I could find virtually no consensus as to the classification, diagnosis, or even the existence of “sex addiction,” a syndrome described by various terms over the decades: nymphomania, satyriasis, sexual impulsivity, hypersexuality, and, recently, compulsive sexual behavior (CSB; Coleman, 1987). In addition to this lack of consensus on such preliminary conceptual terms, I could find no empirical documentation of the effectiveness of sex addiction treatment in reducing the severity of CSB symptoms, nor could I find evidence to support the proposed link between CSB symptom severity and propensity to engage in SBV, a link that several authors heretofore have made on the basis of clinical intuition or anecdote (Birchard, 2004; Blanchard, 1991, as cited in Irons & Schneider, 1994; Celenza & Gabbard, 2003; Irons & Schneider, 1994, 1999; Laaser, 1998; Schneider, 2004).

The goals of this quantitative, exploratory study were three-fold: (a) investigate the relationship between reported CSB symptom severity and reported SBV risk; (b) measure any reported changes, both between-group and within-group, in CSB symptoms, SBV risk factors, and occupational status after satisfactory discharge from residential treatment for sex addiction; and (c) identify meaningful predictors of changes in CSB symptoms, SBV risk, and occupational

status at the time of study participation. Additionally, I explored the general personal and occupational dispositions of professionals referred to residential sex addiction treatment, both before admission and up to five years after discharge.

Definition of Terms

Sexual addiction: This term was first coined in 1976 by Patrick Carnes (1992) and entered the professional lexicon in 1983 with the publication of his book, *The Sexual Addiction*. For the purposes of this study, “sexual addiction” refers to a pattern of pathological, self-destructive, and ostensibly uncontrollable sexual behaviors (Carnes, 1992). Despite the fact that the terms “sexual addiction” and “sex addiction” appear interchangeably in the literature, in this document the terms “sex addiction” and “sex addict” are used rather than “sexual addiction” or “sexual addict,” except when directly quoting others who used the latter terminology. This determination was made because, for the purposes of this study, I believe that the term “sex addiction” is more grammatically consistent with the terminology of other addictive disorders, such as alcohol addiction, cocaine addiction, heroin addiction, gambling addiction, and internet addiction, among others.

Compulsive sexual behavior (CSB): The term CSB was coined by Eli Coleman (1987) to describe symptoms and behaviors he believed were consistent with Carnes’s (1992) conception of sex addiction. However, Coleman conceptualized these symptoms as being more closely related to symptoms of neurotic compulsion rather than substance dependence, and therefore proposed that the disorder was more properly conceived as part of the obsessive-compulsive spectrum of disorders. For the purposes of this study, the terms sex addiction and compulsive sexual behavior are used interchangeably.

Sexual boundary violation (SBV): In this study, the term SBV refers to actions, gestures,

or comments by a professional in a fiduciary relationship that are seductive, sexually suggestive, or sexually demeaning to the individual seeking the professional's care, advice, support, or assistance. Such actions or gestures include any physical contact between the fiduciary and the beneficiary that is sexual or may reasonably be interpreted as sexual, regardless of whether such contact is consented to or initiated by the beneficiary.

Fiduciary relationship: For the purposes of this study, the term fiduciary relationship is used to describe a relationship between two or more individuals, sometimes referred to as the fiduciary and the beneficiary(ies), in which the fiduciary agrees, either tacitly or implicitly, to represent faithfully the best interests of the beneficiary(ies) in the performance of a service. The beneficiary(ies), reciprocally, trusts the fiduciary to perform such services in good faith and without prejudice or malice.

Professional: In this study, the term professional refers to any person who enters into a fiduciary relationship with a beneficiary, including but not limited to physicians, dentists, nurses, pharmacists, psychotherapists, pastors, attorneys, and educators.

Post-treatment: For the purposes of this study, the term "post-treatment" will refer to the experiences reported by respondents at the time of their participation in the study, i.e., between February 15, 2011 and March 30, 2011, inclusive. As study participants had discharged from residential treatment at the designated facility at least one year, and up to as many as five years, prior to study participation, the term post-treatment does not reflect respondents' experiences upon their immediate discharge from residential treatment. Therefore, none of the data collected can be used to infer the effectiveness of the residential treatment per se. Comparisons of so-called "post-treatment" and "retrospective pre-treatment" experiences can be used only to infer respondents' perceptions of their personal growth from one time period to another.

Retrospective pre-treatment: For the purposes of this study, the term “retrospective pre-treatment” or alternately, simply “pre-treatment,” refers to respondents’ recollections of their experiences in the six months or so before their compulsive sexual behavior became known by other, significant persons in their lives. Respondents to this study were not assessed either prior to or at the actual time they presented for residential treatment; therefore, respondents’ recollections of their pre-treatment experiences in the several months prior to treatment cannot be used to infer the effectiveness of the residential treatment per se. Comparisons of so-called “post-treatment” and “pre-treatment” experiences can be used only to infer respondents’ perceptions of their own personal growth from one time period to another.

Study Parameters

To conduct this study, I obtained a de-identified data set of all patients who discharged from residential treatment in the impaired professionals program at a private, residential addictions treatment facility in the south-central United States during the study window, i.e., the the period between January 1, 2005 and December 31, 2009, inclusive. This de-identified data was categorized into two groups: professionals who satisfactorily completed residential treatment and those who did not. Additionally, these two groups were further categorized by their primary presenting problem: alcohol dependence, substance dependence, sex addiction, compulsive gambling, and disordered eating. From this information, I tabulated descriptive data on all the patients treated in the impaired professionals program during the study window; however, only professionals who satisfactorily completed residential treatment for sex addiction during the study window were considered eligible to participate. This initial pool of potential respondents was divided into two groups: (a) professionals who reportedly violated sexual boundaries with patients, clients, or staff (BV group); and (b) those who reportedly did not (NBV group). Finally,

these two groups were subdivided into categories based on the year of their discharge from residential treatment. Individuals from the sample pool who agreed to participate in the study completed a demographic information form of my own construction and two validated instruments, one measuring CSB symptom severity and another assessing frequency of reported risk factors for SBV.

The Sexual Symptoms Assessment Survey (S-SAS; Raymond, Lloyd, Miner, & Kim, 2007) was used to assess the severity of CSB symptomatology. The Boundary Violation Index (BVI; Swiggart, Feurer, Samenow, Delmonico, & Spickard, 2008) was used to assess for the presence of risk factors associated with SBV. The demographic form was constructed to collect data on: (a) respondents' occupational status, including type of work performed, status of professional license, annual income, and changes in overall job status and satisfaction; and (b) participation in post-discharge treatment, medication, counseling, psychotherapy, or recovery support. The study questionnaire was constructed such that participants completed both of the assessment instruments and certain demographic items twice: each in the context of a specific period in their lives. First, respondents completed the S-SAS, the BVI, and the demographic information form while considering their thoughts, feelings, behaviors, and occupation status at the time of study participation. Then, respondents completed the same items while considering their thoughts, feelings, behaviors, and occupation status "in the six months or so before other, significant people in your life became aware of your compulsive sexual behavior." Responses to items made in this latter context were construed as a retrospective, "pre-treatment" score, subject to the limitations specified later in this document.

Research Questions

A total of ten research questions were tested. A detailed exploration of the questions

themselves and a discussion of the various statistical tools used to analyze the data is provided in Chapter 3 of this document. However, so that the reader has a preliminary understanding of the direction of this study, the ten questions are listed here.

1. Among all professionals who presented for residential treatment at the designated facility, does treatment type, i.e., sex addiction treatment or other addiction treatment, predict discharge status, i.e., satisfactory/completed or unsatisfactory/not completed?
2. Among all professionals discharged from residential sex addiction treatment, does offender group, i.e., sexual boundary violator or non-violator, predict discharge status, i.e., satisfactory/completed or unsatisfactory/not completed?
3. Among respondents satisfactorily discharged from residential sex addiction treatment, how are reported CSB symptoms related to reported SBV risk both at post-treatment, i.e., at-time-of-study-participation, and at retrospective pre-treatment?
4. Among respondents satisfactorily discharged from residential sex addiction treatment, do sexual boundary violators and non-violators differ in CSB symptom severity reported at post-treatment, i.e., at time of study participation, when compared to recollections of their pre-treatment CSB symptom severity?
5. Among respondents satisfactorily discharged from residential sex addiction treatment, do sexual boundary violators and non-violators differ in frequency of SBV risk factors reported at post-treatment, i.e., the time of study participation, when compared to recollections of their pre-treatment SBV risk factor frequency?
6. Among respondents satisfactorily discharged from residential sex addiction treatment, do sexual boundary violators and non-violators differ in the reported status of their professional licenses at the time of study participation?

7. Among respondents satisfactorily discharged from residential sex addiction treatment, what are meaningful predictors of change in CSB symptom severity, controlling for passage of time and degree of intake pathology?
8. Among respondents satisfactorily discharged from residential sex addiction treatment, what are meaningful predictors of change in SBV risk factor frequency, controlling for passage of time and degree of intake pathology?
9. Among respondents satisfactorily discharged from residential sex addiction treatment, do decreases in reported CSB symptom severity predict reported professional license status at time of study participation?
10. Among respondents satisfactorily discharged from residential sex addiction treatment, do decreases in reported SBV risk predict reported professional license status at time of study participation?

Additionally, the study was used to investigate demographic and descriptive data on participants' occupational status at time of study participation, and their perception of changes in both job status and satisfaction compared to the jobs they had prior to presenting for treatment. Finally, the study questionnaire was used to collect data detailing respondents' participation in post-discharge treatment, therapy, and/or ongoing recovery support.

Summary

In this chapter, I have endeavored to introduce briefly three core topics: the fiduciary relationship, professional sexual boundary violation, and sex addiction. Additionally, I have outlined in broad strokes the terms, rationale, goals, and methodology of the present study. However, the topics prefaced thus far are complex and have generated significant discussion and debate among theorists, academicians, and clinicians. Before proceeding, then, it may be helpful

to review some of the extensive scholarly literature relevant to professional boundary theory, sex addiction, and sexual boundary violation in professional relationships.

CHAPTER 2

REVIEW OF RELATED LITERATURE

Despite the wide consensus among clinicians, commentators, and theorists that Sexual boundary violation (SBV) in professional relationships causes serious and lasting harm to clients seeking help, SBV remains an enduring and prevalent problem second only to wrongful death or suicide as the leading cause of malpractice complaints (Norris, Gutheil, & Strasburger, 2003). Far from being limited to the inexperienced or naive practitioner, violations of sexual boundaries have been perpetrated upon clients by some of the most respected and prominent professionals in their respective field (Gabbard, 1996).

Several writers have suggested a link between sex addiction and the incidence of boundary violations (Birchard, 2004; Blanchard, 1991, as cited in Irons & Schneider, 1994; Irons & Schneider, 1994, 1999; Laaser, 1998) and that sex addiction is a form of impairment similar to alcohol and substance dependence for which a professional may be successfully treated (Carnes, 1992; Celenza & Gabbard, 2003; Gabbard, 1999; Schneider, 1989, 2004; Weiss, 2004). Other writers, however, have considered SBV as more accurately comparable to acts of rape or incest (Pope, 1990), sexual offending (Abel, Osborn, & Warberg, 1998; Simon, 1999), and childhood sexual abuse (Penfold, 1998); still others have conceptualized it as a social policy dilemma (Strasburger, 1999) and as a violation of the public trust (Federation of State Medical Boards, 2006). Perhaps the most forceful condemnation of SBV came from pioneering sex researchers William Masters and Virginia Johnson, who opined that “when sexual seduction of patients can be firmly established by due legal process... the therapist should be sued for rape rather than for malpractice, i.e., the legal process should be criminal rather than civil” (Masters & Johnson, 1976, as cited in Penfold, 1998, p. iv).

To better understand the complex phenomena of SBV in professional relationships, then, it may be useful to first explore the nature of the professional relationship and the role of boundaries within it, the controversial addiction-model of problematic sexual behavior, and the phenomenon of and risk factors predicting SBV. Toward that end, this literature review will be divided into three major subsections: (a) professional boundary theory; (b) the “impairment” of sex addiction; and (c) boundary violation in professional relationships.

Professional Boundary Theory

A professional boundary may most “parsimoniously be defined as the ‘edge’ of appropriate [professional] behavior” (Gutheil & Gabbard, 1998, p. 410). It is “the demarcation between the self and the object... the envelope within which treatment takes place” (Gabbard & Lester, 1995, as cited in Glass, 2003). One may rightly wonder how and when the concept of professional boundaries came to be part of the professional relationship.

The Hippocratic Oath and the Fiduciary Relationship

From the time of Hippocrates in the 4th century B.C.E., it has been recognized that physicians are individuals in whom a special privilege has been entrusted and from whom a unique duty is expected (Edelstein, Temkin, & Temkin, 1987). With the physician’s elite training came the responsibility to uphold a certain level of ethical conduct, perhaps most famously codified in the oath commonly attributed to Hippocrates. Although its true authorship may never be known, the Hippocratic oath (see Appendix A) remains the treatise that inspired and continues to inform modern, ethical, medical practice (Edelstein, Temkin, & Temkin, 1987; Moline, 1986; Suits, 2003). Despite the fact that the often misquoted phrase, “First, do no harm” is not actually found in the oath, the prescriptions that one does find in the document remain instructive to physicians today (Sharpe, 1997; Suits, 2003). For example, within this covenant is perhaps the

first enunciation of the concepts that came to define the fiduciary obligation: the healer's duty, among others, to beneficence, nonmaleficence, confidentiality, and patient autonomy (Edelstein, Temkin, & Temkin, 1987; Rybak, 2009; Sharpe, 1997; Suits, 2003).

Beneficence, nonmaleficence, and autonomy. The Hippocratic oath is infused with statements concerning the physician's duty to administer only those remedies that promote the health and well-being of patients and to scrupulously avoid causing harm (Beauchamp & Childress, 1979, as cited in Sharpe, 1997). This duty includes not only judiciously selecting and prescribing dietetic remedies but also refusing to administer deadly drugs, even if requested, to the patient or to the patient's unborn child. Ethicists have cited these latter prohibitions as evidence that the seemingly modern ethical dilemmas of physician-assisted suicide and abortion have existed since at least classical times (Suits, 2003). Additionally, to practice fully the duties of beneficence and nonmaleficence, physicians must remain keenly aware of the limits of their competence. For example, a doctor in Hippocrates's time was forbidden to perform surgery, even upon those in acute pain from kidney or gall stones, but to defer to those specially trained in the procedure. This restriction has been cited as evidence that the field of urology may have been the first medical specialty (Herr, 2008).

Furthermore, the Hippocratic oath is perhaps the earliest pronouncement of the physician's duty to respect the autonomy and confidentiality of the patient and the first iteration of the concept of boundaries in the doctor/patient relationship (Rybak, 2009). For example, adherents to the oath were enjoined to keep private any personal information obtained about the patient during the course of treatment, "holding such things to be holy secrets" (attr. to Hippocrates, as cited in Moline, 1986, p. 506). Furthermore, and of particular interest regarding the present study, is the perhaps surprisingly prescient Hippocratic injunction that

whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons [emphasis added], be they free or slaves. (attr. to Hippocrates, as cited in Edelstein, Temkin, & Temkin, 1987, p. 6)

Not only does this portion of the oath demand that physicians respect the basic humanity of all persons, regardless of gender or social class, but also that they maintain a relationship with patients, and indeed with all people in the household, that was strictly professional. In other words, physicians were to establish and adhere to boundaries in the professional relationship and not to exploit for personal gratification the position of power and influence that accompanied advanced medical training (Sharpe, 1997; Suits, 2003).

The fiduciary relationship. The relationship between physician and patient as described in the Hippocratic Oath can be said to be similar to a concept that originated in contemporaneous Roman law, the fiduciary relationship (Black, 1990). The root of the word fiduciary is the Latin *fide*, meaning faithfulness, allegiance, and loyalty; therefore, a fiduciary is an individual engaged to represent faithfully the interests of another. This other person, sometimes referred to as the beneficiary, reciprocally places trust in the fiduciary to safeguard the person's health, property, money, safety, or well-being. The fiduciary relationship, then, is a relationship

...of such a character that each must repose trust and confidence in the other and must exercise a corresponding degree of fairness and good faith. Out of such a relation, the law raises the rule that neither party may exert influence or pressure upon the other, take selfish advantage of his [*sic*] trust, or deal... in such a way as to benefit himself [*sic*] or prejudice the other except in the exercise of the utmost good faith and with the full knowledge and consent of that other.... (Black, 1990, p. 625)

Although the core principles of the fiduciary relationship may have been first enunciated by classical ethicists in the medical profession (Sharpe, 1997; Suits, 2003), in modern practice, a fiduciary can be conceived of as any individual who accepts the faith and trust of another, presumably less-skilled or knowledgeable, person. In practical effect, then, any professional

engaged for the benefit of another is commonly considered to be bound by a fiduciary obligation. Such professionals include but are not limited to medical, mental, and spiritual health providers; legal and other advisers; and educators (Bloom et al., 1999; Feldman-Summers, 1989; Moline, 1982; Plante & Aldridge, 2005; Plante & Nugent, 1999).

The Role of Boundaries in Fiduciary Relationships

Professionals in fiduciary relationships set and maintain boundaries with clients to promote a trusting, working alliance that exists solely for the client's benefit (Simon, 1992). Rather than creating walls between professional and client, appropriate boundaries define a fluctuating, reasonably neutral, safe space that enables the helping professional to best serve the client's interests and fulfill the fiduciary duty (Simon, 2001). When professional boundaries become blurred or are violated, not only can the professional's neutrality become compromised but the client's safety, health, and well-being can suffer.

Setting and appropriate professional boundary. A precise definition of appropriate professional boundaries remains elusive, a difficulty complicated by a number of varying factors: the type of help being provided, the status of the working alliance, and various personal characteristics of both the professional and the client (Simon, 1992). For example, the boundaries observed by a urologist or obstetrician would likely be different than those maintained by a dentist or nurse. The boundaries set between a teacher and a student would likely differ from those between a psychotherapist and a client. However, even within a specific profession like psychotherapy, experts have expressed theoretically-based disagreements on the placement, rigidity, and permeability of professional boundaries (Blatt, 2001; Williams, 1997). Other commentators have suggested that appropriate boundary setting also depends on culture (Kroll, 2001) and professional context (Gutheil & Gabbard, 1998). For example, in the culture of the

health care professions, most physicians expect their patients to address them by their surname preceded by the title “Doctor” (Farber, Novack, Silverstein, Davis, Weiner, & Boyer, 2000). The patient who refers to a doctor by first name is typically thought to have crossed a culturally-defined boundary, whereas the client of an attorney or counselor likely would not.

Regardless of profession, appropriately placed and observed boundaries serve to maintain the professional’s neutrality, foster the individuality and autonomy of the client, protect the client’s confidentiality, and create a consistent, private, professional setting with clearly delineated roles for both client and professional (Simon, 1992). Some boundaries can be concrete and overtly stated, such as those that address specific parameters of the appointment: time, place, length, duration, and cost. Other boundaries can be abstract and tacitly or subtly expressed, such as those that concern the nature of the relationship: appropriate attire, language, self-disclosure, and social or physical contact (Clipson, 2005). Helping professionals, whether they be doctors, lawyers, nurses, dentists, psychologists, counselors, social workers, or even teachers and clergy, generally agree that appropriate adherence to and understanding of professional boundaries is essential to providing competent service to those seeking their help (Abel, Osborn, & Warberg, 1998; Clipson, 2005; Moline, 1982; Plaut, 1997).

Furthermore, professional boundaries are maintained not only with current patients and clients, but also with the friends, family members, and/or any other person involved in the patient’s care, well-being, or decision-making (Federation of State Medical Boards, 2006). Many authorities have insisted that the boundaries of the professional relationship endure even after termination of the professional relationship, although considerable controversy on this point remains (Applebaum & Jorgenson, 1991; Crausman, 2004; Johnson, 2006a; Lazarus, 1995; Shavit & Bucky, 2004). Other writers have suggested that boundaries, in addition to demarcating

the relationship between professional and client, also define appropriate interaction between professionals and their subordinates, students, and staff (Spickard, Swiggart, Manley, & Dodd, 2002; Swiggart, Feurer, Samenow, Delmonico, & Spickard, 2008).

Confusion about professional boundaries. Professionals likely remain somewhat unclear in their understanding and application of boundary theory because it has typically been an area of insufficient training and education in preparatory programs (Hamilton & Spruill, 1999; Housman & Stake, 1999; Kay & Roman, 1999; Swiggart, Starr, & Finlayson, 2002; White, 2003).

However, professionals are likely not alone in their confusion, as clients, too, may be unsure of how to relate with their helping professional (Cooper & Jenkins, 2008; Farber et al., 2000).

Perhaps such client confusion is exacerbated by the typical—and frequently unrealistic—representation of helping professionals in popular media (Gharaibeh, 2005).

In a recent study, Gharaibeh (2005) reviewed 106 motion pictures featuring or portraying psychotherapists. Despite the author's judgment that the therapists were portrayed as generally friendly in 63.6% of the films, Gharaibeh (2005) found that 44.9% of films portrayed some sort of therapeutic boundary violation, of which nearly 25% were sexual in nature. Ultimately, Gharaibeh (2005) concluded that the practices depicted in nearly half of the films would constitute professional incompetence if they had occurred in an actual session. Gharaibeh's (2005) findings likely do not constitute a new phenomenon, as, some 20 years earlier, Gabbard and Gabbard (1985) investigated portrayals of psychiatrists in motion pictures and similarly discovered frequent depictions of mishandled transference and countertransference reactions.

Perhaps the effects of fictional depictions such as these are reflected in physicians' actual experiences with patients. Farber, Novack, Silverstein, Davis, Weiner, and Boyer (2000) surveyed 375 physicians and found that, in the preceding 12 months, 89% of respondents

reported treating patients who transgressed professional boundaries with them in some way. Of the doctors surveyed, nearly 75% stated that one or more patients had addressed them by first name. Forty-three percent of the physicians reported experiencing verbal abuse from patients, 39% stated they were asked personal questions about themselves by patients, 31% reported treating patients that they experienced as being “overly affectionate” toward them, and 27% claimed they some of their patients had attempted to socialize with them outside the office (Farber et al., 2000). Serious transgressions of professional boundaries by patients, such as using inappropriate sexual language with physicians (10%), engaging in physical assaults on the physician (4%), and initiating sexual contact with the physician (2%), were reportedly relatively rare but were not unheard of (Farber et al., 2000). Female physicians were at least twice as likely to report treating overly affectionate patients (46% vs. 23%), or experiencing inappropriate sexual comments (17% vs. 8%) from and sexual contact (3% vs. 1%) by patients than were their male counterparts (Farber et al., 2000).

Resistance to professional boundaries. Despite the broad agreement as to the necessity and utility of consistently maintained professional boundaries, some practitioners resist a rigid adherence to them (Combs & Freedman, 2002; Kroll, 2001; Siegel, 1986). In his book *Love, Medicine, and Miracles*, Bernie Siegel challenged his fellow physicians to think beyond the traditional boundaries between doctor and patient and to embrace more fully the healing power of warmth, caring, and genuineness in their medical practice. Other helping professionals, especially those in the field of psychotherapy, have agreed with Siegel (1986). Combs and Freedman (2002) suggested that rigid adherence to boundaries, despite their utility in promoting client safety and autonomy, could actually stifle a client’s self-exploration and personal enrichment. In fact, the authors wrote, “hierarchically enforced rules about boundaries make us

vulnerable to frivolous or misguided lawsuits, and this vulnerability makes it hard to be vulnerable in our therapeutic relationships” (Combs & Freedman, 2002, p. 207). Rather than attempting to determine where appropriate boundaries must be set and enforced, the authors suggested that professionals orient themselves in their professional relationships “through asking, ‘What sort of relationship does this situation call for?’ and, ‘What are the effects of my actions on this relationship and its members?’” (Combs & Freedman, 2002, p. 205).

Kroll (2001) suggested that the renewed emphasis on boundary theory in professional literature throughout the 1990s was a reactionary backlash, particularly by members of the psychoanalytic community, to the boundary experimentation that occurred in some of the humanistic psychotherapies popular in the 1960s and 1970s. Others writers proposed that not only are boundary crossings inevitable in professional relationships but that some are actually beneficial to the client or patient if handled appropriately (Barnett, Lazarus, & Vasquez, 2007; Combs & Freedman, 2002; Lazarus, 1995). Ironically, Gutheil (1992a, 1992b, 1998, 1999; Gutheil & Gabbard, 1992, 1998) and Gabbard (1994, 1995, 1996, 1999), two of the more prolific contributors to the literature of professional boundaries and who, along with Simon (1992, 1999, 2001), have seemed to be the authors most commonly cited by opponents of boundary theory, frequently acknowledged as much, clearly stating that some boundary crossings are beneficial and even therapeutically necessary.

Boundary Crossing Versus Boundary Violation

Gabbard (2001) and Gutheil (2006) have suggested that most of their critics’ resistance to boundary theory is based upon their erroneous assumption that any deviation from professional protocol leads inevitably to sexual misconduct. This assumption, Gutheil and Gabbard (1998) stated, likely stems from a cursory or selective reading of their opinions that has tended to

overlook the distinction made between boundary crossing and boundary violation (Gutheil & Gabbard, 1998).

A boundary crossing, in Gutheil and Gabbard's (1998) conception, is a benign deviation from professional protocol that is likely the byproduct of the basic humanness of the helping professional and the client. Boundary crossings can be beneficial when they occur solely for the client's benefit and when they remain transparent and discussable (Gutheil & Gabbard, 1998). Most boundary crossings are not problematic and can include, for example, calling a patient before or after a surgical procedure, suggesting a lower fee in cases of financial hardship, allowing sessions to run over when necessary, and accepting small gifts from clients.

In fact, Gutheil and Gabbard (1998) have posited that not crossing a professional boundary when appropriate could lead to a rupture in the relationship, an interruption in care, and potentially to client harm. Other commentators have tended to agree, stating that appropriate boundary crossings serve to fulfill the "culturally expected human dimension" of the professional relationship (Glass, 2003, p. 434). Clipson (2005) concurred, writing that "it would be a mistake to assume... that all boundary crossings are inevitably bad... one could argue that [some crossings] are necessary in order for the therapeutic alliance to be maintained" (Clipson, 2005, p 192).

A boundary violation, conversely, is clearly harmful to and perhaps even exploitive of the client (Gutheil & Gabbard, 1998). Boundary violations, rather than occurring for the benefit of the client, usually address some financial, political, emotional, or physical need of the professional. A boundary violation can usually be discerned from a boundary crossing by its opaqueness rather than its transparency and by the professional's likely resistance to discuss it with the client or with supervisors and colleagues. Professionals who violate boundaries can

cause various forms of harm, ranging from merely wasting clients' time and money to victimizing them outright (Gutheil & Gabbard, 1998).

Building upon Gutheil and Gabbard (1998), Glass (2003) constructed an elegant Venn diagram to illustrate his conception of the relationship between boundary crossings, boundary violations, ethical practice, and malpractice. Rather than Gutheil and Gabbard's (1998) dichotomous conception of "crossings are beneficial" and "violations are harmful," Glass (2003) suggested that both crossings and violations could fall within the realms of either ethical practice or malpractice. However, the author conceded that crossings were more likely to be ethical than were violations and that violations were more likely to fall into the "gray area" than into the realm of ethical practice (Glass, 2003).

For example, Glass theorized that otherwise benign boundary crossings can fall into the realm of unethical practice when they "become so profuse, prolonged, unquestioned, and unconnected to any obvious therapeutic intent that, in the aggregate, they... verge on malpractice" (Glass, 2003, p. 436). Conversely, boundary violations can fall into the "gray area" between ethical practice and malpractice when the professional commits them either with therapeutic intent or without obvious maleficence. For instance, Glass (2003) wrote that client consent is generally not required when publishing or presenting the findings of a specific case as long as the identity of the client is adequately disguised. However, clients who become aware of such publications or presentations may be bothered or offended to find themselves "talked about," even obliquely. This type of conscientious boundary violation falls into the "gray area" between ethical practice and malpractice because, although such discussions serve the interest of the therapist, they are generally not exploitive of the client (Glass, 2003).

Glass also introduced the idea of "pseudo boundary violations," breaches of

confidentiality and client autonomy that, despite their sometimes therapeutic necessity, may be experienced as a violation by the client. Such “pseudo violations” include so-called “Tarasoff warnings,” mandated reporting of child welfare, and involuntary hospitalization or medication when legally authorized (Glass, 2003). Finally, Glass (2003) spent considerable time commenting on the “slippery slopes” that he posited might unwittingly lead a practitioner from ethical practice toward a “gray area” or from a “gray area” to outright malpractice.

The “Slippery-Slope” from Crossing to Violation

The proposition that a “slippery slope” exists between boundary crossings and subsequent boundary violations is certainly not new. Holroyd and Brodsky (1980) conducted one early study of psychologists, the results of which suggested that sexual intercourse with clients was typically preceded by an escalation of behaviors that began with subtle, non-sexual boundary crossings. For example, Holroyd and Brodsky (1980) found that the incidence of sexual intercourse between patient and psychologist was highest among the 50% of practitioners who stated that non-erotic touching could be beneficial for clients, even if only occasionally. Additionally, the authors found that the risk of sexual intercourse was greatest among heterosexual male psychologists who reported that they engaged in such non-erotic contact with female clients more often than with male clients (Holroyd & Brodsky, 1980). Other commentators have also observed that SBV is typically the final consequence of a series of other, less egregious boundary crossings (Gabbard, 1994; Gutheil & Gabbard, 1998; Simon, 1992). In fact, Beecher (2005) likened the “slippery slope” to a “grooming sequence,” a term typically used to describe the gradual seduction of vulnerable persons in cases of sexual abuse.

Typical trajectory of the slope. Simon (1999) wrote that, except in instances where a client is raped, “the road to therapist-patient sex is paved with progressive treatment boundary

violations... [that are] ...remarkably predictable” (pg. 31). Simon (1999) noted a typical progression: (a) gradual erosion of the professional’s neutrality, (b) boundary violations begin to occur after a session but before the client has left the office, (c) professional visits become opportunities for socialization with the client, (d) particular patients/clients begin to be treated as “special,” (e) confidential information about other patients is disclosed, (f) the professional engages in self-disclosure not directly related to client growth, (h) non-sexual physical contact begins, (i) professional visits become extended in time or scheduled for the end of the day, (j) personal contact outside of the professional setting occurs, (k) the professional stops billing the client, (l) a dating relationship begins, and (m) sexual contact occurs (Simon, 1999).

A number of critics have objected to the conception of a “slippery-slope” between boundary crossing and violation primarily because they have seemed to assume that any incursion onto “the slope” would lead inevitably to SBV (Barnett, Lazarus, Vasquez, Moorehead-Slaughter, & Johnson, 2007); Combs & Freedman, 2002; Glass, 2003; Kroll, 2001; Lazarus, 2005). Glass (2003, p. 435) wrote that boundary crossings “could be experienced as intrusive or seductive and could become a step down the ‘slippery slope’, but are not intrinsically so.” Similarly, Barnett et al. (2007, p. 403) stated that, in some situations, crossing boundaries “may be considered clinically relevant and appropriate. In fact, to not cross some boundaries might be seen as inimical to the goals of the... relationship.” The authors went on to propose several rules-of-thumb to help the clinician determine whether a particular boundary crossing is more likely to be either therapeutic or problematic (Barnett et al., 2007).

A delicate balance. Among most commentators, then, a consensus seems to have emerged that the “slippery slope,” rather than being a path upon which the professional must never step, describes a continuum of attitudes and behaviors that has only the potential to lead to

boundary violations if the professional remains unaware of it. Glass (2003) is but one commentator of many who has suggested that the professional must balance a general adherence to professional boundaries with an ability to appropriately but infrequently cross them when deemed to be in the best interest of clients. Noted psychotherapist Irvin Yalom (2001) highlighted his own attempts to resolve this conflict by titling two successive essays in a recent book “Don’t Be Afraid of Touching Your Patient” (Yalom, 2001, p. 187) and “Never Be Sexual with Patients” (Yalom, 2001, p. 191).

Similarly, Gerstein (2004) has written of her personal dilemmas surrounding the appropriateness of physical contact with, particularly the hugging of, clients. For much of her career as a counselor and psychotherapist specializing in eating disorders, Gerstein (2004) considered hugging to be a technique used mainly by inexperienced clinicians who could not express in words their therapeutic warmth and care. Gerstein’s opinion has since evolved such that she is now more open to the idea of hugs in therapy but that she remains scrupulously cognizant of the ramifications of the act on the client, the counselor, and the professional relationship.

Clipson (2005) has suggested that professionals must gingerly traverse the professional boundary like a performer on a high-wire, allowing for a warm, empathic, and appropriately physical relationship with clients to emerge organically while simultaneously remaining aware of their own potentially problematic needs in the process. Minor deviations in boundary adherence inevitably occur during this process because the professional, like the tightrope walker, must first “begin to lose his [*sic*] balance before the central nervous system can compensate and allow a return to [equilibrium]” (Clipson, 2005, p. 192). Most writers agree that it is more important for professionals to be aware of minor boundary incursions when they occur and either to correct

them or use them therapeutically than to become obsessed with never committing them at all. Ultimately, then, professionals must use their own judgment when setting and maintaining boundaries, a task requiring them to “rely on internal monitoring, a form of scrutiny that will always be imperfect” (Gabbard, 1996, pg. 316).

Curiously, most professionals do not receive sufficient training or guidance in this area of ethical decision-making (Hamilton & Spruill, 1999; Housman & Stake, 1999; Kay & Roman, 1999; Swiggart & Starr, 2002; White, 2003). As such, even a reasonably well-adjusted professional’s emotional needs and personal conflicts are, from time to time, likely to interfere with boundary-setting judgment, a situation that led Clipson (2005) to devise a number of useful “decision-trees” to help the practitioner navigate this often confusing internal terrain. One may wonder, however, that if even relatively healthy individuals can have difficulty setting and maintaining appropriate boundaries, how much more problematic can this task be for the impaired professional?

Personal Impairment and Fiduciary Duty

Implicit in the fiduciary relationship is the assumption that the professional is sufficiently competent to warrant the client’s trust (Moline, 1986). State licensing boards attest to the professional’s competence when issuing a professional license. Credentialing bodies such as the American Medical Association (AMA), the American Bar Association (ABA), the American Nurses Association (ANA), and the American Counseling Association (ACA) do much the same when they confer membership to applicants. The author of the Hippocratic oath suggested that the professional’s training and experience affected professional competence (Herr, 2008); however, such competence can vary over time, either increasing with continued training and experience or decreasing due to illness or impairment (Federation of State Physician Health

Programs, 2008). Impairment, then, can negatively affect the professional's competence to practice, which can in turn hamper the ability to faithfully serve and safeguard the client's health and well-being.

Although formal efforts to deal with physician impairment have existed in the United States since 1958, state licensing boards have typically treated alcohol and substance dependence among doctors as a disciplinary issue rather than as an illness (Federation of State Physician Health Programs, 2010). Beginning in the late-1950s and continuing into the early-1970s, professional organizations such as the Federation of State Medical Boards (FSMB) encouraged state licensing boards to create Impaired Professionals Programs (IPPs), subcommittees charged with assisting ill or impaired doctors. The FSMB and other similar groups suggested that an IPP—or, as more commonly referred to now, a Physician Health Program (PHP)—would be better suited than a purely disciplinary committee to balance the licensing board's competing duties of ensuring public safety and protecting doctors' right to due process (FSMB, 1995; FSPHP, 2005). However, the consensus of medical regulatory opinion did not turn from enforcement to rehabilitation until 1974 when the AMA published its watershed policy paper *The Sick Physician: Impairment by Psychiatric Disorders, Including Alcoholism and Drug Dependence* (AMA, 1974, as cited by FSPHP, 2010). By 1980, nearly 95% of U.S. medical boards had established IPPs or PHPs, although there was a distinct and problematic lack of standardization in these programs from state to state (FSPHP, 2010).

The Federation of State Medical Boards (FSMB), founded in 1912, is a national, non-profit, professional organization that represents members of the 70 medical boards of the United States and its territories (FSMB, 2010). In 1993, the FSMB commissioned a task force to investigate physician impairment and to provide recommendations to the medical boards of

individual states. The result of this two-year project was the Report of the Ad Hoc Committee on Physician Impairment (FSMB, 1995). The committee was charged with: (a) developing a model Impaired Physician Program (IPP); (b) initiating dialog between the FSMB, the AMA, individual state medical boards, and the general public on the subject of physician impairment; and (c) pursuing federal and state legislative actions that could provide authorities with additional enforcement power over the treatment and supervision of impaired professionals (FSMB, 1995).

The FSMB (1995) defined physician impairment as “the inability... to practice medicine with reasonable skill and safety by reason of: (a) mental illness; (b) physical illness...; (c) habitual or excessive use or abuse of: (d) ...controlled substances; (e) alcohol; or (f) other substances that impair ability” (FSMB, 1995, Section IV, paragraph 1). After much internal debate on which forms of physician impairment to address at length in their report, the committee chose to focus their attention upon alcohol and chemical dependency, citing the widespread prevalence of this form of impairment (FSMB, 1995). However, observing that alcohol and substance dependence were not the only impairments to which physicians were susceptible, the task force stated that similar reports on other illnesses and impairments would be forthcoming. Particularly germane to the topic of this dissertation, the committee declared that a separate report on SBV would be commissioned in the future. This document (FSMB, 2006), published 11 years after the ad hoc committee’s 1995 report, is discussed in more detail later in this chapter.

Perhaps responding to the FSMB’s opinions, state medical boards gradually improved and attempted to better standardize their approaches to physician impairment. Soon, however, members of PHPs and IPPs, despite operating under the authority of the state medical board, found that their roles and duties were, although frequently complementary to those of the board,

not identical. For example, a state's licensing board has the authority to discipline a professional by restricting or denying the right to practice; a PHP, by contrast, is typically a non-disciplinary body that supervises the rehabilitation of referred licensees. Once treatment is deemed successful, the PHP supports and advocates for the professional before the state licensing board, the body that determines the professional's suitability to return to practice (Federation of State Physician Health Programs, 2005). Over time, members of state IPPs and PHPs, initially represented by the FSMB, increasingly noted that a new national organization might be better able to address the unique needs of impaired physicians and the professionals who treat them.

Similar to the FSMB, the Federation of State Physician Health Programs (FSPHP), chartered in 1990, is a nation-wide, non-profit organization made up of members of the PHPs of individual states. The FSPHP issues opinions and guidance for state medical boards and PHPs in a continuing effort to improve and better standardize the treatment of impaired professionals. In 2005, the FSPHP issued its most recent guidelines for the rehabilitation of impaired professionals. A state's PHP, the organization recommended, should: (a) assess the validity of claims against the physician and the practitioner's eligibility for rehabilitation; (b) supervise the treatment planning and course of therapy for the professional; (c) adjust and supervise aftercare and relapse-prevention; and (d) oversee, typically for a period of five years after successful rehabilitation, the physician's post-treatment monitoring and supervision (FSPHP, 2005).

Similar to the FSMB's 1995 report, the FSPHP guidelines of 2005 described in great detail recommended rehabilitation and supervision practices for professionals with symptoms of alcohol and substance dependence. Additionally, however, the FSPHP (2005) recommended that state PHPs should also evaluate physicians with symptoms of other forms of impairment that compromised professional practice, specifically mentioning sex addiction (FSPHP, 2005). A

year later, the FSMB (2006), perhaps responding to the FSPHP's (2005) inclusion of "sex addiction" as a form of impairment for which a treatment referral may be indicated, stated that

although an addictive disorder, mental disorder, sexual disorder, [or] phase of life crisis may be a contributory circumstance [to sexual misconduct], boards are still charged with taking appropriate steps to see that the public is protected. While sexual addiction is a frequently used phrase, it is not recognized as a disease in the *Diagnostic and Statistical Manual of Psychiatric Disorders, Version IV (DSM-IV)*. (Federation of State Medical Boards, 2006, Section I, paragraph 3)

It appears that the FSMB (2006) may not have been as amenable to the notion that sex addiction is a contributing—and, they seem to assume, exculpatory—factor in SBV as was the FSPHP (2005). This recent, albeit relatively minor, public disagreement between the FSPHP (2005) and the FSMB (2006) underscores the general disagreement among commentators on the nature of—and indeed the very existence of—sex addiction as an "impairment", and may provide a convenient transition to the second major subdivision of this literature review.

The "Impairment" of Sex Addiction

Many terms have been used to describe problematic patterns of excessive or distressing sexual behavior, including nymphomania, satyriasis, erotomania, hyperlibido, hyperphilia, paraphilia, sexual deviance, sexual perversion, and—anachronistically, perhaps—"Don Juanism." Most of these terms are now either obsolete, imprecise, or inaccurately used interchangeably (Giugliano, 2009). As such, a more thorough understanding of the differing conceptualizations of this controversial phenomenon may be helpful before discussing how it may relate to SBV.

Carnes's Addiction Model

Patrick Carnes, in a paper presented in 1976, was the first author to speak of "out-of-control" sexuality as an "addiction" (Carnes, 1992). Working with drug addicts and alcoholics at a suburban hospital, Carnes (1992) noticed similarities in addictive process between substance dependence and certain repetitive, seemingly compulsive behaviors, including gambling,

overeating, shopping, theft, and sex. Carnes wrote his first book, *The Sexual Addiction*, in 1983, a work that, despite being widely debated among addiction specialists, did not receive mainstream attention until he re-titled and republished it in 1987 as *Out of the Shadows: Understanding Sexual Addiction* (Carnes, 1992).

MacAuliffe and MacAuliffe (1975, as cited in Carnes, 1992) said that an alcohol- or substance-dependent individual is someone who has “a pathological relationship with a mood-altering chemical.” Carnes borrowed and adapted this phraseology to describe his conception of the sex addict: an individual whose “[pathological] relationship with a mood altering ‘experience’ becomes central to his [*sic*] life” (Carnes, 1992, p. 4). The sex addict, in Carnes’s view, “substitutes a sick relationship to an event or process for a healthy relationship with others” (Carnes, 1992, p. 4). In so doing, the sex addict’s life with family, friends, and work becomes less important and less subjectively “real” than the secret and shameful “double life” of out-of-control sexual behavior (Carnes, 1992). Carnes conceived the sex addict, in the throes of the addictive cycle, as entering a “trance-like state” similar to

two lovers who are so absorbed in one another that they forget about their surroundings. The “intoxication” of young love is what the addict attempts to capture. It is the pursuit, the hunt, the search, the suspense heightened by the unusual, the stolen, the forbidden, [and] the illicit which are intoxicating to the sexual addict. (Carnes, 1992, p. 10)

The sex addict’s “trance-like state” of excitement-seeking is similar, in Carnes’s view, to the compulsive gambler who feverishly stakes the few coins remaining in his pocket on a roll of the dice or a long-shot on the roulette wheel, or to a voyeur who waits for hours by a window for a few seconds of surreptitiously glimpsed nudity (Carnes, 1992).

In Carnes’ conception, sex addicts typically experience a four-stage cycle: (a) preoccupation, wherein “the addict’s mind is completely engrossed with thoughts of sex” (Carnes, 1992, p. 9); (b) ritualization, the specific and idiosyncratic routines that serve to

heighten the preoccupation; (c) the compulsive sexual behavior itself, which, because of the momentum provided by the preoccupation and ritualization stages, is at this point in the cycle, uncontrollable; and (d) despair, the shameful “feeling of utter hopelessness addicts have about their behavior and their powerlessness” to control it (Carnes, 1992, p. 9). This despair typically leads to feelings of worthlessness and self-hatred that the addict attempts to ameliorate by again losing himself in fantasies of sex, thus reigniting the self-destructive and unmanageable addictive cycle (Carnes, 1992).

Despite the remarkably predictable patterns of thoughts, feelings, and behaviors inherent in the addiction cycle, Carnes (1992) found that sex addiction itself has no single presentation; rather, individuals could manifest symptoms of sex addiction in any of three levels (Carnes, 1992). Level 1 behaviors are actions typically regarded as normal, acceptable, or tolerable but that become problematic because of their frequency or destructiveness (Carnes, 1992). Common examples of Level 1 behaviors include masturbation, use of pornography, and the frequenting of strip clubs, massage parlors, or prostitutes. Level 2 behaviors are acts that are “clearly victimizing and for which legal sanctions are enforced” (Carnes, 1992, p. 27). These behaviors are typically conceived of as “nuisance offenses” (Carnes, 1992, p. 37) such as exhibitionism, voyeurism, indecent phone calls, and indecent liberties. Level 3 behaviors, by contrast, have grave consequences for victims and bring severe legal sanctions for perpetrators. Such behaviors can include incest, child molestation, or rape (Carnes, 1992).

Despite presenting his three levels in a hierarchical fashion, Carnes (1992) was careful to state that the degree of a sex addict’s pathology or the damage and destruction resulting from the behaviors did not necessarily depend on the egregiousness of the sexual act. In other words, Carnes clarified, “suggesting three levels does not mean that addicts cannot destroy their lives

with Level 1 behavior. Many addicts have done just that without ever venturing into Levels 2 or 3” (Carnes, 1992, p. 27). Carnes (1992) believed that it was the compulsive quality of the behavior and the effect these compulsions had on the addict’s emotional, financial, and relational well-being that were more indicative of pathology than were the specific sexual acts themselves.

To help his reader better understand the three levels of sex addiction, Carnes (1992) included five corollaries to his conceptualization. Corollary 1 stated that every level of sex addiction was ultimately experienced by the addict as painful, despite the irony that the behavior was initially engaged in to ameliorate pain (Carnes, 1992). Corollary 2 declared that acts of sexually deviant behaviors did not, of themselves, indicate the presence of “sex addiction.” Rather, sex addiction was indicated only when the individual used the behavior as the primary and uncontrollable mechanism through which to alter a negative mood state (Carnes, 1992). Corollary 3 stated that all levels of addiction transcended personality, gender, or socio-economic status. In other words, anyone, regardless of gender, sexual orientation, personality type, or social position, could become sexually addicted, an idea that was antithetical to the stereotype of the sexual deviant common at the time (Carnes, 1992). Corollaries 4 and 5, respectively, concerned (a) the interrelatedness of each level of addiction to the other levels and (b) the interrelation of sex addiction to other problematic behaviors susceptible to addictive process: gambling, eating, spending, and shopping to name but a few. Increasingly, compulsive internet, computer, and video game use has been included as one of these so-called “process addictions” (Block, 2007; Charlton, 2002).

Carnes's Critics

Carnes (1992) conceded that his conceptualization of the sex addict was based solely upon his clinical experience and intuition, stipulating that, at least at the time of his writing, there

was no evidence to support an addiction model for problematic sexuality. Critics of Carnes's work seized upon this dearth of empirical data and the non-clinical, popular writing style Carnes employed in his books as weaknesses that undermined the fundamental legitimacy of "sex addiction" as a disorder. Some critics condemned Carnes' conception on sociological and therapeutic grounds, whereas others disputed it based upon its apparent conflict with basic constructs of addiction theory.

Levine and Troiden (1988) viewed the very idea of "sex addiction" as an attempt to pathologize non-normative sexual conduct that had been "stigmatized by dominant institutions" (Levine & Troiden, 1988, p. 347). "The invention of sexual addiction and sexual compulsion as 'diseases,'" the authors continued, "threatens the civil liberties of sexually variant peoples" (Levine & Troiden, 1988, p. 361). Levine and Troiden (1988) were not alone in their opinion, however, and similar objections have persisted over the ensuing decades. For instance, as recently as 2006, Giles, commenting on a then-current study of excessive sexual behavior (Långström & Hanson, 2006, as cited in Giles, 2006), wrote that that study's authors

have not produced any evidence for the view that there is such a thing as 'excessive' levels of sexual behavior or a 'distinct disorder' of hypersexuality. Rather, it seems that, like the claims of Augustine, their assertions here are merely attempts to stigmatize a type of sexual behavior of which they do not morally approve. (Giles, 2006, p. 642)

Similarly, Speziale (1994), although not necessarily objecting to sex addiction on sociological grounds, cautioned that a diagnosis of "sex addiction" could confound the course of marriage and family therapy rather than aid it. For example, in an attempt to defend against feelings of guilt, betrayal, and inadequacy arising from marital infidelity, individuals in couple or marriage counseling could come to view sexual affairs as a problem to be cured rather than as a symptom of underlying relational dissatisfaction (Speziale, 1994). In a published case study, Speziale wrote of her concern that the male partner's "willingness to assume the sick role and his

spouse's eagerness to label him the identified patient... derailed treatment for individual, marital, and family issues" (Speziale, 1994, p. 516). Speziale believed that her attempt to redirect the therapy from the husband's "sex addiction" to the underlying structural issues and interpersonal deficits in their marriage led the couple to end treatment prematurely and participate in sex-addict and sexual co-addict self-help groups (Speziale, 1994).

Other critics argued against the concept of "sex addiction" on the grounds of basic addiction theory. Barth and Kinder (1987) and Coleman (1987) were some of the first critics to raise perhaps the most commonly cited objection to Carnes' model: the apparent lack of physiological dependence on sexual behavior, one of the criteria that differentiates substance dependence from abuse. Renshaw (1986) noted similar flaws in the analogy to alcoholism, including Carnes' assertion that the entire range of human sexuality from masturbation to rape could potentially become "addictive." Despite conceding that "the main benefits of Carnes' approach... should not be discarded with the chaff" (Renshaw, 1986, p. 67), Renshaw nonetheless wrote that "elevating sexual 'addiction' to the status of a diagnosed illness by describing the conduct as totally out of personal control must be regarded with extreme caution by both the medical and legal professions" (Renshaw, 1986, p. 67).

Many writers were less circumspect in their criticism, charging that "Carnes [had] vandalized the scientific concept of addiction and [was] using it to develop a pop psychology" (Dolan, 1990, paragraph 8). Robert Csandl, then the executive director of Treatment Trends in Allentown, Pennsylvania, opined that "even if you're using the word addiction metaphorically, it blurs good assessment, which is essential to starting appropriate treatment" (Dolan, 1990, paragraph 8). Influential Johns Hopkins University sex researcher John Money commented on the "fad" of sex addiction, stating that "people trying to make money on it better hurry up... it'll

probably dry up in five years” (Dolan, 1990, paragraph 8). The general consensus of Carnes’ critics was that the concept of sex “addiction” was little more than a catch-phrase, inaccurate at best, potentially damaging at worst.

Alternative Conceptualizations

Although Carnes’ model was the first to gain significant attention, it was hardly the only conceptualization of problematic, seemingly out-of-control sexual behavior. Some theorists considered the phenomenon as more closely related to impulse control and obsessive-compulsive disorders, whereas other clinicians saw similarities between Carnes’s addiction model and other, more commonly diagnosed anxiety and sexual desire disorders.

Sexual “impulsion” or “compulsion.” Barth and Kinder (1987) considered so-called “addictive” sexual behavior as more properly included in the spectrum of impulse control disorders. Barth and Kinder’s (1987) conception has found recent empirical support (Miner, Raymond, Mueller, Lloyd, & Lim, 2009), philosophical support (Potenza, 2006), and even diagnostic support, as impulsive-compulsive sexual disorders are included in the American Psychiatric Association’s latest edition of the *Clinical Manual of Impulse-Control Disorders* (Hollander & Stein, 2006).

The same year, Eli Coleman (1987), observing that so-called “addictive” sexual behaviors seemed to share more commonalities with obsessive-compulsive disorder than substance dependence, coined the term “compulsive sexual behavior” (CSB; Coleman, 1987). Coleman's initial conception of the phenomenon, developed in subsequent writings over the ensuing decades (Coleman, 1987, 1991, 2001, 2005, 2006), is the one he believes most accurately describes the etiology, function, and course of the disorder. From Coleman's perspective, CSB could be defined as “a clinical syndrome characterized by the experience of

sexual urges, fantasies, and behaviors that are extreme in number and intrusiveness, engaged in as a moderator of emotional distress, and involve significant disruption in normal interpersonal functioning” (Coleman, 1987, p. 189). Such behaviors can have either paraphilic or non-paraphilic features and are primarily “driven by anxiety reduction mechanisms rather than by sexual desire” (Coleman, 1991, p. 37).

Reiterating that there was no “substance” in sexual behavior upon which the sex addict could become physiologically dependent, Coleman stated flatly that “the term ‘addiction’ is inappropriate” (Coleman, 1991, p. 45). Rather, Coleman (1991) believed that CSB was most accurately conceived of as a type of compulsive behavior that serves to temporarily reduce feelings of depression or anxiety but that ultimately caused more distress than the initial feelings were engaged in to ameliorate. Echoing Csandl’s (Dolan, 1990, paragraph 8) critique, Coleman’s primary objection to Carnes’s addiction-model was that it was an oversimplification of a more complex phenomenon that, useful perhaps “as a metaphor, [was] not proper scientific terminology” (Coleman, 1991, p. 45).

Sex addiction as a desire disorder. Kaplan (1995) proposed that sex addiction was more appropriately included on the continuum of sexual desire disorders than as a substance dependence or impulse control disorder. If, Kaplan (1995) hypothesized rhetorically, hypoactive sexual desire disorder (HSDD) is a pathologically low level of sexual desire, could not the disorder of “sex addiction” be accurately considered a pathologically elevated level of desire? In coining the term hyperactive sexual desire disorder, Kaplan herself noted the primary obstacle to such a conception: the lack of an agreed-upon definition of “normal” sexual desire (Kaplan, 1995).

In an attempt to define a “normative” level of sexual desire upon which the diagnosis of

both hyperactive and hypoactive desire disorders could be based, Kafka (1997) studied a factor he termed Total Sexual Outlet (TSO). An individual's TSO was the total number of orgasms an individual experienced during the course of a typical week, regardless of how they may have been achieved (Kafka, 1997). Based on the data he collected during structured interviews with study respondents, Kafka proposed that "a persistent TSO of 7 or more orgasms/week for a minimum duration of 6 months be considered as the lower boundary for hypersexual desire in males" (Kafka, 1997, p. 505). Other specialists criticized Kafka's definition almost immediately because it was based solely on the raw number of orgasms experienced without considering whether the orgasms themselves or the circumstances in which they occurred were viewed as problematic (Klein, 1997). Kafka later clarified his definition, stating that only hypersexuality causing clinical levels of distress should be considered pathological (Kafka & Hennen, 1999).

Building upon Kaplan's (1995) and Kafka's (1997, 1999) work, Kingston and Firestone (2008) recently proposed the term problematic hypersexuality (PH) to better differentiate between normal variations in sexual desire and pathological behavior. Still, even this qualification to the concept of hypersexuality would likely not satisfy all critics. Klein objected to the term "hypersexuality" not only because it did not distinguish between problematic and non-problematic behavior but also because "so-called hyperactive [sexual] desire" (Klein, 1997, p. 205), rather than being a true diagnosis, was more likely a "layperson's way of defining those situations where sexual desire is a singular, fixed, unconscious way of reducing anxiety" (Klein, 1997, p. 204). As such, Klein proposed that "sex addiction" was, in actuality, more akin to generalized anxiety disorder than to substance dependence (Klein, 1997). Klein wrote, a bit combatively, perhaps, that

most so called 'sex addicts' are either: 1) people whose sexual interests are non-normative, which disturbs either them or others; or 2) people whose anxiety-driven

choices, though gratifying in the short run, are eventually self-destructive. Neither state is an ‘addiction.’ (Klein, 1997, p. 205)

Carnes (1996) himself most recently addressed the ongoing dispute between his and Coleman's conceptualizations in an editorial (Carnes, 1996), and the controversy among other specialists has continued as recently as several months prior to this present writing (Samenow, 2010a).

In Defense of the Addiction Model

Carnes and his advocates defended an addiction model of out-of-control sexuality by comparing it to the American Psychiatric Association’s diagnostic criteria for substance dependence without physiological dependence (Carnes, 1996; Schneider, 1989, 2004). To qualify for this diagnosis, at least three of seven criteria must be met, two related to decreased control over the use of the substance, two others to its continued use despite negative consequences, and one to excessive thoughts about, behaviors oriented around getting or using, or time spent recovering from the substance. Schneider (1989, 2004) stated that if the word “substance” was replaced in the diagnostic criteria set with the terms “sexual fantasy,” “sexual urge,” or “sexual behavior,” the same criteria could be used to define addictive sexual disorders. Commonly, many and sometimes all these criteria are observed in sexually addicted individuals (Schneider, 1989, 2004).

Another common criterion for substance dependence is tolerance, the need for steadily increasing amounts of the substance to achieve the same intoxicating effect. Carnes observed that the behavior of sex addicts tends to follow a similar pattern, in that the frequency and intensity of sexual thoughts and actions, even if they had been satisfying at one time, become less rewarding with repetition (Carnes, 1996). Such “tolerance” for sexual behavior typically compels the sexually addicted individual to seek out increasingly frequent and more intense forms of sexual

stimulation, potentially leading the addict to escalate from Level One behaviors to Levels Two and Three behaviors (Carnes, 1992).

Still another common conception of substance dependence that parallels a feature of sex addiction is that, for the substance-dependent individual, alcohol or drugs become the primary means of mediating distressing feelings (Murphy & Khantzian, 1995, as cited in Doweiko, 2006). Although anecdotal evidence has existed for decades to support a similar function of out-of-control sexual behavior, recent research has revealed a correlation between urges to engage in compulsive sexuality and the presence of negative emotional states such as depression and anxiety (Bancroft & Vukadinovic, 2004).

Finally, perhaps the most compelling objection to the addiction-model of compulsive sexuality is the seeming lack of physiological dependence on the behavior (Barth & Kinder, 1987; Coleman, 1987, 1991). Whereas Schneider (1989) avoided addressing this objection directly, preferring instead to compare sex addiction to the diagnostic criteria for substance dependence without physiological dependence, data may exist to contradict this purported absence. One early study demonstrated a link between sexual activity and increased levels of the neurotransmitter dopamine, the same neurotransmitter activated by cocaine use (Washton, 1989). The study's results not only suggested a multiplying effect of cocaine use on sexual compulsivity but also formed the basis of the hypothesis that a "sexually addicted" individual could become physiologically dependent on the endogenous release of dopamine that occurred with sexual activity in much the same way that the cocaine-addicted individual is dependent upon the dopamine-agonist cocaine (Washton, 1989).

Recent research has tended to support this hypothesis. Several studies have shown that sexual activity, along with other psychosocial processes such as gambling or obsessive shopping,

is associated with the endogenous release of opioids in the central nervous system (Berlin, 2008). This release can mimic the cycle of tolerance and withdrawal seen in physiological dependence to opiates, a possibility that supported other researchers' contentions that a sexually "addicted" person could experience physiological dependence upon either the endorphins or the dopamine produced by the body as a result of sexual behavior. Ironically, Coleman (2005), who for decades had argued against Carnes' addiction-model of sexual compulsivity, wrote one of the more complete and concise examinations of the impact of neurotransmitter function on compulsive sexual behavior. Although Coleman (2005) did not speculate on the potentially "addictive" qualities of endogenously produced dopamine or opioids, he nevertheless described compellingly their action and the action of other neurotransmitters in sexual desire and dysfunction.

Assessing Sex Addiction and Sexual Compulsivity

Adding to the clinical and diagnostic confusion on the appropriate categorization of sex addiction is the variety of assessment instruments commonly used to measure levels and types of sexual behavior. Such instruments include the: (a) Sexual Addiction Screening Test (SAST; Carnes, 1989), (b) Sexual Compulsivity Scale (SCS; Kalichman & Rompa, 1995), (c) Compulsive Sexual Behavior Inventory (CSBI; Miner, Coleman, Center, Ross, & Rosser, 2007), and (d) Sexual Symptom Assessment Scale (S-SAS; Raymond et al., 2007). Each of these various instruments, however, has different psychometric properties and was designed for use in differing contexts.

Sexual Addiction Screening Test. As its name implies, Carnes's (1989) SAST is an instrument designed to screen for the presence of sexually addictive thoughts and behaviors. It was "designed to assist in the assessment of sexually compulsive or 'addictive' behavior... [and] to discriminate between addictive and non-addictive behavior" (Carnes, 1989, p. 218.) The

inventory consists of 25 questions about specific sexual thoughts and behaviors, to which respondents are instructed to give dichotomous, Yes or No responses. Carnes (1989) averred that the SAST was satisfactorily valid and reliable, as 96.5% of individuals who endorsed 13 or more items on the SAST were subsequently diagnosed by trained clinicians as sexually addicted.

However, the SAST has been found to be limited. For example, the SAST is primarily a screening tool designed to identify addicted individuals who are likely to be sexually addicted rather than to rate the degree of their symptomatology (Raymond et al., 2007). Furthermore, the dichotomous nature of the instrument allows for no indication of the frequency, severity, intrusiveness, or distress caused by such behaviors, although Carnes (1989) suggested that his instrument “apparently taps into the desire to stop” (p. 217).

Sexual Compulsivity Scale. The SCS (Kalichman & Rompa, 1995) is a 10-item instrument originally designed to assess for the frequency and degree of sexual thoughts, feelings, and behaviors associated with the risk of HIV/AIDS contraction. Kalichman and Rompa’s (1995) instrument, although not designed to identify sexually addicted individuals, has become a widely used assessment tool to measure a respondent’s perceived degree of control over and frequency of negative consequences from sexual thoughts, feelings, and behaviors. Rather than requiring a dichotomous response to test items, Kalichman and Rompa (1995) utilized a four-point Likert-type scale which provides for a greater degree of response variation. Furthermore, the instrument is brief, is easy to administer and score, and has been reported to have good reliability and validity (Kalichman & Rompa, 2001).

As useful as the SCS may be, as a tool for assessing sex addiction, the instrument may be similarly limited. The primary limitation cited is that the test's developers designed the SCS to identify individuals who engaged in high-risk behaviors and to assess the varying degrees of

control they perceived they had over their actions. Although the Likert-type scale may allow a researcher to infer the severity and frequency of an individual's urges to engage in CSB, the developers did not design the SCS to measure changes in these urges over time, and no published data indicate its validity for such a purpose (Raymond et al., 2007).

Furthermore, because the SCS was designed to predict high-risk behaviors in the context of HIV/AIDS contraction, the instrument developers gathered validity and reliability data from a pool of exclusively gay and bisexual men (Kalichman & Rompa, 1995), a fact that could limit the instrument's validity with other populations. Later, Kalichman and Rompa (2001) tested the SCS's validity and reliability with a sample of heterosexual men and women. However the generalizability of findings from that study may be limited, as well, because participants for this second round of validity and reliability testing were selected from inner-city welfare offices and substance abuse clinics and support groups wherein persons of lower socioeconomic status and members of ethnic minorities were overrepresented.

Compulsive Sexual Behavior Inventory. Although many researchers have used the SAST and the SCS, their limitations notwithstanding, to assess for the presence of sex addiction, others have attempted to develop instruments they believed would be more accurate and useful. The result of Miner et al.'s (2007) recent work is the revised version of the CSBI, an assessment tool first introduced six years earlier by Coleman and his colleagues (Coleman, Miner, Ohlerking, & Raymond, 2001). The authors of the CSBI claim that theirs is the only published instrument that measures all three major components of CSB—sexual behaviors that are: (a) extreme in number and intrusiveness; (b) done compulsively to alleviate emotional distress; and (c) causes of significant disruption in normal, daily functioning (Miner et al., 2007). Additionally, the instrument assesses for both paraphilic and non-paraphilic interest and utilizes a 5-point, rather

than the SCS's 4-point, Likert-type scale for increased sensitivity.

The developers of the CSBI have subjected the instrument to several rounds of validity and reliability testing and have normed it for three sample groups: those exhibiting non-paraphilic CSB, pedophiles in treatment for sexual offenses, and a control group of normal adults recruited through newspaper ads (Coleman et al., 2001). Miner et al. (2007) recently conducted further validity and reliability testing and normed the instrument with two additional sample groups: homosexual men and Latino men. Coleman et al. (2001) initially constructed the CSBI to assess for three factors: sexual control, sexual violence, and history of sexual abuse. However, the instrument's designers found that history of sexual abuse was not significantly associated with sexual compulsivity so they eliminated those test items from the most recent version of the assessment (Miner et al., 2007).

However, some limitations of the CSBI may include the fact that it is primarily a screening instrument designed to distinguish sexually compulsive individuals from those who are not. However, the discriminant validity of the CSBI has yet to be established for this purpose (Miner et al., 2007). Furthermore, the instrument was not designed to measure changes in symptoms over time. It is possible that a researcher could utilize the Likert-type scale of response choices on the CSBI, similar to the response choices on the SCS, to infer the current state of an individual's varying symptoms of CSB. However, no data has been published to date that demonstrates the instrument is reliable or valid for such use.

Sexual Symptom Assessment Scale. The S-SAS (Raymond et al., 2007), the instrument that has appeared most recently in scholarly literature, was designed to measure respondents' subjective experience of the frequency, severity, and controllability of their urges to engage in problematic sexual behavior and to track changes in these urges over time (Raymond et al.,

2007). Consisting of twelve, 5-point Likert-type scaled items, the S-SAS has the added benefit of being both brief and sensitive. Furthermore, the instrument has shown good test-retest reliability, convergent and divergent validity, and high internal consistency (Raymond et al., 2007).

Additionally, the S-SAS has shown strong correlation with both the 2001 version of the CSBI and with clinician ratings of CSB symptomatology (Raymond et al., 2007).

The instrument's authors stated that they based the S-SAS on the extensively-studied Gambling Symptom Assessment Scale (G-SAS; Kim & Grant, 2001, as cited in Raymond et al., 2007) by replacing all references to "gambling" in the G-SAS to "problematic sexual behaviors" in the S-SAS (Raymond et al., 2007). Whereas Kim and Grant (2001, as cited in Raymond et al., 2007) designed the G-SAS to measure respondents' perceived frequency and intensity of urges to engage in gambling, Raymond et al. (2007) designed their instrument to measure respondents' subjective experience of urges to engage in CSB. Like the G-SAS, the S-SAS produces a single score between 0-96, with higher scores indicating increased frequency and severity of sexually compulsive urges (Raymond et al., 2007).

The G-SAS was designed to measure the varying experience of compulsive urges to gamble during "the past seven days" and has been shown to be reliable and valid in measuring changes in those urges when administered as frequently as weekly (Kim & Grant, 2001, as cited in Raymond et al., 2007). Raymond et al. (2007) proposed that the S-SAS would likely be reliable and valid in measuring similar changes in urges to engage in problematic sexual behavior. As with the SAST (Carnes, 1992), the SCS (Kalichman & Rompa, 1995), and the CSBI (Miner et al., 2007), the S-SAS (Raymond et al., 2007) is subject to limitations in its use. However, these limitations are discussed in more detail in Chapter 3 of this document, as the S-SAS is the instrument selected for use in the present study.

Sexual Addiction and the Diagnostic and Statistical Manual

Clinicians who specialize in sexual compulsivity have asserted that CSB has reached epidemic proportions (Cooper, 1998; Freeman-Longo & Blanchard, 1998), and the National Council on Sexual Addiction Compulsivity has estimated that 6 - 8% of Americans are sexually addicted (Amparano, 1999). However, the multiplicity of views on the nature of problematic sexuality has complicated the diagnosis of the disorder. Currently, the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (*DSM-IV-TR*; APA, 2000) delineates four categories of sexual disorders: (a) sexual dysfunctions, i.e., disturbances in normal sexual desire or performance; (b) paraphilias, i.e., non-normative and distressing conceptions of what one finds sexually arousing; (c) sexual identity and/or developmental disorders; and (d) sexual disorders or dysfunctions not otherwise specified (Manley & Koehler, 2001). Whether conceived of as an addiction-, compulsion-, impulsion-, anxiety-, or desire-based disorder, CSB can include aspects of all the *DSM-IV-TR* categories but is not described adequately by any one of them (Giugliano, 2009).

At present, there is no *DSM-IV-TR* criteria set that defines any form of compulsive sexuality, a fact that has contributed to conceptual and diagnostic confusion and has been used either to minimize the condition or to deny its existence outright (Bancroft & Vukadinovic, 2004; FSMB, 2006; Giles, 2006; Guigliano, 2009; Kingston & Firestone, 2008; Schneider, 1994). The diagnostic silence on the condition found in the latest edition of the manual has not always existed, however, as previous editions have included references to "addictive" behaviors, including sex addiction (Manley & Koehler, 2001).

Historical diagnosis. In 1980, the *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition (*DSM-III*; APA, 1980) included for the first time "Pathological

Gambling” as an “addictive” disorder, basing its diagnosis upon the existing criteria for substance dependence without physiological dependence (Blume, 1988). Schneider (1989) and other writers have used much the same set of criteria to justify their addiction-based conceptualization of compulsive sexuality, and by the 1987 release of the revised edition of the manual, the *DSM-III-R*, “nonparaphilic sex addiction” was listed as a condition for which a diagnosis of Sexual Disorder Not Otherwise Specified could be given (Manley & Koehler, 2001). However, because the editors of the *DSM-III-R* provided no guidance for clinicians to utilize or differentially diagnose the term “nonparaphilic sex addiction,” inclusion of the phrase in the manual led to heated and nearly immediate controversy.

One critic averred that, although there was “abundant clinical evidence of sexual activity that can be characterized as excessive... [there was] ...no scientific data to support a concept of sexual behavior that can be considered addictive” (Schmidt, 1992, as cited in Manley & Koehler, 2001, p. 257). By the time of the release of the fourth edition of the manual seven years later, the term “sex addiction” had been removed (Manley & Kohler, 2001). Interestingly, pathological gambling, the behavior upon which an “addiction” model of compulsive sexuality was initially based, was included not with the other “addictions”, i.e., alcohol, cocaine, and other substances, but in the Disorders of Impulse Control Not Elsewhere Classified section of the *DSM-III*, where it, along with kleptomania, pyromania, and intermittent explosive disorder, remains as of this writing (APA, 2000).

Current diagnosis. Currently, the diagnosis typically utilized by practitioners treating problematic, compulsive hypersexuality is 302.9 Sexual Disorder Not Otherwise Specified (J. Montgomery, personal communication, October 22, 2009). Many clinicians have settled upon this diagnosis as the one that is currently most appropriate for individuals exhibiting symptoms

of sexual compulsivity, citing example number two: “Distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used” (*DSM-IV-TR*; APA, 2000, p. 582). Other common diagnoses made for persons reporting sexually addictive behaviors include 312.30 Impulse-Control Disorder Not Otherwise Specified, and, when such compulsions fall into Levels 2 or 3 in Carnes’ (1992) model of sexually addictive behaviors, various paraphilias: 302.4 Exhibitionism; 302.82 Voyeurism; 302.89 Frotteurism; 302.2 Pedophilia; or 302.9 Paraphilia Not Otherwise Specified (J. Montgomery, personal communication, October 22, 2009).

The controversy over how best to diagnose sexual disorders in general, and sexual compulsivity in particular, is unlikely to be resolved in the near future, although several commentators have suggested changes to the manual. Manley and Koehler (2001) proposed adding a new category of sexual disorder to future editions: Sexual Behavior Disorders. This new category would contain three subcategories: (a) sexually excessive behaviors, (b) sexually restrictive behaviors, and (c) sexual behavior disorders not otherwise classified. Furthermore, Manley and Koehler (2001) advanced the novel proposal that sexual disorders can be experienced as bipolar. In other words, an individual with a sexual behavior disorder could cycle between sexually excessive and sexually restrictive, culturally normative and culturally deviant expressions of sexual behavior (Manley & Koehler, 2001). More recently, other clinicians have called for a near complete revision of the entire spectrum of sexual dysfunctions and disorders to be categorized and distinguished by gender, suggesting that these disorders typically have gender-specific presentations and require gender-specific criteria and treatment (Seagraves, Balon, & Clayton, 2007).

Whether practitioners conceive of CSB as an addictive, compulsive, impulse-control,

anxiety, or desire disorder, no author has yet published a unified theoretical model to explain the phenomenon (Bancroft & Vukadinovic, 2004). However, with the forthcoming publication of the *DSM-V*, clinicians and commentators in the field have resumed the discussion of precisely what the disorder should be called. Samenow (2010a) has summarized the benefits and shortcomings of several of the most prominent clinical terms thus far coined, and has provided the most recent, multi-disciplinary justification of the "addiction-model" of problematic sexuality (Samenow, 2010b).

Kafka (2010) has recently reiterated his position that the phenomena be categorized as hypersexual desire disorder in the as-yet-unpublished *DSM-V*. Kafka's (2010) conception, which Samenow (2010a) concedes has tended to be favored by authors in the recent professional literature, has been recently both criticized by Winters (2010) and empirically supported by Reid (2011), who developed a screening instrument for the disorder. Agreement between clinicians and theorists will likely remain elusive however, because, as Carnes (1996) concluded,

the words addiction and compulsion as they are currently used and defined are probably inadequate for the new paradigm required to make the necessary classification changes... [but] ...to achieve such a change will require a level of generosity and collaboration that has not typified professional interaction across these fields thus far. (p. 148)

Treatment for Sex Addiction

Practitioners and theorists have introduced several protocols for treating compulsive sexuality, each treatment regime based upon the theoretical construct endorsed by its author. In *Out of the Shadows: Understanding Sexual Addiction*, Carnes (1992) adapted the twelve-step model of Alcoholics Anonymous (AA), replacing the one reference to "alcohol" in the traditional twelve steps with "sexual addiction" (Carnes, 1992, p. 137). Other than this single change in phraseology, Carnes' adaptation was virtually a word-for-word iteration of the 12-step path of recovery for alcoholism. Experienced in cognitive-behavioral therapy (CBT), Carnes (1992)

incorporated common CBT techniques such as disputing and reframing core beliefs with a program of written and oral assignments into the spiritually-based recovery program of Alcoholics Anonymous. In several subsequent writings (Carnes, 1989; Carnes, 1991; Carnes & Adams, 2002), Carnes expanded upon these ideas to become a leading voice in the treatment of sex addiction.

Carnes's stages of recovery. In the original twelve steps, alcoholism was conceptualized as a lifelong condition requiring daily management rather than as a temporary problem needing time-limited treatment. As such, there is no "cure" for alcoholism, only daily management of the emotional, cognitive, behavioral, relational, and spiritual aspects of self and the conviction that the alcoholic "will not drink today" (Carnes, 1994). Similarly, the sex addict does not attempt to "cure" the condition but rather to manage its effects on a daily basis. However, one vital distinction exists between recovery from alcoholism and recovery from sex addiction remains. Whereas the recovering alcoholic commits to abstaining from alcohol for life, the recovering sex addict does not commit to life-long celibacy (Carnes, 1991). Carnes conceived sex for the recovering sex addict, similar to food for the recovering bulimic, as a biological need. Therefore, rather than proposing that recovering persons abstain from sex entirely, Carnes (1991) suggested that they must learn to experience sex in healthier, more satisfying, self-affirming ways (Carnes, 1991).

Carnes (1991) outlined the three primary stages of recovery that occur roughly within the first year, third year, and fifth year of recovery. Each stage of recovery contained a repeating series of sub-stages: (a) developing, (b) crisis/decision, (c) shock, (d) grief, (e) repair, and (f) growth. Carnes (1991) dedicated most of his second book to guiding the recovering sex addict through these stages, providing cognitive exercises and various assignments and worksheets

through which the individual could dispute thoughts, reframe core beliefs, and effectively “work the steps” of recovery.

Residential sex addiction treatment. In 1985, Carnes founded the Institute for Behavioral Medicine in Golden Valley, Minnesota, the first inpatient facility treating sex addiction (Dolan, 1990). Other practitioners soon followed, incorporating medical and psychiatric treatment with psycho-education, cognitive, behavioral, psychodynamic, and humanistic psychotherapy, as well as daily 12-step work. Weiss (2004) wrote one of the more complete protocols for sex addiction treatment, outlining a multi-phase recovery plan of between 15 and 35 days, although typical lengths of stay at many residential facilities range from 30, to 60, to even 90 days or more (J. Montgomery, personal communication, October 22, 2009).

Weiss (2004) suggested that appropriate treatment should begin with a detailed intake that includes medical, psychosocial, and psychosexual assessment upon intake. Various individuals at the facility, including physicians, nurses, and psychotherapists, perform these assessments over a period of several days. The individual’s primary treating therapist can develop an individualized treatment plan only after such a thorough, multifaceted assessment has been conducted (Weiss, 2004). Residential treatment for sex addiction tends to be “task-centered” (Weiss, 2004, pg. 247). Individuals in treatment typically perform a standardized protocol of recovery-oriented tasks, including attending twelve-step meetings with fellow patients, writing and presenting a personal sobriety plan, completing and presenting a thorough, personal sexual life-history, and carrying out various other assignments designed to help the individual through the process of recovery (Weiss, 2004).

Group work is essential in recovery for sexual compulsivity, as one of the core tenets of Alcoholics Anonymous is that an addict cannot rely solely upon internal resources, i.e.,

"willpower," to recover (Carnes, 1991). As members new to the group hear and provide feedback on their peers' assignments, individuals in early recovery learn that they are not alone in their feelings, thoughts, or behaviors. Such awareness alone is likely to be at least minimally therapeutic; however, group participation also prepares recovering individuals to write and share their own life stories. Over time, group sharing allows people who initially presented to treatment seeking help to develop into persons capable of offering help to others, increasing self-worth and self-efficacy in their own recovery. Carnes (1991) cautioned that participation in twelve-step groups alone was usually not sufficient for most recovering individuals, especially those in the initial phases of recovery, and that in-patient treatment and subsequent personal therapy and was found to be a frequent adjunct to such support group work.

So-called "cross addictions" are common, and many individuals with sex addiction have comorbid dependence on alcohol or other substances or processes (Carnes, 1991; Weiss, 2004). Therefore, individuals in residential treatment for sex addiction frequently and concurrently perform group- and step-work for alcohol dependence, substance dependence, pathological gambling, eating disorders, and other potentially compulsive behaviors. However, people experiencing physiological dependence upon or symptoms of withdrawal from alcohol or substances are typically detoxified under medical supervision first, as recovery from the so-called "process addictions" usually cannot begin until any symptoms arising from withdrawal from exogenous substances are treated (Weiss, 2004).

Sex Addiction and Sexual Offending

The suggestion that sex addiction could be a contributing factor in various sexual offenses has been perhaps the most controversial aspect of an addiction-model of compulsive sexuality. Carnes himself (1992) suggested that sex addiction could explain instances of sexual

offending, particularly when the addict's behaviors fell into Levels 2 and 3 of his three-tiered model; however, he was not alone in his hypothesis. Blanchard (1990, as cited in Irons & Schneider, 1994) proposed several characteristics he believed could clinically differentiate the sexually addicted from the non-addicted sex offender. The following year, Blanchard (1991, as cited in Irons & Schneider, 1994) hypothesized that sex addiction could be a significant component in the sexual exploitation of psychiatric patients by their caretakers and therapists. Irons and Schneider (1994, 1999) built upon Blanchard's work, offering an addictions-based model for the assessment and treatment of sexually exploitive health professionals. Laaser (1998) and Birchard (2004) have suggested that sex addiction could be a factor in the sexual abuse of parishioners by members of the clergy. Similarly, Kafka (2003) and Coleman (1987) wrote that hypersexual desire disorder and compulsive sexual behavior, their respective conceptualizations of sex addiction, could contribute to sexual offending.

Despite Weiss's hypothesis that the majority of sex addicts do not, in fact, become sex offenders, he conceded that "sexual addiction by definition is a behavior that is repetitive, often escalating and out-of-control. Inevitably, some sexually addicted patients have engaged in sexual offending behaviors to varying degrees" (Weiss, 2004, p. 245). For example, Irons and Schneider (1994) observed that 54% of the 137 helping professionals referred to them for treatment after allegations of sexual impropriety were, based upon their clinical observations, sexually addicted. Within the subgroup of professionals deemed to be "sexually exploitive," Irons and Schneider (1994) averred that a full two-thirds were addicted to sex. Furthermore, Irons and Schneider (1994) stated that certain of their archetypal categories of boundary violator contained especially high rates of sex-addicted persons, reporting that 62% of the professionals deemed to be Self-Serving Martyrs, 91% of Dark Kings, and 94% of False Lovers were sexually addicted (Irons

& Schneider, 1994).

Abel, Osborn, and Warberg (1998) justified extending sexual offender treatment to professionals who violated sexual boundaries with clients, noting several powerful similarities between paraphilic sex offenders and perpetrators of SBV. In both groups, Abel et al. (1998) observed, the perpetrators

are primarily males; there is a compulsive quality to the perpetrators' behavior; the perpetrators operate from an unequal power base; ...attempts are made by the perpetrators to conceal their sexual activity from others; treatment is frequently not self-motivated, but results from others becoming aware of the sexual misconduct; stress, anxiety, depression, drug misuse, or skills deficits are common antecedents to the sexual behavior; paraphilic arousal patterns sometimes lead to the misconduct; victims are generally selected because of their helpless, vulnerable, or suffering state; there is an organized, planned grooming or seduction of the victims; cognitive distortions are almost always used by the perpetrators to justify their behavior; ...and the perpetrators' initial presentation [to treatment] is that of a hostile, angry individual who denies the accusations against him/her. (Abel et al., 1998, p. 320)

In addition to these similarities, clinical assessment and subsequent treatment of sex offenders is also remarkably similar to that of sex addicts, as a comparison between the dozens of protocols provided in such comprehensive references as the *Sourcebook of Treatment Programs for Sexual Offenders* (Marshall, Fernandez, Hudson, & Ward, 1998), the *Handbook of Addictive Disorders: A Practical Guide to Diagnosis and Treatment* (Coombs, 2004), and the *Clinical Management of Sexual Addiction* (Carnes & Adams, 2002) would demonstrate.

The similarities between sex addiction and sex offender treatment, commonly accepted by practitioners in the field, tend to be underappreciated and perhaps even dismissed by others, perhaps due in part to the political considerations noted by one of Carnes' early critics. Renshaw (1986) wrote of her concern that conceptualizing incidences of sexual offending as stemming from an uncontrollable "addiction" could allow a perpetrator to disavow personal responsibility for criminal actions and provide justification for authorities to treat rather than punish the

offender. Recently, the FSMB (2006) implied much the same thing when it reminded physicians that “sex addiction” was not a diagnosable disorder and suggested that discipline for boundary violation, regardless of the underlying impairment that may have contributed to the offense, would not be circumvented.

The controversy between treatment and punishment, sex addiction and sexual offending, will not likely be resolved in the near future. However, the idea that sex addiction treatment may be appropriate for sexual offenses could serve as an expedient topical pivot to the third primary section of this literature review.

Sexual Boundary Violation in Professional Relationships

Sexualized interaction or overt sexual contact between professional and client is the clearest and most agreed-upon professional boundary violation (Glass, 2003), second only to suicide as the most frequent basis of malpractice complaints (Norris, Gutheil, & Strasburger, 2003). The proscription of sexual activity between physicians and their patients was codified as long ago as the time of Hippocrates in the 4th century B.C.E. (Gross, 2008). Nevertheless, SBV in professional, fiduciary relationships has persisted throughout the millennia and continues to generate discourse and dilemma for professional, ethical, and legal societies. Recently, the FSMB (2006) joined the debate.

Types and Degrees of Sexual Boundary Offenses

The FSMB, as previously discussed, is a private, nationwide, professional organization that, despite having no specific legislative or disciplinary authority, offers opinions and provides rule models for members of state medical boards to aid their decision-making. In 2006, the FSMB defined two distinct types of sexual boundary encroachments—*sexual impropriety* and *sexual violation*—and proposed different disciplinary measures for each. As outlined by the

FSMB, sexual impropriety included any “behaviors, gestures, or expressions that are seductive, sexually suggestive, disrespectful of patient privacy, or sexually demeaning to a patient” (Federation of State Medical Boards, 2006, Section II, paragraph 3). The Federation provided the following examples of such impropriety: (a) inadequate disrobing or draping practices, (b) intentionally watching a patient dress or undress, (c) inappropriate comments about a patient’s body or undergarments, (d) commenting on the patient’s potential sexual performance, and (e) soliciting a romantic relationship with a patient. By contrast, sexual violation, more flagrant than sexual impropriety, involves “sexual contact between a physician and patient, whether or not initiated by the patient, ...that is sexual or may be reasonably interpreted as sexual” (FSMB, 2006, Section II, paragraph 4). Similarly, the Federation provided several examples of sexual violation, including kissing in a romantic manner, inappropriate touching of a sexualized body part, encouraging the patient to masturbate or suggesting that the patient witness the physician doing so, and sexual intercourse or other intimate genital contact between physician and patient (FSMB, 2006).

The FSMB’s examples of various sexual boundary encroachments appear on a continuum from supposedly less blatant behaviors to increasingly egregious infractions. However, the Federation’s attempt to divine a “midpoint” on this continuum that would separate impropriety from violation could be seen as arbitrary. For example, “performing an intimate examination... without clinical justification” is considered by the Federation of State Medical Boards (2006) as sexual impropriety rather than sexual violation despite the fact that it involves inappropriate physical contact and is a clear violation of patient autonomy. Although the harm caused by such behavior may not rise to the level of sexual violation as defined by the Federation, it also may not be equivalent to that caused by inappropriate draping practices or sexualized comments.

Curiously, the Medical Council of New Zealand (1992, as cited in Enborn & Thomas, 1997) had addressed this dilemma nearly 15 years earlier: rather than a two-level hierarchy, the Council proposed a three-tiered model of boundary incursions.

The Medical Council of New Zealand (1992, as cited in Enborn & Thomas, 1997), like the FSMB (2006), considered sexual impropriety and sexual violation as the two extremes in their conception of sexual boundary offenses. However, the Council placed a third category, *sexual transgression*, i.e., “sexualized or inappropriate touching short of sexual contact,” between the two extremes (Medical Council of New Zealand, 1992, as cited in Enborn & Thomas, 1997, p. 1341). This additional category of sexual transgression, were it to be adopted by licensing boards in the United States, may provide disciplinary bodies a more accurate scale upon which to gauge the severity of various types of boundary breaches. For example, several other scenarios that the FSMB (2006) considered sexual impropriety might be more accurately considered sexual transgression, including “touching the genital mucosal areas without the use of gloves” and “subjecting a patient to an intimate examination in the presence of medical students or other parties... without the patient’s informed consent” (Federation of State Medical Boards, 2006, Section II, paragraph 3).

Boundary Violation across Professions

The FSMB is but the most recent national body to propose a rule model for sexual impropriety; however, nearly every professional discipline has addressed some aspect of the topic in their codes of ethics. In perhaps none of the various helping professions has the incidence of SBV been more discussed than in the profession of psychotherapy. One of the earliest-known, specific cases of SBV occurred in 1784, when Benjamin Franklin was appointed by Louis XVI to head a commission investigating the sexual abuse of female patients at a clinic

where early practitioners were experimenting with hypnotism (Lazarus, 1995). Several of the pioneers of psychoanalysis, including Jung, Breuer, and Ferenczi, engaged in what are now considered clear boundary violations by having sexual or sexualized relationships with patients in their care (Gabbard, 1995). Many writers, beginning with Freud himself (1915, as cited in Gabbard, 1995), have suggested that psychotherapy is an intrinsically erotic relationship (Mann, 1997) or that it commonly has, at minimum, erotic undertones (Chiesa, 1999; Doctor, 1999; Gartrell, 1998).

Perhaps the risk of SBV in counseling and psychotherapy is so pronounced because of the frequency, duration, and nature of the interaction itself. For example, few people visit their doctors, dentists, lawyers, nurses, or financial consultants for hourly visits every week over a period of months or years; however, client contact of this nature is *de rigueur* for the counselor or psychotherapist. Furthermore, although most professionals become privy to some intimate details of their clients' lives, such familiarity is more likely a byproduct of the service provided rather than, as in psychotherapy, its primary goal.

Schwartz and Olds (2002) stated provocatively that, in essence, "psychotherapy is a setup for boundary violations" (p. 484). For Schwartz and Olds (2002), psychological "closeness," a typical consequence of interpersonal sharing that is inherent in and even actively encouraged in some models of psychotherapy, commonly leads to a desire for physical closeness and the temptation to act on those feelings. Reminiscent of the "slippery slope," Schwartz and Olds (2002) posited that "drifts toward sexual boundary violations can arise from the everyday dynamics of closeness, even in the absence of individual pathology or intent" (p. 480). The authors then provided specific suggestions for utilizing eight common characteristics of psychological closeness for maximum client benefit while simultaneously minimizing the risk of

impropriety (Schwartz & Olds, 2002).

Despite early awareness of the intrinsic intimacy of the psychotherapeutic relationship and the tendency for sexual boundaries to become blurred for both client and clinician, some humanistic therapists in the 1960s and 1970s sought to maximize this naturally-occurring erotic undercurrent (Schoener, Milgrom, Gonsiorek, Leupker, & Conroe, 1989). Many innovators in the so-called human potential movement, especially those working at the Esalen Institute in California, experimented with the sensual and erotic in their “T” groups, believing that openly shared and expressed eroticism could be utilized for therapeutic client growth (Schoener et al., 1989). Such experimentation, though, was not limited to only one isolated clinic or a few eccentric practitioners. Abraham Maslow (1965, as cited in Schoener et al., 1989), one of the primary thinkers in humanistic psychotherapy, wrote of his curiosity as to whether nudity in group therapy would be beneficial to increasing genuineness and self-disclosure, a technique with which some other clinicians experimented over the following decade (Bindrim, 1982, as cited in Schoener et al., 1989). Perhaps more provocatively, Fritz Perls, despite not specifically endorsing sexual intimacies with clients, spoke rather nonchalantly about erotic physical contact being a natural and expected potential consequence of the intense emotional sharing that occurred in his Gestalt therapy (Shepard, 1975, as cited in Shoener et al., 1989).

Other writers were not as circumspect, however, and frankly advocated sexual activities with clients as being beneficial in general psychotherapy (McCartney, 1966; Shepard, 1971) and in sex therapy in particular (OB-Gyn News; CBS-TV, as cited in Schoener et al., 1989). This view was radical even when it was proposed, as evidenced by the fact that only 4% of psychologists in one contemporaneous study endorsed it (Holroyd & Brodsky, 1977) and that McCartney was subsequently expelled from his profession and Shepard eventually lost his

license to practice (Schoener et al., 1989). Radical or not, however, the idea of “therapeutic love” between therapist and client has remained a stubborn idea to suppress completely.

As recently as 1996, Haule published *The Love Cure: Therapy Erotic and Sexual*. In this work, Haule proposed that a client’s experience of an “erotic” relationship with a therapist—carefully distinguished from a “sexual” relationship, even if merely semantically—was vital to effective therapy. Haule (1996) wrote of the “unitive moment in which our I and you feel drawn into a oneness that would dissolve our former identities into a greater whole” (p. 118), adding that a client’s experience of this “unitive moment” with a therapist in session was, if not therapy’s ultimate goal, at least essential to client growth. Despite writing as a sole author, Haule used the plural form throughout his book, writing of his concern that

not being able to exclude... sexuality from this picture, we came dangerously close to approving of sexual activity as a tool to enhance erotic union—even in the domain of therapy. Our fear of being found in conflict with the ‘fundamentalism’ of the persona field (*any aspect of sex in the context of therapy is always wrong*) [italics in original] caused us no little anxiety. (Haule, 1996, p. 122)

Proponents of boundary theory would likely consider the interventions countenanced in *The Love Cure* either to be evidence of Haule’s poorly-defined sense of personal identity, a thinly-veiled justification of what would otherwise be malpractice, or, more likely, both.

Given the unique risks inherent in—and the frequent experimentation by practitioners of—counseling and psychotherapy, psychiatry was the first professional specialty to adopt formally a prohibition against sexual activity with patients (Lazarus, 1995). In 1973, the American Psychiatric Association published *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*, which stated unequivocally that “sexual activity with a patient is unethical” (APA, 1973, as cited in Lazarus, 1995). This proscription was followed shortly thereafter by the American Psychological Association in 1977, by the ACA (then the

American Association for Counseling and Development) in 1983, and by the American Medical Association in 1990 (Beecher & Altchuler, 2005, Carr, 2003; Plaut, 1997). In 2002 these professions were joined, belatedly some commentators might suggest, by the American Dental Association (Sfikas & George, 2004) and most recently by the American Bar Association, a profession within which resistance to an absolute ban on sexual activity with clients was fierce and prolonged (Bower & Stern, 2003; Corboy, 1992; Hansen, 2001; Tuite, 1992).

Even among the medical profession, however, writers as recently as 1999 felt a need to reiterate the philosophical arguments favoring a “zero-tolerance policy” of physician-patient sexual relationships (Cullen, 1999). Perhaps in an effort to settle the matter conclusively, in 2006 the FSMB stated once again that “sexual behavior between a doctor and patient is never diagnostic or therapeutic” and is “always unethical” (FSMB, 2006, Section II, paragraph 1). At present, the professional codes of ethics of all helping professions now include this prohibition, and most include prohibitions of sexual contact with family and friends of clients, former and potential clients, and even staff, colleagues, and subordinates (Barnett & Lazarus, 2007).

Assessing the Prevalence of SBV

It is by no means uncommon for helping professionals to experience feelings of attraction toward those they serve. In a study of psychologists, 88% of respondents reported having felt sexually attracted toward one or more clients (Rodolfa, Hall, Holms, Davena, Komatz, Antunez, Hall, 1994). Similarly, Giovazolias & Davis (2001) found that 87.5% of responding psychologists reported having such feelings. However, accurately gauging how many professionals may have acted on those feelings is difficult. Several common statistics have been used: self-reports from offending professionals, complaints to licensing boards, outcomes of malpractice suits, reports from victims’ subsequent therapists, reports from professionals who

were aware of a colleague's improprieties, and percentage of disciplinary actions eventually taken. Unfortunately, all of these metrics are prone to substantial error, making an accurate estimate of the prevalence of SBV difficult to obtain.

Self-reports from offending professionals. In one of the earliest studies of its kind, Kardener, Fuller, and Mensh (1973) surveyed male physicians of varying specialties practicing in Los Angeles County, California. The authors found that 12.8% of their respondents claimed to have engaged in some kind of sexual behavior with a current patient and that 7.2 % had specifically engaged in sexual intercourse. In another early and often-cited study, Holroyd and Brodsky (1977) conducted a nationwide survey of psychologists and found that 7.7% reported having engaged in sexual relations with a current patient. Holroyd and Brodsky (1977) were perhaps the first researchers to note the overwhelming gender disparity of admitted perpetrators, as the results of their study showed 12.1% of the male psychologists they surveyed acknowledged SBV compared to just 2.6% of the females.

In a national study, Gartrell, Herman, Olarte, Feldstein, and Russell (1986) found that 6.4% of responding psychiatrists, 7.1% of the male and 3.1% of the female respondents, reported having had sexual contact with patients. This study was notable in part because Gartrell et al. (1986) asked respondents whether they had engaged in SBVs with only one patient (66.7% of those reporting sexual contact), with two patients (20%), or with three or more patients (7.6%). Similar to Holroyd and Brodsky (1977), Gartrell et al. (1986) found that 88% of the violators were males who reported crossing boundaries with female patients, whereas only 3.5% of the violators were females who reported engaging in sexual contact with male patients. The remaining 8.5% of violators reported that they had crossed boundaries with patients of the same sex, 84% of whom were male. A summary of results from several of the most commonly cited

studies of self-reported incidences of SBV across various professions is provided in Table 2.1.

Table 2.1

Prevalence of Sexual Boundary Violation Based upon Self-reports from Offending Professionals

Study Author(s)	Date	Population	Location	%	N	M%	F%
Kardener et al.	1973	Physicians	Los Angeles	7.2	460	--	--
Holroyd & Brodsky	1977	Psychologists	United States	7.7	666	12.1	2.6
Pope et al. ^a	1979	Psychologists	United States	7.0	480	12.0	3.0
Bouhoutsos et al.	1983	Psychologists	California	3.3	704	4.8	0.8
Gartrell et al.	1986	Psychiatrists	United States	6.4	1449	7.1	3.1
Pope et al. ^a	1986	Psychologists	United States	6.5	585	9.4	2.5
Pope et al. ^a	1987	Psychologists	United States	1.9	460	3.6	0.5
Borys & Pope	1989	Mental health	United States	1.3	1021	0.9	0.2
Wilbers et al. ^b	1992	OB/Gyn	Netherlands	4.0	722	3.7	0.3
Col. Phy/Sur of BC ^b	1992	Physicians	Brit. Col.	4.1	1446	3.8	0.3
Gartrell et al.	1992	Physicians	United States	9.0	1891	10.0	4.0
Thoreson et al.	1993	Counselors (male)	United States	7.3	366	7.3	--
Lamont et al. ^b	1994	OB/Gyn	Canada	4.0	618	3.0	1.0
Thoreson et al.	1995	Counselors (female)	United States	0.9	377	--	0.9
Bayer et al.	1996	Physicians	United States	3.4	787	3.9	0.8
Bachmann et al.	2000	Psychiatric nurses	United States	13.0	279	17.0	11.0

^a as cited in Pope, 1994

^b as cited in Carr, 2003

Taken as a group, the various studies summarized in Table 2.1 indicate a self-reported range of SBV prevalence from 1.3% (Borys & Pope, 1989) to 13% (Bachmann, Bossi, Moggi, Stirnemann-Lewis, Sommer, & Brenner, 2000) for an average self-reported prevalence of 5.9%. This estimate of average prevalence is provided for convenience of discussion rather than for statistical purposes, however, as the methodology and procedures of the various studies were not identical. In fact, it is likely that the self-report figures obtained by each of the various researchers were subject to significant non-response bias, as the response rate of the studies was seldom greater than 50%. Furthermore, several authors reported having to discard substantial

numbers of incomplete questionnaires, and others reported outright hostility to the questionnaires, as evidenced by the return of otherwise blank survey instruments defaced with offensive language.

Complaints to professional licensing boards. Aware of the inconclusive nature of self-report surveys, other researchers have attempted to gauge the frequency of SBV by analyzing complaints to licensing boards. In most cases, licensing boards receive such complaints either from the victim, typically when the professional has attempted to discontinue the relationship, or from the friends or family of the victim once the relationship is discovered (Beecher, 2005). Enborn and Thomas (1997) discovered that 74% of board complaints were made by victims or victims' family, a figure similar to the 64% of cases reported by Bloom et al. (1999). However, basing an estimate of the prevalence of SBV upon victim complaints is problematic, primarily because 95% of victims do not file such complaints (Bouhoutsos, Holroyd, Lerman, Forer, & Greenberg, 1983). Other researchers have found similarly low rates of victim complaints to licensing boards, ranging from 2% (Beecher, 2005) to 8% (Strasburger, Jorgenson, & Sutherland, 1992). A summary of results from several of the most commonly cited studies of SBV victim licensing board complaints is provided in Table 2.2.

Table 2.2

Percentage of Victims Who Reported Sexual Misconduct to Licensing Boards

Study Author(s)	Date	Population	Location	%	N
Bouhoutsos et al.	1983	Psychologists	California	3.0	704
Gartrell et al.	1987	Psychiatrists	National	5.0	920
Strasburger et al.	1992	Physicians	National	8.0	592
Beecher	2005	Physicians	Minnesota	2.0	941

Perhaps victims of SBV do not report their experiences to authorities because they may not feel especially “victimized” by the experience and/or realize that the SBV was an ethical and, increasingly, a legal violation on the part of the professional. However, even among those victims who recognize the impropriety of the SBV, many—perhaps most—never report their experiences to authorities (Penfold, 1999). Victims may choose to remain silent about their experiences not only because of feelings of shame, humiliation, guilt, and betrayal but also because of the overriding fear that they would not be believed (Penfold, 1999). Victims’ fears of dismissal have likely been justified because, from the earliest days of psychoanalysis, many clinicians have assumed that claims of sexual impropriety were generally false, rooted in the—usually female—client’s unconscious, sexual longing for the—typically male—therapist (Pope, 1990). Scholars have suggested that this idea may have originated as early as Freud’s renunciation of his seduction theory, which, once accepted and reiterated by psychoanalysts for decades thereafter, became difficult to exorcise from the therapeutic zeitgeist (Pope, 1990).

In fact, as recently as 1971, Brownfain concluded that

the greatest number of [sexual malpractice] actions are brought by women who lead lives of very quiet desperation, who form close attachments to their therapists, who feel rejected or spurned when they discover that relations are maintained on a formal and professional level, and who then react with allegations of sexual improprieties. (Brownfain, 1971, as cited in Pope, 1990, p. 228)

Today, however, the opposite assumption is now more common, and the vast majority of victims’ complaints are presumed to have merit (Beecher, 2005). Bemmann and Goodman (1989, as cited in Council on Ethical and Judicial Affairs, 1991) found that the incidence of false accusations has been rather low, typically less than 5% of reported cases (Gutheil, 1989). Other commentators have posited that, even among the relatively few claims eventually found to be groundless, most were typically the result of patient misunderstanding or anxiety exacerbated by

hasty remarks and abrupt actions or recommendations of the professional (Beecher, 2005; Bloom et al., 1999). Sederer and Libby (1995) cautioned against a swing in opinion from “all claims are false” to “all claims are true,” and several authors have offered guidelines for the forensic evaluation of a claim’s veracity (Gutheil, 1992; McCraith & Thomas, 1999; Somer & Saadon, 1999). The typical client sexually exploited by a professional is likely unaware of this scholarly discourse, however, and the victim’s fear of not being believed likely remains the greatest impediment to reporting misconduct (Penfold, 1999). As such, victim reports probably reflect the prevalence of SBV no more accurately than do self-reports from offending professionals.

Frequency of disciplinary actions. Gauging the prevalence of SBV upon the frequency of disciplinary actions by licensing boards is similarly problematic. For example, such actions typically stem from victims’ reports which, as previously discussed, are most likely under-representative of the actual prevalence of violations. Furthermore, this under-reporting is then compounded by the fact that licensing boards of different states use differing criteria and standards of evidence before making judgments (Avery & Gressard, 2000; Bloom et al., 1999; FSMB, 2006).

Nonetheless, many researchers have investigated the frequency of licensing board disciplinary actions for SBV. The FSMB (1996, as cited in Enborn & Thomas, 1997) reported that, between 1990 and 1992, just 3.4% of all medical board disciplinary actions were the result of an allegation of sexual misconduct. Another study showed that, from 1989-1994, between 2.1% and 5.2% of all medical board actions—an average of 4.1% over the five years—were for sexual offenses (Dehlendorf & Wolfe, 1998). Additionally, although not reporting disciplinary actions for sexual misconduct as a percentage of total board actions, Crausman (2004) stated that of the approximately 4,000 practicing physicians in Rhode Island, only 24 doctors had been

disciplined for sexual impropriety by that state’s medical board during a 10-year period. Other researchers have published similar studies of rates of disciplinary actions for findings of SBV, results of which are summarized in Table 2.3.

Table 2.3

Licensing Board Disciplinary Actions for Sexual Misconduct as a Percentage of Total Actions

Study Author(s)	Date	Population	Location	%
Stevens et al. ^a	1996	Nurses	National	0.6
FSMB ^b	1992	Physicians	National	3.4
Dehlendorf & Wolfe	1998	Physicians	National	4.1
Enborn & Thomas	1997	Physicians	Oregon	5.9
Morrison & Morrison	2001	Physicians	California	8.0
Morrison & Wickersham	1998	Physicians	California	9.0
Nugent, Gill, & Plaut	1996	Physicians	Maryland	11.9
Foremans & Stahl	2004	Chiropractors	California	22.6

^a as cited in Baca, 2009

^b as cited in Enborn & Thomas, 1997

These figures, however, like rates of perpetrator self-report and victim complaint, are also probably underestimates of the true prevalence of SBV. Enborn and Thomas (1997) suggested that rates of disciplinary action may not be indicative of the actual occurrence of misconduct because, in all but the most flagrant cases, licensing boards typically begin an investigation only after receiving multiple complaints against a physician (Enborn & Thomas, 1997). It is likely, then, that a significantly greater number of professionals engage in inappropriate behavior than are ever disciplined for it.

It is of interest to note that rates of disciplinary actions may be related to the timing of Pronouncements by, and variation between the policies and opinions of, professional ethics committees. For example, the American Psychiatric Association formally prohibited sexual

contact with patients in 1973 (APA, 1973, as cited in Lazarus, 1995) whereas the AMA did not do so until 1990 (Council on Ethical and Judicial Affairs, 1991). Dehlendorf and Wolfe (1998) found that between 1989 and 1994, the percentage of SBV-related disciplinary actions against psychiatrists declined 55%—from 39.4% to 21.6%—whereas the percentage of family physicians and general practitioners disciplined for such offenses nearly tripled—from 9.1% to 24.5%. If there is a relationship between the timing of an ethical committee’s pronouncement of certain behaviors as unethical and rates of discipline for that violation, then some professional ethicists may question why certain professions, specifically nursing, dentistry, and law, did not formally address the issue of SBV until as recently as 2001.

Malpractice suits and reports from victims’ subsequent therapists. Some researchers have based SBV prevalence upon the outcomes of malpractice suits; however, this methodology has also been found to be problematic because the majority of these civil cases are settled out-of-court, without an admission of guilt, and with strict “gag orders” in place (Johnson, 2006). Additionally, even when the result of a malpractice settlement is made known, Harbison and Moyer (2000) found that in only 2.2% of cases did the suit specifically claim sexual misconduct. Instead, 43.7% of reported malpractice suit settlements were brought for allegations of “unprofessional conduct” or “professional impropriety” rather than for “sexual misconduct.” Malpractice actions brought under the generic banner of “misconduct” or “impropriety,” although potentially expediting justice for and protecting the confidentiality of the victim, likely conceal the true incidence of SBV (Harbison & Moyer, 2000).

Victims of SBV are more likely to seek subsequent counseling than to file a licensing board complaint (Wohlberg, 1999); however, basing the prevalence of SBV upon reports from victims’ subsequent therapists is also problematic. Rather than errors of under-reporting,

researchers have found that surveying subsequent treating therapists yielded rates of SBV prevalence that were more likely subject to over-reporting due to so-called “therapist-shopping” (Wohlberg, 1999, p. 255). Therapist-shopping is a colloquial term that refers to a phenomenon wherein clients—in this case, victims of SBV—typically report their experiences to several therapists before finding one with whom they ultimately decide to work. In fact, Leupker (1999) found that, on average, victims of SBV who sought subsequent treatment reported the offense to a mean of 2.36 other helping professionals during this initial stage of treatment-seeking.

Perhaps the phenomenon of therapist-shopping has contributed to the disproportionately large percentage therapists who reported treating victims of SBV compared to rates of self-report by perpetrators or complaints by victims. For example, Parsons and Wince (1995) surveyed 678 mental health professionals practicing in Rhode Island and found that 26% reported treating or evaluating at least one client who had been sexually involved with a prior helping professional, 85% of whom were reportedly male. Bouhoutsos et al. (1983) surveyed 704 psychologists practicing in California and found that 45% had encountered at least one patient who reported sexual contact with a previous therapist. Pope and Vetter (1991, as cited in Pope, 1994) reported that 50% of the psychologists in their 1991 national survey claimed to have treated at least one victim of SBV. Finally, in their national survey of psychiatrists, Gartrell, Herman, Olarte, Feldstein, & Localio (1987) discovered that 65% of respondents reported that they had treated, on average, 3.29 patients who reported sexual misconduct by a former therapist. An overview of several other surveys of subsequent treating therapists is presented in Table 2.4.

Reports from offending professionals’ colleagues. Gauging the prevalence of SBV upon the frequency of reports from offending professionals’ colleagues is likely to be as invalid a method as any other. For example, Gartrell et al. (1987) found that 39% of the 1,370

Table 2.4

Percentage of Subsequent Therapists Who Reported Treating a Victim of SBV

Study Author(s)	Date	Population	Location	%	N	M%	F%
Bouhoutsos et al.	1983	Psychologists	California	45	704	6	94 (victims)
Gartrell et al.	1987	Psychiatrists	National	65	1423	9	91 (victims)
Pope & Vetter ^a	1991	Psychologists	National	50	—	13	87 (victims)
Stake & Oliver ^a	1991	Psychologists	Missouri	44	—	—	—
Gartrell et al.	1992	Physicians	National	23	1891	—	—
Parsons & Wince	1995	Psychotherapists	Rhode Island	26	678	85	15 (offndrs)

^a as cited in Pope, 1994

psychiatrists who responded to a nationwide survey reported being aware of other psychiatrists who had been sexually involved with patients. Similarly, Bernard et al. (1992) conducted a national survey of attorneys, 31% of whom reported that they were aware of other attorneys who had been sexually involved with clients. These figures are likely to overestimate the true prevalence of SBV because, similar to reports from victim's subsequent therapists, the actions of a single perpetrator may be known by several colleagues.

Ironically, Gartrell et al. (1987) found that, of the 39% of psychiatrists aware of a colleague's misconduct, only 6% reported the transgression to an authority. Similarly, of the 65% of therapists who reported treating a victim of SBV, only 8% reported the violation despite the fact that 87% stated they believed the contact was harmful (Gartrell et al., 1987). In their study of licensing board complaints of SBV, Bloom et al. (1999) found that only 13% of such complaints were forwarded by the perpetrators' colleagues and that no complaints were initiated by professional ethics committees. This disparity not only (a) supports the assumption that rates of licensing board complaints likely do not represent the actual prevalence of SBV, but also (b) probably influenced licensing boards and credentialing bodies to require professionals with

knowledge of a colleagues' impropriety to report it.

If one were to average the findings in Table 2.4, various methodological differences between studies notwithstanding, it could be said that 42.2% of subsequent treating therapists have encountered at least one patient who claimed sexual misconduct by a prior professional. This figure is more than seven times greater than the average rate of 5.9% of professionals who self-reported such conduct extrapolated from Table 4.1. Even taking "therapist shopping" into consideration, the disparity between reported victims and reported perpetrators could still be as great as three-to-one, another factor that tends to indicate that the true prevalence of SBV is substantially higher than has been self-reported by offenders or that rates of disciplinary actions, outcomes of malpractice suits, or reports to medical boards may suggest.

Typologies of Boundary Violator

As there is likely no one "best method" to estimate the prevalence of SBV, several authorities have suggested there is no one "type" of boundary-transgressing professional. In fact, Celenza and Gabbard (2003) have posited that the stereotypical image of the sexually exploitive professional is probably inaccurate. Perhaps due to the particularly egregious cases of sexual misconduct publicized in the media or the often unrealistic depiction of helping professionals portrayed in books and movies, a number of myths about sexual boundary violators have developed (Celenza & Gabbard, 2003).

Myth versus data. In the popular imagination, the sexually inappropriate professional: (a) is psychopathic, (b) has exploited many clients over a number of years, and (c) is not a candidate for rehabilitation (Celenza & Gabbard, 2003). Certainly, some professionals fit this stereotype. However, the proportion of such psychopathic or predatory professionals among known boundary violators has been found to be relatively small: 20% in one study (FSMB,

1995) and 25% in another (Celenza & Gabbard, 2003). Rather, specialists in the field of SBV have found that it is the single-victim, non-pathologic boundary transgressor that is more frequently encountered. Schoener (personal communication, as cited in Celenza & Gabbard, 2003) claimed that more than 50% of cases he treated fit this description. Other researchers have found that single-victim transgressors were similarly common, comprising 66% of cases found in one study (Gartrell et al., 1987) and as many as 75% of cases in another (Celenza & Gabbard, 2003). Additionally, as many 80% of the professionals who have committed SBVs were found to have engaged in conduct that would not have been problematic if it had occurred outside the professional relationship (Abel, Osborn, & Warberg, 1998; FSMB, 1995).

The myth that the majority of professional boundary violators are paraphilic, pathologic, and predatory may have been unwittingly substantiated by Holroyd and Brodsky (1977) who, in their early and often-referenced study, reported that 80% of offending professionals did so more than once. This study has since been criticized for a number of methodological problems, notably the researchers' failure to differentiate between multiple infractions with a single client and multiple offenses with different individuals (Celenza & Gabbard, 2003). Other commentators have suggested that the myth may persist because it is a form of ego defense (Gabbard, 1996; Norris, Gutheil, & Strasburger, 2003). In an article intended to be read by his fellow psychoanalysts, Gabbard wrote that an "us-versus-them" or "bad apple" conception of boundary offenders provides "little room for us to learn about our own vulnerability to boundary violations" (Gabbard, 1996, p. 665) or to fully appreciate the continuum of behaviors from non-sexual boundary crossings to the potential for subsequent sexual misconduct (Gabbard, 1996). In the quest to understand more fully the varying presentations of exploitive professionals, theorists have proposed several different conceptual models of sexual boundary transgressors.

Schoener and Gonsiorek's six-type model. Based upon their work with professionals charged with SBV, Schoener and Gonsiorek (1988) posited the existence of six categories of offender, which they listed in order of increasing pathology and decreasing suitability for rehabilitation. The authors hypothesized that sexually exploitive professionals are either: (a) uninformed or naïve, (b) healthy to mildly neurotic, (c) severely neurotic, (d) displaying impulse control problems, (e) sociopathic or narcissistic personality disordered, or (f) psychotic or borderline personality disordered (Schoener & Gonsiorek, 1988).

Uninformed or naïve perpetrators are usually trainees or professionals new to practice who have received substandard training. These professionals "operate from a base of ignorance rather than impulsiveness" (Schoener & Gonsiorek, 1988, p. 228), showing little understanding of professional standards or of the harm that such violations can cause clients. Healthy to mildly neurotic transgressors are generally aware of ethical issues raised by sexual misconduct and may engage in only limited, isolated violations. Professionals of this type often terminate the behavior on their own, and many self-report and request help. Severely neurotic professionals may have chronic issues with depression, anxiety, inadequacy, and isolation. These professionals may indeed feel guilt and remorse at their behavior, but this guilt usually leads only to a cycle of shame and self-punishment rather than to behavior change (Schoener & Gonsiorek, 1988).

Professionals with impulse control issues often display a lack of judgment in many areas of their lives, including sexuality (Schoener & Gonsiorek, 1988). These individuals may show guilt or remorse but usually do not have a true understanding of the harm they have caused. These impetuous practitioners typically anger their clients, who are then likely report the behavior. Sociopathic or narcissistic professionals, in addition to exhibiting poor impulse control, tend to exploit clients with deliberation and cunning. Rather than angering clients with their

impropriety, sociopathic or narcissistic perpetrators can skillfully manipulate their victims into compliance. When caught, they often present as remorseful for offenses that are already known but remain secretive about the full extent of their misconduct (Schoener & Gonsiorek, 1988). The psychotic or borderline personality disordered professional has many of the same characteristics of the sociopathic and narcissistic professional but also demonstrates impaired reality testing or a marked instability of affect. Sociopathic/narcissistic and psychotic/borderline offenders are unlikely to respond to rehabilitation efforts (Schoener & Gonsiorek, 1988).

Gabbard's four-type Model. Rather than six, Gabbard (1994) identified four broad categories into which sexual boundary transgressors typically fell. Gabbard classified such violators as those exhibiting: (a) psychoses, (b) predatory psychopathy and/or paraphilias, (c) lovesickness, and (d) masochism. In Gabbard's (1994) model, both the psychotic and the predatory professional are described similarly to the most disturbed practitioners in Schoener and Gonsiorek's (1988) six-type model. As such, these categories of offenders will not be expounded upon here, especially because both writers found that boundary violators who exhibited such pathologies were relatively uncommon and were typically not amenable to rehabilitation. Gabbard's (1994) unique conception of "lovesick" and "masochistic" offenders, however, professionals whom he stated he encountered much more commonly, warrant elaboration.

Gabbard described "lovesick" professionals as "essentially ethical individuals... who find themselves vulnerable and desperately needy for the love and attention of others" (Gabbard, Peltz, & COPE Study Group on Boundary Violations, 2001, p. 670) and those with the "fantasy that love in and of itself is curative" (Gabbard, 1994, p. 129). Gabbard (1994) reported that most of the professionals he encountered fell into the "lovesick" category, and he offered as corroboration Gartrell et al.'s (1986) finding that 65% of boundary-transgressing professionals

claimed they were in love with their victims. In Gabbard's experience, a lovesick professional is typically a

middle-aged male therapist who falls in love with a much younger female patient while he is experiencing divorce, separation, disillusionment with his own marriage, or the loss of a significant person in his life. He may begin to share his own problems with his patient and present himself... as needy and vulnerable. (Gabbard, 1994, p. 126)

Such lovesick professionals may engage in inappropriate self-disclosure with clients in an attempt to elicit support and sympathy. Role-reversals of this type, Gabbard observed, are common precursors to SBVs (Gabbard, 1994).

Conversely, masochistic boundary violators are, in Gabbard's typology, professionals who may "take on impossible cases and resort to heroic measures to save suicidal patients, often without regard to their own welfare" (Gabbard et al., 2001, p. 671). Such measures commonly involve boundary violations of some type that professionals act upon under the belief that such uncommon and risky behaviors are necessary to help clients (Gabbard et al., 2001). Typically, the masochistic offender has fundamentally self-destructive tendencies and can be manipulated or intimidated by certain, often borderline, narcissistic, or dependent, clients (Gabbard, 1994). These clients may ask for overt, concrete demonstrations of caring from the professional, such as asking to be held during vulnerable moments, which may escalate to requests for kisses and other increasingly sexualized contact. The masochistic professional typically is unable to set limits in the professional relationship, either for fear of hurting and angering the client or because of a basic lack of assertiveness, and often finds that the client's need for such reassurance is insatiable (Gabbard, 1994).

Gabbard's (1994, 1999) and Gutheil and Gabbard's (1992) suggestion that clients may play a role in some instances of professional boundary violation has been quite controversial, however. Gutheil and Gabbard (1992) strongly denied their critics' assertions that discussing

client traits was, in effect, “blaming the victim.” Rather, the authors averred, researchers concerned with reducing the frequency of SBV must challenge themselves to explore the complex dynamics of both client and professional despite objections that the authors’ suspected were likely politically motivated (Gutheil & Gabbard, 1992).

Mark Laaser (1998) has written candidly about his personal experiences as a sexually exploitive Christian counselor and pastor. Based upon his descriptions of the thoughts, feelings, and behaviors he experienced, Laaser seems to fit the general description of Gabbard’s (1994) “lovesick” professional; however, he seems also to have exhibited pervasive overtones of masochism. For example, Laaser (1998) confessed

I was naïve, ignorant of the concept of boundaries, and unfamiliar with transference. I was also depressed (but would have denied it) and sexually addicted. ...I was starved for love and nurture but had no idea how to find these in healthy ways. ...My insecurities as a person and as a man led me to want to be a care-giving rescuer. My delusions told me that I was going to be the great, loving person who healed the wounds of the women I counseled, many of whom were also starved for love, nurture, and touch. ...I led a double life. To the world, I was a charismatic and talented leader, counselor, preacher, and teacher. ...At one level I genuinely cared for the people I worked with. No one knew of the dark side of loneliness and anger that affected my spirit or of the sexual fantasies that burned inside my soul. (Laaser, 1998, pp. 18-19)

Irons and Schneider’s six-type Model. In addition to Gabbard (1994) and Schoener and Gonsiorek (1988), Irons and Schneider (1994, 1999) proposed their own typology of boundary violator. Although not referencing Schoener and Gonsiorek’s (1988) work specifically, it seems that Irons and Schneider (1994, 1999) were nonetheless greatly influenced by their predecessors’ six-type conceptualization. Irons and Schneider’s (1994, 1999) model, similar but less clinical than Schoener and Gonsiorek’s (1988) categorization, illustrated each of six “archetypes” of boundary transgressor using character sketches of hypothetical offenders rather than with psychiatrically diagnostic terminology. These six archetypes were comprised of the: (a) naïve

prince, (b) wounded warrior, (c) self-serving martyr, (d) false lover (e) dark king, and (f) madman (Irons & Schneider, 1994, 1999).

Naïve princes are generally new to the helping profession and typically feel somewhat invulnerable due to personal pride and the power of their new status (Irons & Schneider, 1994, 1999). These professionals typically develop “special relationships with seemingly admiring clients. Subsequently, a blurring of professional roles typically occurs which ultimately results in sexual misconduct. These offenders are generally psychologically healthy, feel shame and remorse when confronted, and are typically good candidates for rehabilitation (Irons & Schneider, 1994). Wounded warriors are typically professionals in mid-career who attempt to deal with professional demands and personal issues through the temporary escape of boundary-violating sexual activity. Like naïve princes, these practitioners tend to be generally healthy but exhibit mild to moderate symptoms of depression, anxiety, and possibly substance abuse or dependence. These professionals are also relatively amenable to treatment as long as they remain in a state of “recovery” upon return to practice (Irons & Schneider, 1994, 1999).

Self-serving martyrs are professionals in mid-to-late career who feel they have made personal sacrifices in pursuit of their helping career, but who have become isolated, resentful, and angry at the apparent lack of appreciation for their sacrifices (Irons & Schneider, 1994, 1999). These boundary violators either knowingly or unknowingly groom a succession of “special” clients for personal and eventually sexual relationships, typically justifying them as rewards for their self-denying dedication to their professions. Upon discovery of their activities, inpatient treatment is typically required while they abstain from practice, and, if return is possible, their practice is often restricted in some way. False lovers are typically charming, creative, and energetic and often engage in several types of high-risk behaviors. These persons

usually meet the criteria for several Axis I disorders, and they often have obsessive-compulsive, narcissistic, and dependent personality characteristics. Professional rehabilitation is possible but by no means is assured (Irons & Schneider, 1994, 1999).

Dark kings tend to be driven by grandiosity and a desire to control and dominate others (Irons & Schneider, 1994, 1999). These professionals likely have a number of disordered personality characteristics, including narcissistic, sociopathic, borderline, and schizotypal disorders. Many practitioners in this category are involved in either civil or criminal prosecution, and most are unable to return to practice. Finally, madmen are boundary-transgressors with a major Axis I disorder that is typically severe, often with psychotic or dissociative features. Successful rehabilitation is unpredictable at best; rarely can these professionals return to practice (Irons & Schneider, 1994, 1999).

Irons and Schneider's (1994, 1999) archetypal model, useful as it may be, can be interpreted as essentially Schoener and Gonsiorek's (1988) six-type model described in common, relatively non-clinical language and illustrated with hypothetical case examples. Schoener and Gonsiorek (1988) found that the two extremes of their six-type hierarchy of boundary violators, the uninformed/naïve and the severely emotionally disturbed, were relatively uncommon in their clinical experience. Irons and Schneider (1994) reported much the same, although their work is unique in that they documented the reported prevalence of each archetype of offender they treated. A side-by-side comparison of the two models, along with Irons and Schneider's reported prevalence of each type, is provided in Table 2.5.

Parker and Guest's (2003) developmental typology. In yet another attempt to categorize the sexual boundary violator, Parker and Guest (2003) adapted Margaret Mahler's developmental theory of childhood individuation and separation to conceptualize and treat different types of

Table 2.5

Apparent Similarities between Two Six-Type Models of Sexual Boundary Transgressor

Schoener & Gonsiorek (1988)	Irons & Schneider (1994)	Prevalence
1) Uninformed and naïve	1) Naïve Prince	7.9%
2) Healthy to mildly neurotic	2) Wounded Warrior	21.6%
3) Severely neurotic	3) Self-Serving Martyr	23.9%
4) Impulse control disordered	4) False Lover	19.3%
5) Sociopathic/Narcissistic	5) Dark King	12.5%
6) Psychotic/Borderline	6) Madman	14.8%

Note. Prevalence = percentage of boundary violators treated by Irons and Schneider (1994) who, as a result of these authors' clinical observation, met criteria for each of their six proposed archetypes. Schoener and Gonsiorek (1988) did not report categorical prevalence other than to suggest that categories 1 and 6 were not commonly encountered and that categories 3 and 4 were most frequently encountered.

sexual offenders. Parker and Guest (2003) posited that specific forms of sexual offenses could be predicted by—and that effective therapy must be matched to—the perpetrator's level of psychosocial development (Parker & Guest, 2003). Unfortunately, a thorough examination of Mahler's developmental theory is beyond the scope of this writing. However, to summarize, Mahler (1975, as cited in Parker & Guest, 2003) divided psychological development from birth to approximately age six into four stages: (a) autistic, (b) symbiotic, (c) separation/individuation, and (d) oedipal. Persons who become arrested in any of these developmental stages typically grow to display a number of diverse pathologies, especially related to their ability to form and maintain healthy relationships (Mahler, 1975, as cited in Parker & Guest, 2003). Such pathologies can manifest themselves in the types of sexual offending behavior in which the individual engages (Parker & Guest, 2003).

Individuals arrested in the autistic stage have an inability to form bonds with others, and the extreme anxiety produced at the thought of such relationships can result in dissociative symptoms (Mahler, 1975, as cited in Parker & Guest, 2003). Examples of sexual acting out by

individuals arrested in this stage of development include activities that keep them isolated from the threatening prospect of actual interpersonal contact: pornography, voyeurism, and masturbation (Parker & Guest, 2003). Persons arrested in the symbiotic stage of development have an intense need for— but an inability to form—true, interpersonal bonds (Mahler, 1975, as cited in Parker & Guest, 2003). When persons in this stage sexually act out, they typically do so with soothing, nurturing individuals over whom they feel a degree of control, often frequenting prostitutes, massage parlors, and strip clubs, or engaging in multiple affairs with lower status individuals (Parker & Guest, 2003).

A developing person can experience two primary challenges in Mahler's (1975, as cited in Parker & Guest, 2003) separation/individuation stage, challenges that can result in either narcissistic or borderline traits. Narcissistic traits can arise if a child is pressured to separate from an attachment figure prematurely (Johnson, 1985, as cited in Parker & Guest, 2003); borderline traits can arise should the child be thwarted in developmentally-appropriate attempts to individuate (Masterson, 1981, as cited in Parker & Guest, 2003). The narcissistic sexual offender defends against the underlying feeling of inferiority by behaving in a superior manner, often engaging in sexual behavior with an individual over whom there is a significant power differential (Parker & Guest, 2003). Borderline sexual offenders typically sexualize their need to avoid abandonment, sometimes going so far as to engage in sexual activity in conflict with their own morals. These sexualized behaviors are commonly a defense against the feelings of chronic emptiness typical of the borderline personality (Parker & Guest, 2003). The narcissistic and borderline tendencies of many sexual boundary violators were addressed in Gabbard's (1994) four-type model and in Schoener and Gonsiorek's (1988) and Irons and Schneider's (1994) six-type models, tending to support Parker and Guest's (2003) developmental conceptualization of

the sexual offender.

Professional and Legal Consequences

Depending on the severity and frequency of reported offenses, professionals who have engaged in SBV can face occupational, professional, and various legal penalties. There are a number of authorities who can receive reports of a professional's sexual misconduct, including immediate supervisors, ethics committees of professional societies, state licensing boards, and civil or criminal prosecuting attorneys. However, the responses to complaints at all levels have been found to be inconsistent at best (Abel, Osborn, & Warberg, 1998; Enborn & Thomas, 1997) and have tended to range from lethargic to conspiratorial (Gabbard et al., 2001).

Researching multiple cases, Gabbard et al. (2001) found that many perpetrators' immediate supervisors generally responded slowly. "Often the [boundary violating] behavior was fairly well known... [but] pervasive denial was rampant, and threats of litigation [by the accused professional] often deterred any definitive action" (Gabbard et al., 2001, p. 660). The authors found that a sense of "institutional inertia" (Gabbard et al., 2001, p. 602), often exacerbated by fear of lawsuit by the victim, the accused therapist, or both, tended to prevent investigation of claims. Other contributors to sluggish institutional responses included: (a) potential shame or embarrassment to the establishment, (b) fear of the negative perception that publicity of the offense might engender, and (c) a desire to protect the accused (Gabbard et al, 2001).

Some institutions "circled the wagons" (Gabbard et al., 2001, p. 666), whereas others endeavored to reframe the complaint as an attempt by the—typically female—client to destroy the—usually male—therapist. Furthermore, many supervisors and colleagues, who may have developed bonds of respect and idealization with an accused professional, tended to dismiss claims of impropriety as merely examples of their esteemed peer's "creative or unorthodox

methods" (Gabbard et al., 2001, p. 667). Perhaps most insidiously, owners and operating officers of some institutions, possibly perceiving financial dependence upon the reputation of the accused practitioner, virtually colluded with the offender by, either intentionally or unintentionally, minimizing the offense or attempting to defame the victim (Gabbard et al., 2001).

Professional credentialing bodies such as the AMA, the ACA, and the APA can penalize a member found to violate the organization's ethical codes in ways ranging from formal admonishment, censure, up to and including suspension or expulsion from the body (Benedek & Wahl, 1999). However, views of what are appropriate ethical sanctions are highly variable (Richards & Noblin, 1999). Professional ethics committees can forward complaints to the licensing boards of their respective states, although Bloom, Williams, & Ulwelling (1999) found that none of the licensing board complaints they studied had been initiated by such means. Expulsion from a professional society can be a blow to a perpetrator's reputation, but it is typically not sufficient to protect the public from further offenses, because such organizations have no regulatory authority over members.

To prevent future violations, state licensing boards can restrict or terminate a professional's legal authorization to practice, and charges of SBV frequently bring such sanctions (Bloom et al., 1999). For example, 41% of adjudicated cases in one study (Morrison & Wickersham, 1998) and as many as 72% of cases in another study (Dehlendorf & Wolfe, 1998) resulted in the revocation, suspension, or surrender of a professional license. Additionally, perpetrators of SBV are at risk for both civil liability from malpractice suits (Carr, 2003; Haspel, Jorgenson, Wincze, & Parsons, 1997) and criminal penalties, up to and including incarceration (Hoge, Jorgenson, Goldstein, Metzner, Patterson, & Robinson, 1995). As of 2003, sixteen state legislatures had made SBV in certain professional relationships a criminal offense similar to rape

or sexual abuse (Carr, 2003). However, tremendous state-to-state discrepancies exist in nearly all aspects of the problem, including: (a) what actions constitute sexual impropriety, (b) reporting requirements of persons aware of misconduct, (c) standards of evidence in adjudicating cases, and (d) appropriate sanctions or penalties for those found to be guilty (Avery, 2000; FSMB, 2005; Haspel et al., 1997; Strasburger, 1999).

Furthermore, even within a single state, authorities from various helping professions used different standards when investigating cases or attempting remediation. This disparity was one that Nugent, Gill, and Plaut (1996) attempted to rectify in their *Report of the Maryland Task Force to Study Health Professional-Client Sexual Exploitation*. Recently, however, national bodies like the FSMB (2006) and the FSPHP (2005) have published similar model guidelines so that state medical boards and PHPs may better standardize their approaches to investigating, adjudicating, penalizing, and potentially rehabilitating professionals accused of SBV.

Despite the tremendous variety of criminal, civil, and professional sanctions available to authorities who discipline transgressing professionals, most commentators have found the response to claims of SBV to be lacking. Some authorities have virtually ignored so-called “minor” boundary infractions, allowing multiple complaints against a practitioner to accumulate before taking disciplinary action (Enborn & Thomas, 1997). Abel, Osborne, and Warberg (1998) found that the “disposition of cases [was] highly idiosyncratic and unpredictable” (p. 321), and that most regulatory and disciplinary bodies have dichotomously either minimized claims of SBV or reacted rigidly to them. For example, most disciplinary actions were limited to either remedial boundary training or to reflexive revocation of a professional’s license (Abel et al., 1998; Schoener, 1999), neither response was likely to be particularly effective in protecting the public or in strengthening the profession (Abel et al., 1998).

Enborn and Thomas (1997) found great disparity between types of boundary transgressions reported and severity of disciplinary actions taken. For example, reported incidences of sexual impropriety, the “least serious” category in the three-tiered hierarchy studied, despite having generated the majority (39%) of all complaints, resulted in only 5% of the board’s disciplinary actions. Furthermore, the relatively few disciplinary actions the board took in those instances were initiated only after a physician had received multiple complaints (Enborn & Thomas, 1997). Reported incidences of sexual transgression, a more blatant boundary encroachment, although still requiring several complaints to trigger a consequence, accounted for 31% of complaints and 27% of disciplinary actions. The most egregious boundary transgressions, sexual violation, comprising 30% of the complaints and 54% of disciplinary actions, required only one complaint to result in a board action (Enborn & Thomas, 1997).

Ironically, the apparently lax response by licensing boards to so-called “minor” boundary incursions may have actually contributed to the persistence of SBV. In effect, by allowing a professional to be cited for multiple “improprieties” and even several “transgressions” before initiating an investigation or levying disciplinary sanctions, the licensing board studied by Enborn and Thomas (1997) may have enabled the professional to escalate along the “slippery slope” of progressively more flagrant boundary crossings that other commentators have described (Gabbard, 1994; Gartrell et al., 1986; Gutheil & Gabbard, 1998; Simon, 1992). As of their writing, Abel et al. (1998) found that licensing boards did not commonly refer offending professionals to treatment for sex addiction or compulsivity. However, it is possible that, when appropriate, such treatment could help professionals develop insight into their relationships with clients, potentially interrupting their progression along the continuum of increasingly problematic boundary crossings that can precede sexual exploitation.

Identifying Professionals at Risk for Boundary Violation

Unlike measures of sexual compulsivity, for which several clinicians have created validated instruments, I discovered only two instruments with published validity and reliability data that purport to assess risk of professional boundary violation: the Exploitation Index (EI; Epstein & Simon, 1990) and the Boundary Violation Index (BVI; Swiggart et al., 2008).

Exploitation Index. Created by Epstein and Simon (1990), the EI was “designed to serve as an early warning indicator of boundary violations” (Epstein & Simon, 1990, p. 450) in the patient-psychiatrist relationship. The EI assesses for the presence of thoughts, feelings, behaviors, and attitudes that exemplify one or more of seven constructs that Epstein and Simon (1990) hypothesized were contributing factors in patient exploitation: (a) generalized boundary violations, (b) eroticism, (c) exhibitionism, (d) dependency, (e) power- seeking, (f) greediness; and (g) enabling (Epstein & Simon, 1990). The EI was designed to assess respondents’ risk of exploiting patients utilizing a 32-item, four-point Likert-type scaled questionnaire. Respondents were to indicate whether they experienced each of the 32 assessed criteria “Never,” “Rarely,” “Sometimes,” or “Often.”

Epstein and Simon (1990) determined that physicians who scored in the 90th percentile, a raw score of 27 or higher on a scale of 0-96, were at high risk of engaging in exploitive boundary violations with patients. The instrument developers proposed that the EI could be useful not only as a diagnostic tool to identify individuals at high risk for patient exploitation but also as an educational tool to help practitioners better understand and assess their own potential to exploit. As evidence, the authors stated that the majority of participants in the EI’s validity and reliability study reported that, by completing the instrument, they were alerted to the presence of thoughts, feelings, attitudes, and behaviors that they had not previously realized contributed to their

increased risk for boundary violations (Epstein & Simon, 1990, 1992).

Despite its utility as both a screening and educational tool, the EI has several limitations in assessing boundary violation. Principally, the instrument was designed to assess a physician's risk of exploiting clients, a phenomenon related to but not identical to SBV. For example, Epstein and Simon (1990) viewed boundary violation as one factor among several that contributed to their overall construct of exploitation. However, Swiggart et al. (2008) found no evidence to support all seven of these constructs in a conceptualization of SBV. Another limitation may be that, because the EI was designed for use and validated exclusively by psychiatrists, the instrument may not be particularly useful for other types of physicians or professional helpers.

Boundary Violation Index. Approximately 18 years after the introduction of the EI, Swiggart et al. (2008) published the BVI, purporting it to be the only widely published instrument to date that had been demonstrated valid and reliable in assessing SBV risk. Swiggart et al. (2008) designed the BVI to assess for the reported frequency of thoughts, feelings, behaviors, and attitudes associated with increased risk of physician sexual misconduct with patients and staff (Swiggart et al., 2008). Similar to the EI, the authors of the BVI proposed that, in addition to its value as a screening tool, the BVI could also be valuable in identifying those who lack training in or awareness of boundary issues, in preventing initial offenses, and in monitoring offending physicians who have returned to practice (Swiggart et al., 2008).

The BVI was based upon the EI (Epstein & Simon, 1990, 1992) but was briefer and more specifically focused on assessing professionals' risk of SBV rather than their exploitive potential in general. Swiggart et al. (2008) found that, of Epstein and Simon's (1990) seven-factor construct of patient exploitation, only one factor, boundary violation, was associated with risk

for SBV. Therefore, developers of the BVI utilized only those items that were found to load at $\geq .50$ on boundary violation regardless of the EI subscale upon which they may have initially appeared (Swiggart et al., 2008). The instrument's authors found that the BVI exhibited high internal consistency as well as strong criterion-related and construct validity. Furthermore, because the BVI included only those items that loaded on one factor, boundary violation, the BVI was seen as more sensitive and specific than the EI while being briefer than the EI by seven items (Swiggart et al, 2008).

Another difference between the two instruments is that the developers of the BVI set a substantially lower discriminative threshold than did the EI's authors. The BVI produces a raw score between 0 and 75, with higher scores associated with greater risk for boundary violation. Swiggart et al. (2008) found that individuals with raw scores ≥ 6 , the 80th percentile, were 20 times more likely to have violated sexual boundaries than were individuals with scores of 5 or lower. Swiggart et al. (2008) criticized Epstein and Simon's (1990) determination that only those individuals with scores falling in the 90th percentile on the EI were at "high risk" for boundary violation. The BVI's authors proposed that their instrument's substantially lower cut-off point would better protect the public from sexually exploitive physicians while allowing room for normal variation in boundary-setting practices (Swiggart et al., 2008). Its advantages notwithstanding, the BVI has limitations in its applicability for the current study. These limitations are explored in more detail in Chapter 3 of this document.

Rehabilitation for Sex Addiction and Sexual Violations

Despite the tendency of institutions to "circle-the-wagons" (Gabbard et al., 2001, p. 666) and the relatively slow and inconsistent responses of regulating and judicial bodies (Abel, Osborn, & Warberg, 1998; Enborn & Thomas, 1997), substantiated claims of SBV often result in

license revocation, suspension, or surrender (Dehlendorf & Wolfe, 1998; Morrison & Wickersham, 1998). Perhaps these disciplinary measures are, as Abel et al. (1998) have suggested, a reactionary form of overzealous enforcement that occurs in part to compensate for licensing board inaction on other occasions. With some exceptions, however, many boundary transgressors are good candidates for rehabilitation and return to practice (Celenza & Gabbard, 2003; Gabbard, 1994, 1999; Irons & Schneider, 1994, 1999; Plaut, 2001; Schoener, 1995). The challenge for rehabilitators, then, is to assess which offenders are most appropriate for treatment and to devise the most effective individualized treatment plan.

Preconditions to treatment. Schoener (1995) wrote that boundary violators were to meet three essential conditions before rehabilitation was indicated. In Schoener's (1995) protocol, an offending professional must first: (a) admit guilt and understand the harm caused, (b) believe he or she has a problem that requires rehabilitation, and (c) agree to a post-treatment assessment with the full knowledge that such an assessment may not be favorable or lead to a return to practice. Other clinicians who work with perpetrators SBV (Celenza & Gabbard, 2003; Plaut, 2001) required that professionals also meet Schoener's (1995) criteria before accepting them for treatment. Additionally, Celenza and Gabbard (2003) wrote that a professional suitable for rehabilitation must feel empathy for the victim, experience "genuine remorse... for the misconduct, and demonstrate that he or she profoundly regrets what happened" (Celenza & Gabbard, 2003, p. 629).

Perhaps such stringent prerequisites to rehabilitation serve to counter the perception by critics that, by offering boundary violators treatment and a potential return to practice, licensing boards only continue to whitewash the problem. However, clinicians who adhere to these prerequisites may be overlooking the possibility that the process of rehabilitation might help

offenders who initially lack remorse and empathy to gain these qualities. This contradiction is one that neither Schoener (1995) nor Plaut (2001) addressed, an omission that seems to have contributed to an inherent paradox in the latter's protocol. For example, Schoener's (1995) preconditions appear to be in conflict with the goals of Plaut's (2001) own treatment plan: helping transgressors take responsibility for their offense, appreciate the harm done, and empathize with the victim.

Similarly, Gabbard (1999) wrote that the infatuation a "lovesick" professional usually espouses at initial assessment—a factor that would contraindicate rehabilitation in Schoener's (1995) model—typically diminishes over time. As this ardor wanes, Gabbard found, a professional previously unsuitable for treatment became a "remorseful, reflective, ...highly motivated" candidate for rehabilitation (Gabbard, 1999, p. 215). Recently, Celenza and Gabbard (2003) conceded that whereas "some [professionals] may not have reached this point by the time of the evaluation, they are often progressing in that direction" (Celenza & Gabbard, 2003, p. 629). However, what both Gabbard (1999) and Celenza and Gabbard (2003) have left unsaid is that such insight might occur after the window for potential rehabilitation has closed. Ironically, then, if to be considered appropriate for rehabilitation professionals must already possess some of the qualities that the rehabilitation itself might help them develop, authorities may be unnecessarily limiting the number of professionals who could benefit from treatment.

Once clinicians have determined that rehabilitation is indicated, they must formulate a working hypothesis of the causal factors that contributed to the violation (Schoener & Gonsiorek, 1988). Some of the factors treating therapists must consider in forming their hypotheses include the offender's: (a) prior history of misconduct; (b) personal adjustment; (c) practice style, supervision, and clientele; (d) awareness of professional boundaries; and (e) personal or

situational factors. Without a working hypothesis of the underlying cause of the violation, the rehabilitation counselor cannot formulate a treatment plan and rehabilitation of the professional is not possible (Schoener & Gonsiorek, 1988).

Elements of a treatment plan. Treatment plans for sexual boundary violation are typically task-oriented, focused on helping professionals meet a succession of progressive goals: (a) recognize the harm caused, (b) develop empathy for the victim, (c) assume full responsibility for the exploitive actions, (d) understand the power dynamics in helping relationships, (e) develop insight into any personal issues that may have led to the transgressions, (f) identify potential high-risk situations for re-offense, and (g) develop a personal plan to deal with triggers (Plaut, 2001). Although the components of specific treatment plans vary depending by therapeutic approach, most professionals treated for SBV are assessed for the appropriateness of pharmacotherapy, especially Selective Serotonin Reuptake Inhibitors (SSRIs) (Celenza & Gabbard, 2003; Gabbard, 1999; Plaut, 2001). SSRIs can be particularly helpful in rehabilitating professionals charged with SBV because they can have the dual benefit of moderating the sex drive (Charlton & Quatman, 1997; Kafka, 2007) and alleviating the anxiety and depression that typically underlie CSB (Coleman, 2005). However, other pharmacotherpies are commonly prescribed, including certain testosterone-lowing medications (Berlin, 2005, as cited in Samenow, 2010). Recently, naltrexone, an opiate antagonist found to help curb cravings in alcohol- and substance-dependent individuals, has been found to be effective in reducing urges to engage in compulsive sexual behavior (Raymond, Grant, & Coleman, 2010).

In addition to assessment for pharmaceutical treatment, most standard sex addiction treatment protocols include individual and group psychotherapy, couple and/or family therapy, and psychoeducation on the addictive process, the sexual response cycle, and appropriate

professional boundaries (Irons & Schneider, 1999; Plaut, 2001; Weiss, 2004). Other rehabilitators add several post-treatment interventions, including an individual evaluation of the rehabilitation's effectiveness (Schoener & Gonsiorek, 1988) and a formal protocol of post-treatment surveillance by the reinstated professional's clients, co-workers, staff, family, and friends (Abel, Osborn, & Warberg, 1998). The specific therapies, exercises, and techniques employed during each stage of rehabilitation depend largely on therapeutic orientation upon which the treatment plan is based.

Psychodynamic approaches. Specialists in the field approach boundary violation from differing perspectives. For example, Gabbard's (1994) four-type model is based upon his psychoanalytic approach to therapy, implicit in which is the view that the behaviors and attitudes of transgressing professionals have idiosyncratic and unconscious functions (Gabbard, 1999). The fundamental goals of rehabilitation from this perspective, then, are to (a) uncover the roots of any unconscious intrapsychic conflicts, problematic relationship patterns, or unmet psychological needs and (b) to use this insight to affect change (Gabbard, 1999). During the course of psychodynamic therapy, Gabbard (1999) helped lovesick professionals explore why they may believe they are in love with their clients and how such feelings may have led them to believe that prohibitions of sexual contact did not apply in their cases (Gabbard, 1999). Gabbard found that lovesick professionals commonly reported having received insufficient love and nurturance in childhood, which Gabbard suspected led a lovesick professional to falsely interpret a client's expressions of thanks and gratitude as "approximating the longed-for approval he [*sic*] never received from his [*sic*] parents" (Gabbard, 1999, p. 219).

Conversely, masochistic offenders commonly demonstrate a neurotic need to display indefatigable devotion and selfless care for clients regardless of the personal costs. Furthermore,

masochistic practitioners, especially those with borderline, narcissistic, or dependent personality styles, can develop fantasies that they can—and indeed are obligated to—rescue their clients from their problems, sometimes even through self-destructive boundary-violating relationships with them (Gabbard, 1999). Gabbard (1994, 1999) reported that lovesick and masochistic offenders have shown the greatest potential for psychodynamic rehabilitation, and although not specifically endorsing Carnes' (1992) concept of sex addiction, Gabbard reported that certain paraphilic professionals have responded well to 12-step, recovery-oriented treatments (Gabbard, 1999).

Cognitive-behavioral approaches. Not all treatment providers explore a transgressor's potential intrapsychic conflicts, however. For example, in cognitive-behavioral approaches to rehabilitation, offenders are taught to recognize and interrupt the chain of events that typically precedes boundary violations (Abel, 1999). Cognitive-behavioral therapists typically probe for detailed information about the: (a) setting and sequence of events in which the offense occurred; (b) thoughts, feelings, and fantasies that likely preceded the offense; and (c) the subsequent rationalizations and cognitive distortions employed to justify the violation (Abel, 1999).

Once the sequence of cognitions, emotions, and events has been identified, cognitive therapists help sexually exploitive professionals dispute and disrupt them (Abel, 1999). Common cognitive distortions, observed in as many as 90% of professionals accused of SBV, included the beliefs that: (a) holding a client is an appropriate expression of therapeutic care, (b) victim acquiescence is a sign of consent, and (c) lack of victim complaint is an indication that the behavior was satisfying (Abel, 1999). Practitioners treating perpetrators of SBV from this perspective often employ group therapy, because other sexually inappropriate professionals sometimes “are able to confront and correct the irrationality of each other's idiosyncratic faulty

beliefs” (Abel, 1999, pg. 231). The once-secret thoughts and rationalizations offending professionals initially may have believed were unique can be shown to be not only common but also false when scrutinized by other group members who likely used similar rationalizations (Abel, 1999).

Offending professionals treated from a CBT perspective may also watch videotaped interviews in which victims of other perpetrators describe their thoughts and feelings during and after the misconduct (Abel, 1999). Afterward, boundary transgressors are asked to compose and present to their group a hypothetical interview they imagine their own victims might give after experiencing a boundary violation with them. Able (1999) has written that completing this exercise can help offenders gain a fuller appreciation of the harmful consequences their own victims likely experienced as a result of the impropriety.

Developmental approaches. As discussed previously, Parker and Guest (2003) developed a model of sex offender assessment and treatment based on Mahler’s theory of childhood development. For treatment of sexually exploitive professionals to be maximally effective, therapeutic interventions must be matched to the developmental level of the offender (Parker & Guest, 2003). Treatment goals for offenders arrested in the autistic stage include decreasing impersonal, insular sexual activities like voyeurism, pornography, and masturbation by increasing the professional’s ability to form bonds and have normal relations (Parker & Guest, 2003). To accomplish this goal, therapists work to establish caring, genuine, and empathetic therapeutic bonds with clients that can be generalized to other persons in clients’ lives (Parker & Guest, 2003). The goal for offenders arrested in the symbiotic stage is to reduce the anxiety and depression caused by the desperate need for—but inability to form or maintain—interpersonal attachments (Parker & Guest, 2003). Therapists devise strategies to help clients identify and

express needs, find healthy ways of meeting those needs, and deal with the anger and resentment engendered by past instances of real or perceived abandonment (Parker & Guest, 2003).

Therapeutic goals for offenders with deficits in the separation/individuation stage can address either narcissistic or borderline tendencies (Parker & Guest, 2003). Therapy with narcissistic offenders centers upon mirroring, wherein “the clinician... make[s] every attempt to accurately mirror the client and to acknowledge any empathic failures immediately” (Parker & Guest, 2003, p. 19). After a sufficient experience of therapeutic mirroring, offenders may be more likely to relate to other persons less as objects to be sexually manipulated and more as individuals with needs and thoughts of their own (Parker & Guest, 2003). Treatment for the borderline offender, who has sexualized the desperate need to maintain relationships, again depends primarily on the client’s experience of a therapeutic relationship with the counselor. The goal of therapy for these offenders is to help them “see both the good and bad in a person at the same time, which eventually ends the cycle of idealization and devaluation” (Parker & Guest, 2003, pg. 20).

Returning to Professional Practice

Clinicians who treat sexually abusive professionals typically create personalized aftercare plans, often including continued pharmaceutical treatment, psychotherapy, and recovery-oriented support group participation (Abel et al., 1998). Additionally, such post-discharge recommendations can include monitoring and supervision of, and even restrictions to, the returning offender's future practice. Many clinicians treating sexually exploitive professionals aver that most can satisfactorily complete rehabilitation and return to practice (Abel et al., 1998; Celenza & Gabbard, 2003; Gabbard, 1996; Irons & Schneider, 1999; Plaut, 2001; Schoener & Gonsiorek, 1988). However, there is less agreement over what constitutes “treatment

effectiveness” and recidivism for sexual boundary violators, or what conditions should be placed upon them if they are returned to practice.

Treatment effectiveness and recidivism. Assessing the effectiveness of treatment and attempting to gauge risk of recidivism are likely to be the most challenging components of SBV rehabilitation. Schoener and Gonsiorek (1988), authors of perhaps the earliest treatment protocol for sexually exploitive professionals, conceded that no outcome studies had yet been conducted and advised caution when attempting rehabilitation. Other early writers warned that even successfully treated professionals remained at high-risk for relapse and “should probably avoid [direct patient contact] and instead should confine their work to less intense forms of clinical practice” (Gabbard, 1994, p. 134). Abel et al. (1998) opined that controlled outcome studies of treatment effectiveness would likely be impossible, because allowing a control group of known boundary violators to continue practicing during data collection would be unethical on its face.

However, as an anecdotal report of treatment effectiveness, Abel et al. (1998) reported that, of the physicians referred to them for treatment, 48% completed their program and were returned to practice. Of the 52% who were unable to return to practice, more than two thirds were removed from practice prior to treatment either by their licensing boards or because of pending criminal charges (Abel et al., 1998). Of those who actually received treatment, only 4.6% were subsequently removed from practice due to their poor response (Abel et al., 1998). Additionally, Abel and Osborn (1999) reported a seven-year recidivism rate of less than 1% among those professionals successfully treated in their program, a statistic they stated was significantly lower than the recidivism rate of most paraphilic sex offenders. The authors attributed their success to the: (a) efficacy of the cognitive-behavioral model in general; (b) high

rate of treatment compliance, likely due to the professional's motivation to maintain licensure; and (c) large network of post-treatment support and surveillance, a network typically more involved than that of the typical sex offender (Abel & Osborn, 1999).

Post-treatment monitoring. Perhaps because of the acknowledged difficulty in assessing treatment effectiveness and recidivism rates, recent authors have suggested that rehabilitation specialists and PHPs revise their protocols to strengthen their mandated regimes of post-treatment supervision (Abel & Osborn, 1999; Abel et. al, 1998; Celenza & Gabbard, 2003). Abel and Osborn (1999) developed a comprehensive assessment and monitoring protocol for those persons charged with supervising returning practitioners, including periodic polygraph tests and regular feedback from staff, peers, family, friends, and clients/patients. Reports from the recovering offender's staff, peers, family, and friends would be solicited only from those who had been fully briefed on the returning offender's prior transgressions; however, obtaining information about the experiences of a professional's clients or patients could be problematic. To address the privacy concerns of rehabilitated professionals, Able and Osborn (1999) proposed that clients and patients could provide feedback to the supervisor through a generic "customer satisfaction survey" without revealing the professional's past impropriety or that such misconduct was the reason the feedback was being solicited (Abel & Osborn, 1999). For example, questions regarding any inappropriate comments or behaviors the client may have experienced could be couched as part of the professional's overall "sexual harassment policy" and integrated with other questions regarding the total quality of service clients received (Abel & Osborn, 1999).

This Study in the Context of Existing Literature

As can be inferred from this review of scholarly literature, much has been written about

the nature and maintenance of professional boundaries, professional impairment, sex addiction and its treatment, and sexual boundary violation and its consequences. However, no empirical data have yet been published demonstrating either that: (a) CSB and SVB are correlated phenomena, or (b) CSB symptoms and SBV risk change over time. Irons and Schneider (1994, 1999) were pioneers in conceptualizing and treating SBV as a manifestation of sex addiction, although the relationship they found between the two phenomena was intuitive and anecdotal rather than empirical. Additionally, it should be noted that the few published claims of treatment effectiveness and recidivism that exist (Abel et al., 1998; Abel & Osborn, 1999) were based solely upon the authors' report; they had not submitted for peer review data upon which their reports were based.

Also unstudied is the effectiveness of sex addiction treatment in general, likely due to the fact that no empirically validated instruments yet exist to assess treatment effectiveness (Raymond et al., 2007). Furthermore, no researcher has published data concerning the general personal and professional disposition of boundary violating professionals after any form of treatment, rehabilitation, or boundary training. The paucity of published, empirical studies of these problems constitutes a gap in the scholarly literature that I hope to help remedy, even if only preliminarily, by having conducted the study described in the following chapter.

CHAPTER 3

METHODS AND PROCEDURES

In this chapter, I describe the methods and procedures utilized in this investigation. The chapter is divided into four sub-sections, each of which summarizes a different parameter of the study: (a) selection and recruitment of study participants; (b) research questions and statistical analyses; (c) psychometric properties of assessment instruments, including scholarly justification of demographic information collected; and (d) pilot testing and data collection procedures.

Participants

Many researchers prefer to select study participants utilizing a probability-based selection process such as random sampling (Heppner, Wampold, Kivlighan, 2008). Selecting study participant at random from a qualified pool can maximize the probability that the sample population is actually representative of the population as a whole. However, true random sampling can be a laborious, expensive, and time-consuming process (Heppner, et al., 2008). For example, the National Council on Sexual Addiction and Compulsivity has estimated that 6 - 8% of the American population is sexually addicted (Amparano, 1999), a population which both Carnes (1992) and Irons and Schneider (1994, 1999) have stated includes helping professionals. Presuming that this percentage is accurate, and presuming that helping professionals are as likely as non-helping professionals to exhibit symptoms of sex addiction, it can be extrapolated that 92% to 94% of helping professionals likely do not meet the criteria for sexual compulsivity. Similarly, despite the seeming intractability of SBV (Swiggart et al., 2008), only a minority of helping professionals—between 1.3% (Borys & Pope, 1989) and 13% (Bachmann, et al., 2000), as explored in detail in Chapter 2 of this document—have admitted to crossing sexual boundaries in the practice of their professions. These figures indicate that most helping professionals,

between 87% and 98.6%, are reportedly able to establish and maintain appropriate sexual boundaries with their clients.

Extrapolating from these prevalence rates, then, the probability that a randomly-selected helping professional will have both: (a) experienced clinically significant symptoms of sexual compulsivity; and (b) violated sexual boundaries with a patient, client, or subordinate is exceptionally low, approximately 0.078% - 1.04%. Furthermore, the likelihood that this rare individual, even if happened upon through random selection, would agree to respond candidly to questions about these stigmatized behaviors to an unknown researcher in an unsolicited survey would be lower still. Therefore, I determined that a probability-based method of participant selection would be both inefficient and cost-prohibitive considering my present resources. Following, I describe the methods and procedures I utilized to select participants, assign groups, and recruit respondents.

Participant Selection

Sampling methodology. Rather than utilizing probability sampling, I chose the non-probability-based *purposive sampling* approach to select my study participants. Purposive sampling, sometimes called judgment sampling, is a form of non-probability sampling that “relies on the researcher’s judgment about how to maximize a sample’s representativeness” (Rubin, 2008, p. 189). Especially suited for use with hard-to-find populations, researchers who use the purposive sampling method typically utilize their knowledge of the desired population to determine where a sizable group of such persons can be found. They then develop a sampling plan that—in the researcher's judgment—seems to offer the best chance of producing a representative sample (Rubin, 2008).

In my study, therefore, rather than contacting several thousand current and former

helping professionals hoping to find qualified study participants by random chance, I maximized my sample's representativeness most efficiently by availing myself of the resources of an established, nationally-known facility in the south-central United States. For nearly 20 years, this facility has specialized in treating both sexually compulsive individuals and persons in the helping professions. The facility is a 40-resident inpatient treatment center specializing in the treatment of various behavioral health issues such as alcoholism, substance dependence, compulsive gambling, eating disorders, and sex addiction. In addition to their residential program, the facility also offers intensive outpatient (IOP) treatment for these conditions, as well as a transitional living program for satisfactorily discharged individuals who may not be ready to live full-time in their previous environments.

Patients admitted to residential treatment in the Impaired Professionals Program at this facility are typically referred by their state licensing boards after it has been determined they exhibit symptoms of a behavioral health condition for which residential treatment is indicated. Some patients in the program are referred for residential sex addiction treatment, and some of these individuals have also behaved in a sexually inappropriate manner in the practice of their profession. This treatment center is one of the few facilities in the United States that specializes both in the needs of helping professionals and in the treatment of sexual compulsivity; therefore, patients are referred there from various locations throughout the U.S. and Canada. I believe that the specialized nature of treatment offered by, and the wide, geographically diverse sources of referral to, this facility make it a convenient and economical location from which to select qualified individuals for this study.

Sample pool and group assignments. To collect a pool of potential study respondents, I asked an authorized representative of the designated treatment facility to compile a de-identified

list of individuals who met the study criteria, identified by only the systematic but otherwise arbitrary identification number they were assigned upon admission. To be included in this pool, an individual must have: (a) discharged from residential treatment between 1/1/2005 and 12/31/2009, the study window; and (b) been employed as a healthcare or other professional shortly before their admission to treatment. According to authorized facility personnel, 200 persons met these criteria, and demographic information on these individuals, distinguished only by patient identification number, was provided. The requested demographic information consisted of specific yet non-identifying data for each member of the pool: (a) gender, (b) ethnicity, (c) presenting problem(s), (d) discharge status, and (e) length of stay.

This pool of 200 persons was categorized by: (a) nature of presenting problem, i.e., alcohol or substance dependence, sex addiction, disordered eating, or compulsive gambling; (b) discharge status, i.e., satisfactory vs. unsatisfactory; and (c) year of discharge from treatment. A facility representative also confirmed that each potential study respondent had given—and not rescinded—their consent to be contacted by the facility post-discharge. A summary of this 200-person sample pool by primary presenting problem, discharge year, and mean length of stay, is provided in Table 3.1. Additionally, demographic data for and discharge status of these 200 persons, categorized by professional discipline reported at presentation for treatment, is tabulated in Table 3.2.

The target population for this study is professionals who presented to residential sex addiction treatment during the study window. According to de-identified data provided by the designated facility, of the 200 persons in the sample pool, 84 individuals met these criteria, although a number of these persons reported being treated for other addictive disorders during their time in treatment. Of the 84 persons in the target population, 65 had successfully

Table 3.1

Primary Presenting Problem and Length of Stay for Impaired Professionals Discharged between January 1, 2005, and December 31, 2009, by Discharge Year and Discharge Status

Discharge	N	Primary Presenting Problem				LOS	
		Etoh/CD	SA	ED	CG/G	M	SD
2005							
Satisfactory	28	17	15	1	—	93.4	60.1
Unsatisfactory	8	6	3	3	—	58.9	35.9
Total	33	23	18	4	—	85.0	56.7
2006							
Satisfactory	23	18	14	2	—	128.0	64.8
Unsatisfactory	17	5	5	—	—	53.0	36.3
Total	40	23	19	2	—	96.2	65.7
2007							
Satisfactory	24	18	13	—	—	84.6	34.9
Unsatisfactory	13	10	5	1	2	46.3	32.9
Total	37	28	18	1	2	71.2	38.4
2008							
Satisfactory	39	32	15	7	2	87.9	25.4
Unsatisfactory	9	9	3	1	—	37.9	33.8
Total	48	41	18	8	2	78.3	33.2
2009							
Satisfactory	31	25	8	2	2	89.8	24.5
Unsatisfactory	12	12	3	—	—	47.6	47.6
Total	42	37	10	2	2	77.7	37.5
Total							
Satisfactory	141	110	65	12	4	96.7	41.9
Unsatisfactory	59	67	19	5	2	48.7	37.3
Total	200	177	84	17	6	81.7	46.3

Note. Etoh = alcohol dependence; CD = chemical dependence; SA = sex addiction; ED = eating disorder; CG/G = compulsive gambling/gaming. LOS = length of stay in residential treatment, in days.

the program of therapy and were satisfactorily discharged. Using de-identified patient intake, treatment, and discharge data, I categorized this group of 65 professionals into two subgroups: those individuals who reportedly had violated sexual boundaries with patients, clients, or subordinates prior to their admission to treatment (BV group) and those who reportedly had not

Table 3.2

Occupational and Demographic Data Intake Data for All Professionals Discharged from Any Course of Residential Treatment between January 1, 2005, and December 31, 2009

	Occupation at Intake to Treatment									Total
	Phys	Dent	Coun	Attny	Nurse	Pharm	Pastor	Edu	Othr	
Gender										
Male	81	11	6	10	6	9	5	6	11	145
Female	8	2	2	5	26	2	—	2	8	55
Total	89	13	8	15	32	11	5	8	19	200
Ethnicity										
Asian	4	1	—	—	—	—	—	—	—	5
Black	—	1	—	—	—	—	—	—	—	1
Hispanic	4	1	1	—	—	—	1	—	—	7
White	81	10	7	15	32	11	4	8	19	187
Age										
25-34	6	1	1	5	6	—	—	2	2	23
35-44	27	2	2	3	12	5	2	3	8	64
45-54	38	6	4	4	10	4	2	2	8	78
55-64	16	3	1	3	4	2	1	1	1	32
65-74	2	1	—	—	—	—	—	—	—	3
Discharge Status										
Satisfactory	74	8	4	9	18	10	4	5	9	141
Unsatisfactory	15	5	4	6	14	1	1	3	10	59

Note. Phys = physician; Dent = dentist; Coun = mental health counselor or psychotherapist; Attny = Attorney; Pharm = pharmacist; Edu = educator; Othr = Other helping professional.

(NBV group). Based upon information already on file at the treatment facility, one of these individuals had rescinded consent to be contacted by the facility, two were deceased, and three were incarcerated, for a total of 58 potential study respondents. The demographic characteristics of these 58 study invitees are summarized in table 3.4.

Participant Recruitment

To recruit participants, an authorized facility representative merged potential respondents' names and mailing addresses into corresponding blank data fields in a letter inviting them to participate

Table 3.3

Impaired Professionals Satisfactorily Discharged from Residential Sex Addiction Treatment between January 1, 2005, and December 31, 2009, by Offender Group and Discharge Year

	Occupation Reported at Intake to Treatment								LOS		
	Phys	Dent	Couns	Attrny	Nurse	Pastor	Edu	Othr	<i>M</i>	<i>Mdn</i>	<i>SD</i>
2005											
BV	5	—	—	—	—	2	—	—	72.1	74.0	21.4
NBV	2	—	—	3	1	1	—	1	114.5	99.5	76.0
2006											
BV	5	—	—	—	—	—	—	—	153.8	173.0	51.6
NBV	5	—	—	—	1	—	2	1	164.0	149.0	70.1
2007											
BV	6	—	—	—	—	—	—	—	79.5	83.0	28.2
NBV	4	—	1	1	—	—	—	1	99.9	94.0	47.2
2008											
BV	8	1	—	—	—	—	—	—	90.1	75.0	32.0
NBV	2	—	—	—	2	—	1	1	95.3	88.0	18.8
2009											
BV	3	—	1	—	—	—	—	—	89.5	83.5	27.3
NBV	3	—	—	—	—	—	—	—	77.3	86.0	19.5
Sub Total											
BV	27	1	1	—	—	2	—	—	94.2	80.0	41.0
NBV	16	—	1	4	4	1	3	4	118.0	94.0	62.5
Cum. Total	43	1	2	4	4	3	3	4	106.5	88.5	54.1

in a research study. The letter was printed on the treatment center's letterhead, signed by the facility's clinical director, and sent by an authorized representative of the facility via First Class U.S. Mail to the most recent address on file at the facility. I was informed by a representative of the facility that letters to eight potential respondents were returned to the facility, five of which included a forwarding address and three were unable to be forwarded. I instructed the facility representative to mail a new invitation letter to those potential respondents for whom a forwarding address was available and to discard the three undeliverable letters.

Table 3.4

Pool of Potential Study Participants by Offender Group and Discharge Year

Discharge Year	Offender Group		Total
	BV	NBV	
2005	6	7	13
2006	5	8	13
2007	6	7	13
2008	7	5	12
2009	4	3	7
Total	28	30	58

After an approximately two-week interval, the facility mailed a second invitation letter to all potential study participants at their corrected addresses and, after another two weeks, a final letter of invitation. Each respondent was offered a \$100 American Express Gift Card as a token of appreciation for their participation, an offer that was repeated in each of the three letters. Copies of these invitation letters are provided in Appendix D.

Research Questions and Analytical Methodology

In the introductory chapter of this document, the ten research questions that are the foundation of the study were briefly presented. In this chapter, I provide a more detailed examination of the research questions and the statistical tools utilized in analyzing them.

Research Question 1

The first question tested was: Among all professionals who presented for residential treatment at the designated facility, does treatment type, i.e., sex addiction treatment or other addiction treatment, predict discharge status, i.e., satisfactory/completed or unsatisfactory/not completed? To answer this question, a chi-square test for independence was conducted on two

dichotomous, categorical variables: (a) Treatment Type, the independent variable; and (b) Discharge Status, the dependent variable. De-identified intake, treatment, and discharge records were scrutinized to compile a tally of all 200 professionals who discharged from residential treatment for any reason between January 1, 2005 and December 31, 2009, the study window. This group of discharged professionals was categorized into: (1) treatment type, i.e., treatment for either sex addiction or for some other addictive disorder; and (2) discharge status, i.e., satisfactory/successful treatment or unsatisfactory/unsuccessful treatment, to investigate the degree to which the two variables may have been associated.

Research Question 2

The second question tested was: Among all professionals discharged from residential sex addiction treatment, does offender group, i.e., sexual boundary violator or non-violator, predict discharge status, i.e., satisfactory/completed or unsatisfactory/not completed? To answer this question, a chi-square test for independence was conducted on two dichotomous, categorical variables: (a) offender group, the independent variable; and (b) discharge status, the dependent variable. De-identified intake, treatment, and discharge records were scrutinized to compile a tally of all professionals who discharged for any reason from residential sex addiction treatment during the study window, January 1, 2005 and December 31, 2009, inclusive. This group of discharged professionals was categorized into: (a) offender group, i.e., reported incidence of boundary violation (BV group) or no reported incidence of boundary violation (NBV group); and (b) discharge status, i.e., satisfactory/successful treatment or unsatisfactory/unsuccessful treatment, to investigate the degree to which the two variables may have been associated.

Research Question 3

The third question tested was: Among respondents satisfactorily discharged from

residential sex addiction treatment, how are reported CSB symptoms related to reported SBV risk both at post-treatment, i.e., at-time-of-study-participation, and at retrospective pre-treatment? To answer this question, Pearson product-moment correlation was calculated to measure the strength of relationship between mean S-SAS score and mean BVI score. This relationship was assessed by collecting S-SAS data from each respondent in the context of two distinct time periods: their (a) retrospective pre-treatment experiences and (b) post-treatment, i.e., at time of study participation, experiences. At each observation point, I attempted to determine whether satisfactorily discharged respondents' perceptions of their CSB symptom severity, as measured by the S-SAS, were correlated to perceptions of their SBV risk, as measured by the BVI.

Research Question 4

The fourth question tested was: Among respondents satisfactorily discharged from residential sex addiction treatment, do sexual boundary violators and non-violators differ in CSB symptom severity reported at post-treatment, i.e., at time of study participation, when compared to recollections of their pre-treatment CSB symptom severity? To answer this question, a split-plot ANOVA was conducted to determine whether, after satisfactorily completing treatment: (a) respondents reported a difference over time in CSB symptom severity as measured by the S-SAS, and (b) respondents who reportedly violated professional sexual boundaries differed from respondents who did not report such violations in either their mean S-SAS scores or the rates these scores may have changed over time.

Research Question 5

The fifth question tested was: Among respondents satisfactorily discharged from residential sex addiction treatment, do sexual boundary violators and non-violators differ in the

frequency of SBV risk factors reported at post-treatment, i.e., at time of study participation, when compared to recollections of their pre-treatment SBV risk factor frequency? To answer this question, I conducted a split plot ANOVA to determine whether, after satisfactorily completing treatment: (a) respondents reported a difference over time in SBV risk as measured by the BVI, and (b) respondents who reportedly violated professional sexual boundaries differed from respondents who did not report violations in either their mean BVI scores or the rates these scores may have changed over time.

Research Question 6

The sixth question tested was: Among respondents satisfactorily discharged from residential sex addiction treatment, do sexual boundary violators and non-violators differ in the reported status of their professional licenses at the time of study participation? To answer this question, a chi-square test for independence was conducted on two dichotomous, categorical variables: (a) offender group, i.e., reported incidence of boundary violation (BV group) or no reported incidence of boundary violation (NBV group); and (b) professional license status, i.e., full or restricted license vs. license suspended, surrendered, or revoked. I wished to determine whether individuals who had violated professional boundaries were different from individuals who had not violated such boundaries in the probability that they had retained their professional licenses after treatment.

Research Question 7

The seventh question tested was: Among respondents satisfactorily discharged from residential sex addiction treatment, what are meaningful predictors of change in CSB symptom severity, controlling for passage of time and degree of intake pathology? To answer this question, hierarchical multiple regression was used to explore the predictive power of several

continuous, independent variables upon one continuous, dependent variable: S-SAS-change score. This variable, S-SAS-change, was extrapolated by subtracting each respondents' S-SAS score obtained at the retrospective pre-treatment observation from the score obtained at time of study participation. The first regression model was calculated using two independent variables: (a) number of years since discharge from residential treatment, and (b) number of reported problematic behaviors co-morbid with sex addiction. By conducting this analysis first, the potentially confounding effects of these variables was controlled for when conducting the second regression model with the remaining variables: (c) total days of inpatient and outpatient treatment, (d) number of post-discharge counseling and/or psychotherapy sessions, (e) total days of post-discharge use of prescribed psychopharmaceuticals, (f) number of post-discharge support group meetings, and (g) number of hours of continuing education in professional boundaries.

Research Question 8

The eighth question tested was: Among respondents satisfactorily discharged from residential sex addiction treatment, what are meaningful predictors of change in SBV risk factor frequency, controlling for passage of time and degree of intake pathology? To answer this question, hierarchical multiple regression was used to explore the predictive power of several continuous, independent variables upon one continuous, dependent variable: BVI-change score. This variable, BVI-change, was extrapolated by subtracting each respondent's retrospective, pre-treatment BVI score from the score obtained at time of study participation. The first regression model was calculated using two independent variables: (a) number of years since discharge from residential treatment, and (b) number of reported problematic behaviors co-morbid with sex addiction. By conducting this analysis first, the potentially confounding effects of these variables was controlled for when conducting the second regression model with the remaining variables:

(c) total days of inpatient and outpatient treatment, (d) number of post-discharge sessions counseling and/or psychotherapy, (e) total days of post-discharge use of prescribed psychopharmaceuticals, (f) number of post-discharge support group meetings, and (g) number of hours of continuing education in professional boundaries.

Research Question 9

The ninth question tested was: Among respondents satisfactorily discharged from residential sex addiction treatment, do decreases in reported CSB symptom severity predict reported professional license status at time of study participation? To answer this question, discriminant analysis was conducted to explore the predictive power of reported changes in CSB symptom severity, as measured by S-SAS-change score, upon one dichotomous, categorical variable: professional license status. I wished to discover whether S-SAS-change score could predict membership in one of two licensure groups: (a) professional license retained, either fully or with restrictions; and (b) professional license not retained, i.e., suspended, surrendered, or revoked.

Research Question 10

The final question tested was: Among respondents satisfactorily discharged from residential sex addiction treatment, do decreases in reported SBV risk predict reported professional license status at time of study participation? To answer this question, I utilized discriminant analysis to explore the predictive power of reported changes in BSV risk, as measured by BVI-change score, upon one dichotomous, categorical variable: professional license status. I wished to discover whether BVI-change score could predict membership in one of two licensure groups: (a) professional license retained, either fully or with restrictions, and (b) professional license not retained, i.e., suspended, surrendered, or revoked.

Establishing Statistical Significance and Interpreting Effect Size

For all analyses, statistically significant results were considered to have been obtained when $p \leq .05$. Analyses yielding p values greater than .05 were considered non-significant results. Additionally, in the absence of established effect size norms for this research population, effect size results were interpreted using Cohen's (1988) suggested guidelines for each analysis. For example, all correlation analyses were interpreted using Cohen's (1988, pp. 79 – 81) interpretive guidelines for Pearson product-moment correlation coefficients: $r = .10$ to $.29$ for small effect, $.30$ to $.49$ for medium effect, and 0.50 to 1.0 for large effect. Similarly, in all chi-square analyses, the ϕ coefficient, an effect measure comparable to Pearson's r in both mathematical foundation and interpretation (Pallant, 2007), was interpreted using Cohen's (1988, pp. 79-81) guidelines for r .

In all analyses of variance, effect was interpreted using Cohen's (1988, pg. 284 - 287) suggested partial η^2 minimum cutoffs: $.01$ to $.059$ for small effect, $.06$ to $.139$ for medium effect, and $.14$ or greater for large effect. Additionally, effect size for each ANOVA was calculated in standard deviation units, Cohen's d , and interpreted using Cohen's (1988, p. 22) suggested minimum cutoffs: $d = .2$ to $.49$ for a small effect, $.5$ to $.79$ for a medium effect, and $.8$ or greater for a large effect.

Finally, in all analyses using multiple regression, effect size measures R^2 and β were interpreted using Cohen's (1988, 79 - 81) guidelines for interpreting correlation coefficients. R^2 is literally the product-moment correlation coefficient, r , squared; therefore, Cohen's interpretive guidelines for R^2 are as follows: $.010 - .089 =$ small effect, $.09 - .249 =$ medium effect, $.25$ or greater = large effect. The other effect measure provided by multiple regression, β , is mathematically related to r and interpreted similarly (Howell, 2002): $.10$ to $.29$ for small effect,

.30 to .49 for medium effect, and 0.50 to 1.0 for large effect (Cohen, 1988, pp. 79 – 81).

Instruments

I utilized three instruments for this study: the Sexual Symptom Assessment Scale (S-SAS; Raymond et al., 2007), the Boundary Violation Index (BVI; Swiggart et al., 2008), and a demographic information form of my own construction. Because of the nature of the study, I compiled all three instruments into one questionnaire and have included it as Appendix E in this document. Following is a brief description of the psychometric properties and potential limitations of each instrument in regard to its use in the study.

Sexual Symptom Assessment Scale (S-SAS)

The S-SAS (Raymond et al., 2007) was designed to (a) measure the reported frequency and severity of thoughts about, urges to engage in, behaviors related to, and consequences of CSB and (b) track changes in these factors over time. Consisting of twelve 5-point Likert-type items scored 0, 2, 4, 6, and 8 respectively, the S-SAS produces a single score between 0-96 with higher scores indicating increased frequency and severity of sexually compulsive thoughts, urges, behaviors, and consequences (Raymond et al., 2007). Raymond et al. (2007) found that the instrument has: (a) high test-retest reliability [$r = 0.939$ ($p = 0.000$)]; (b) convergent validity, as evidenced by a medium correlation [$r = -0.434$ ($p = 0.009$)] of the S-SAS with the CSBI (Coleman et al., 2001); and (c) divergent validity, as evidenced by the fact that there was no significant correlation [$r = 0.165$ ($p = 0.345$)] between the S-SAS and clinician ratings of symptoms of general psychopathy (Raymond et al., 2007).

The S-SAS was based upon the Gambling Symptom Assessment Scale (G-SAS; Kim & Grant, 2001, as cited in Raymond et al., 2007), by replacing all references to gambling in the G-SAS with “problematic sexual behavior” in the S-SAS. The G-SAS, which measures a

respondent's varying experience of compulsive urges to gamble over "the past seven days," has been shown to be a reliable and valid measure of changes in urges to gamble when administered as frequently as weekly (Kim & Grant, 2001, as cited in Raymond et al., 2007). The S-SAS's authors proposed that their instrument would likely be reliable and valid in measuring similar changes in urges to engage in problematic sexual behavior (Raymond et al., 2007); however, a validation study of the use of the S-SAS for that purpose had been published at the time this present study was conducted.

Two factors could potentially limit the usefulness of the S-SAS in the present context. First, unlike the SAST and CSBI, the S-SAS does not provide the respondent with a list of specific thoughts, feelings, attitudes, or behaviors to assess. As written, the S-SAS allows respondents to subjectively define the term "problematic sexual behaviors" for themselves. However, also unlike the SAST or CSBI, the S-SAS is not a screening tool; respondents in my study will have already met the criteria for CSB and a screening instrument is not required for this study. Furthermore, I assume that, because of their experience of residential treatment for sex addiction, my study participants will likely already have an accurate understanding of what "problematic sexual behaviors" entail. Therefore, I do not find the omission of specific thoughts, feelings, attitudes, or behaviors from the S-SAS as problematic for use in the present context.

A second potential concern I have about the appropriateness of the S-SAS for this study is that, because the instrument assess three factors but produces only one score, there is no way to determine—based upon score alone—whether a particular respondent found the frequency, severity, and/or controllability of CSB thoughts, feelings, urges, or behaviors to be particularly distressing at any given observation point. In other words, equal scores from two different respondents or two different observations could reflect any combination of higher or lower

frequency, greater or lesser severity, and increased or decreased control over CSB symptoms. For example, an individual with a certain score on the S-SAS could potentially experience nearly constant urges to engage in CSB but report having complete control over whether or not to act upon them. However, another individual could obtain precisely the same score by reporting only occasional urges to engage in CSB but complete lack of behavioral control. There is no way to overcome this shortcoming other than to address it here and to stipulate that results obtained by this instrument are thusly limited.

Finally, being the most recently constructed of the various measures I considered, the S-SAS has to its credit only initial validity and reliability testing; no reports of the instrument's use with other populations in other treatment settings is presently available. In addition to this contextual limitation, Raymond et al. (2007) conceded that "further studies administering the S-SAS repeatedly during a treatment study will need to be done to establish the test's utility as an outcome measure" (Raymond et al., 2007, p. 125). However, because I do not propose to use the S-SAS as an outcome measure but rather as a means to gauge my respondents' subjective experience of CSB symptom severity at two distinct time periods, I believe that the S-SAS is suitable for this purpose. Overall, I have determined that the few deficiencies of the S-SAS are likely outweighed by its many substantial benefits.

Boundary Violation Index (BVI)

The BVI (Swiggart et al., 2008) is the only instrument discovered during a search of professional literature that has been demonstrated to be a reliable and valid measure of risk factors for SBV. The instrument's authors designed the BVI to assess for the reported frequency of thoughts, feelings, behaviors, and attitudes associated with increased risk of physician sexual misconduct with patients and staff (Swiggart et al., 2008). In addition to its value as a screening

tool, the instrument's creators proposed that the BVI could also be valuable in identifying those who lack training in or awareness of boundary issues, in preventing initial offenses, and in monitoring offending physicians who have returned to practice (Swiggart et al., 2008).

The BVI was based upon the EI (Epstein & Simon, 1990, 1992) but is briefer and more specifically focused on assessing a respondent's risk of engaging in SBV. As mentioned previously, Swiggart et al. (2008) found no evidence to support all seven of Epstein and Simon's (1990) constructs of patient exploitation in predicting sexual boundary violation. Rather, Swiggart et al. (2008) found that only one factor, boundary violation, was associated with the phenomenon of SBV. Therefore, developers of the BVI utilized only those EI items that were found to load at $\geq .50$ on the construct of boundary violation regardless of the EI subscale upon which they may have initially appeared (Swiggart et al., 2008). The BVI's authors found that the instrument exhibited high internal consistency as well as strong criterion-related and construct validity. Furthermore, because the BVI included only those items that loaded on one factor, boundary violation, the BVI is simultaneously more sensitive and specific than the EI while being briefer than the EI by seven items (Swiggart et al., 2008).

Another factor I considered favorable in choosing the BVI (Swiggart et al., 2008) over the EI (Epstein & Simon, 1990) is the relatively low threshold that the developers of the BVI established as a "cut-off point" to identify professionals at high risk for SBV. The BVI produces a raw score between 0 and 75, with higher scores associated with greater risk for boundary violation. Swiggart et al. (2008) found that individuals obtaining raw scores ≥ 6 , the 80th percentile, were 20 times more likely to have violated sexual boundaries than were individuals with scores of 5 or lower. Swiggart et al. (2008) criticized Epstein and Simon's (1990) determination that only those individuals with scores falling in the 90th percentile on the EI were

to be considered at “high risk” for boundary violation. The BVI’s authors proposed that their instrument’s substantially lower discriminative threshold would better protect the public from exploitive physicians while allowing for normal variation in boundary-setting by various professionals (Swiggart et al., 2008).

Several potential limitations exist in the use of the BVI for this present study. First, Swiggart et al. (2008) designed the BVI to assess for the presence and frequency of thoughts, feelings, behaviors, and attitudes related to risk for SBV and to differentiate individuals at high risk from those who are not. Because the BVI utilizes a 4-point Likert-type scale, respondents’ BVI scores can be used to infer the varying frequency of these risk factors over time; however no published data exist that confirm the validity of the instrument for this purpose. Another potential limitation of the BVI is that respondents have no way of indicating the relative egregiousness of any high-risk thought, feeling, or behavior; therefore, it is impossible to link an individual’s score on the BVI with the “seriousness” of a potential boundary violation (Swiggart et al., 2008). For example, in an attempt to minimize respondent defensiveness and potential researcher liability, the BVI assesses the frequency of a professional’s “personal relationships”—rather than “sexual relationships”—with clients. By wording test items thusly, Swiggart et al. (2008) likely not only increased the probability that respondents will answer truthfully but also minimized or eliminated the obligation of researchers to report any specific act of misconduct to authorities. However, such generalization may also make the instrument less precise.

Furthermore, as with many self-report assessments, the BVI does not include a mechanism to assess respondents’ test-taking attitudes such as denial, defensiveness, or minimization (Swiggart et al., 2008). In other words, clinicians interpreting test results are unable to determine whether the respondent likely answered truthfully. Finally, because the BVI

is based upon the EI, it is possible that the experienced health professionals who will make up the majority of respondents in this study may be sufficiently acquainted with items on the BVI to modify their responses in a socially-expected manner. However, as the BVI itself has only been in use for two years as of this writing, it is likely that most professionals will be sufficiently unfamiliar with it and will provide valid responses nonetheless. These limitations notwithstanding, the BVI is the tool that best meets the needs of the present study, and I am prepared to accept the few limitations that exist.

Demographic Information Form

In constructing my demographic information form, I chose to gather such general information as a study participant's gender, ethnicity, and age. However, I also wanted to assess: (a) respondent's occupational status and job satisfaction, both prior to admission and after satisfactory discharge from residential treatment for sex addiction; and (b) the extent of any post-discharge psychiatric treatment, counseling, or recovery support they may have received. Most items on the demographic information form were derived intuitively, particularly those items related to overall occupational status. By collecting data on respondents' occupation, license status, and employment status at time of study participation, I believe the employment and occupation status of study participants, both before and after sex addiction treatment, was assessed in at least broad strokes. However, to assess most accurately (a) the types of post-discharge psychiatric treatment, psychotherapy, or recovery support a participant may have received and (b) perceived changes in respondents' job status and satisfaction, I consulted the scholarly literature before completing the demographic information form.

Many rehabilitation specialists have suggested that individuals in recovery for sex addiction continue to use prescribed psychopharmaceuticals after discharge, and continue to

attend individual, group, family, and couples therapy (Abel et al., 1998; Celenza & Gabbard, 2003; Irons & Schneider, 1994, 1999). Carnes (1989, 1992, 1994) has encouraged individuals in recovery for sex addiction to continue attending 12-step support groups at least several times per week after discharge from residential treatment, and ideally to make such activities central to their lives thereafter. Additionally, based upon my experience as a master's-level counseling intern at the designated treatment facility, I am aware that some people addicted to sex are admitted to and discharge from several courses of residential and outpatient treatment throughout their lives. Therefore, in constructing my demographic form, I was careful to provide respondents opportunities to describe their experiences with all these potential forms of post-discharge treatment, counseling, or recovery support.

To find a theoretically-grounded means of assessing a respondent's perception of job status and satisfaction before and after treatment, the scholarly writings from experts in the field of industrial/organizational psychology were consulted. Psychologists and theorists have posited several theoretical constructs of job satisfaction beginning as early as 1935 (Hoppock, 1935, as cited in Stanton, Sinar, Balzer, Julian, Thoresen, Aziz, Fisher, & Smith, 2001). At present, one of the most popular and frequently used measures of job status and satisfaction is the Job Descriptive Index (JDI; Locke, Smith, Kendall, Hulin, & Miller, 1964, as cited in Stanton et al., 2001). Initially published in 1964, the JDI was most recently updated and re-normed in 1997 (Stanton et al., 2001). This current edition of the instrument contains 72-items that assess five facet-scales found to be predictive of job satisfaction: (a) the nature of the work itself, (b) amount of pay, (c) opportunities for promotion, (d) quality of supervision, and (e) interaction with coworkers. Despite its wide clinical use, however, the full JDI is too long to be used in the present study. Other researchers have likely discovered the same limitation with the JDI, as

several authors have attempted to modify it. Stanton et al. (2001) developed an abridged version of the JDI that assesses the same five facet-scales as the full-length JDI but contains only 25 items. Nagy (2002) utilized a single-item approach to measure facet job satisfaction and developed a 7-item instrument that he reported showed strong correlation with the full-length version of the JDI (Nagy, 2002). Along with the original five facets found in the JDI, Nagy (2002) included *overall working conditions* and *degree of personal autonomy* as facets in his measure of job satisfaction.

In constructing my demographic information form, I wished to gauge respondents' subjective experience of the similarities and/or differences in their job status and satisfaction after residential treatment for sex addiction. However, including an additional 25-items from the abridged JDI (Stanton et al., 2001), or even an additional seven items from a single-item approach (Nagy, 2002), would have made the already-lengthy survey unacceptably long. Therefore, despite the fact that a validated measure of job status and job satisfaction was not used, I believe I assessed respondents' perceptions of these factors in a theoretically-grounded manner. For example, items 106 and 107 (see Appendix E) were worded as follows:

Many factors contribute to how an individual defines the status of an occupation. Some of these varying factors include the type of work performed, amount of pay, opportunities for promotion, quality of bosses and coworkers, overall working conditions, and the amount of autonomy and personal freedom one has on the job. All factors considered, how similar is the status of your current job compared to the job you may have had in the six months or so before other, significant people in your life became aware of your compulsive sexual behavior?

In a similar manner, survey respondents were asked to assess their overall level of job satisfaction both before and after treatment for sex addiction, using much the same wording and basic theoretical constructs. Therefore, although not providing an assessment of actual job status or satisfaction, responses to the item can be interpreted as a brief and theoretically-based

indication of respondents' perceptions of their jobs both before and after sex addiction treatment.

Questionnaire Construction

I chose to synthesize items from the S-SAS, the BVI, and my demographic information form into one questionnaire rather than ask respondents to complete several different forms. The questionnaire included rather specific instructions throughout, and, in general, was constructed so that respondents could first rate their "current" experiences, i.e., their experiences at or shortly before the time they participated in the study. Respondents were then asked about any intervening or continuing treatment or recovery support they may have received since being discharged from the designated facility. Finally, respondents were asked to clear their minds of the responses they had previously given and to recall themselves as best as they could in the context of their experiences "in the six months or so before other, significant people in your life became aware of your compulsive sexual behavior." Responses provided in this latter context were interpreted as the "pre-treatment" observation. However, the decision to utilize retrospective recall of pre-treatment conditions rather than a true pre-test deserves discussion.

As mentioned previously, the population of professionals who have a history of SBV and who have successfully completed residential treatment for sexual addiction is exceedingly small. In fact, over the five-year study window from January 1, 2005 to December 31, 2009, the designated facility treated only 67 individuals who met the study criteria, a rate of approximately one professional per month. Administering a true pre-test to each qualified professional upon admission to the facility and hoping that this person would agree to participate in a follow up study some years after discharge was beyond my available resources. Therefore, to utilize the wealth of data already available at the designated treatment facility, I was inspired by a study

authored by Ellen Luepker (1999), who, faced with a similar dilemma, utilized retrospective recall of pre-treatment symptoms rather than a true pre-test.

Luepker (1999) surveyed individuals who had reportedly been sexually victimized by a health care professional and assessed for pre-abuse and post-abuse symptomatology by “comparing recollections of problems experienced before the sexual misconduct versus those reported following the misconduct” (Luepker, 1999, pg. 55). Luepker’s (1999) methodology, therefore, likely did not assess actual victim decompensation after SBV; rather, her study likely gauged victims’ perceptions of the abuse’s impact when compared to their recollections of any preexisting problems. My study, then, was similar to Luepker’s (1999) in that successfully treated professionals were asked to: (a) rate their current experience of CSB symptoms and SBV risk factors, and (b) recollect and retrospectively rate their experience of these same factors prior to treatment. Luepker (1999) found that her methodology produced useful results, and I believe that replicating that methodology in my study did so, as well.

Procedure

I allowed a window of approximately 45 days between the mailing of the first invitation letters and the deadline for survey completion. To collect data, I created a customized questionnaire which integrated items from the demographic information form, the S-SAS, and the BVI, interspersed with completion instructions when necessary, and posted it online at www.stellarsurvey.com. Following is a description of the pilot testing and data collecting procedures utilized during the course of the study.

Pilot Testing Procedure

Once the online questionnaire was completed, I asked a group of approximately one dozen fellow doctoral students in the University of North Texas counseling program to take the

survey. Because I constructed my survey for a very specific population, sexually compulsive professionals who had completed residential sex addiction treatment, I expected that most survey items would not be applicable to respondents in the pilot test. Therefore, participants in the pilot test were instructed to complete the questionnaire with completely fictitious data. The goal of pilot testing the survey was to discover any potential errors in the questionnaire itself, any technical problems with its online administration, and to estimate an average completion time. I also wished to solicit feedback on the composition of the survey: its length, comprehensibility, ease of completion, and degree of incentive provided by the appreciation gift.

Pilot testing commenced only after I received study approval from the University of North Texas Institutional Review Board (IRB), which I obtained on January 24, 2011, and have included as Appendix B to this document. After pilot testing was complete, I made minor grammar and syntax changes to the questionnaire, corrected the few technical problems with the functionality of the Web-based survey that were revealed, and proceeded to data collection.

Data Collection

When the online survey was complete, I provided the treatment facility with (a) the group codes of all the potential participants, who were identified by only the number assigned them at intake, and (b) a template of the three invitation letters which a representative of the facility could address, print, and mail to potential respondents. Because potential respondents had consented to contact by only the treatment facility, the letters were written as if they were from the clinical director of the designated facility and printed on facility letterhead. The clinical director was consulted during the letters' composition and retained final approval of them prior to adding his signature. In the letters, potential respondents were directed to the URL hosting the Web-based questionnaire and were informed they would receive instructions for claiming their

\$100 American Express Gift Card after they completed and submitted the survey. Upon directing their Web browsers to my questionnaire, respondents were given an opportunity to view the Informed Consent form as approved by the UNT IRB, included in this document as Appendix C. Respondents who selected “I consent to participate in the study as described below” and continued into the survey were considered to have given their full and informed consent to participate in the study. Respondents could not proceed into the survey without having given their consent.

Detailed instructions were provided to respondents throughout the questionnaire, including the initial instruction that, although their “rigorous honesty” was appreciated, they were not required to answer any survey item they thought was “too sensitive.” My first inclination was to require that, for a questionnaire to be considered “complete” and eligible for the appreciation gift, a respondent must have provided data for every item on the questionnaire. However, upon consultation with my major professor and participants in the pilot study, it was decided that this requirement would likely serve as a disincentive for study participation.

Study participants viewed the final page of the survey, which included instructions on how they could claim their appreciation gift, only after they had submitted their final survey responses. On this last survey page, respondents were instructed to forward, via electronic message, the street address or Post Office box to which they would like their \$100 American Express Gift Card mailed. Respondents were informed that, because this electronic message was completely independent of the survey itself, there would be no way for any respondent’s identity to be matched to an individual survey response. Additionally, participants were told that they were not required to reveal their identity in order to claim an appreciation gift. For example, respondents could choose to have their gift mailed to “Occupant” at either their home or business

addresses, and that they could also request that their gift be mailed to a neighbor, friend, or relative. In other words, their gift respondents were told that their gift cards could be mailed to any address to which they had even secondary access.

After receipt of approval from the UNT IRB, data collection commenced on February 15, 2011. Study results are provided in the following chapter.

CHAPTER 4

RESULTS

In this chapter, I discuss the results of my study. I provide descriptive data, including study response rate and demographic information regarding several pertinent characteristics of the participants. In addition, I discuss how I treated missing data and potentially defensive responding. Finally, I report the results of statistical analyses to test each research question.

Descriptive Data of Study Sample

Response Rate

Data collection spanned the period from February 15, 2011 and March 30, 2011, inclusive. From the 58 invitation letters mailed over the six-week data collection period, 37 persons logged on to the survey website. Two of those persons dropped out after reading the informed consent, and 35 persons completed the online survey, resulting in a response rate of 60.3%. Response rate by offender group and year of discharge is summarized in Table 4.1.

Table 4.1

Response Rate by Offender Group and Year of Discharge

Discharge Year	Offender Group					
	Boundary Violators		Non-Boundary Violators		Total	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
2005	0	0.0	6	85.7	6	42.9
2006	4	80.0	4	50.0	8	65.0
2007	4	66.7	4	57.1	8	61.9
2008	5	71.4	2	40.0	7	55.7
2009	4	100.0	2	66.7	6	83.4
Total	17	56.7	18	64.3	35	60.3

Demographic Information

Gender, age, group assignment, ethnicity, and income. Of the 35 study respondents, all of whom were male and 89% were Caucasian, the median age was 47.5 years of age for both the 17 respondents in Boundary Violators (BV) group ($M = 50.1, SD = 9.03$) and the 18 respondents in the Non-Boundary Violators (NBV) group ($M = 48.6, SD = 8.14$). Respondents' reported ethnicity and ages appear in Table 4.2.

Table 4.2

Reported Ethnicity and Age of Study Respondents by Offender Group

Group	Ethnicity				Age						
	Asian	Black	Hspnc	White	35-39	40-44	45-49	50-54	55-59	60-64	65-69
BV	2	—	1	14	2	3	4	5	—	1	2
NBV	1	—	—	17	2	4	7	1	2	1	1
Total	3	—	1	31	4	7	11	6	2	2	3

At the time of study participation, the reported median annual income of the 35 respondents was \$125K ($M = 146K, SD = 99.9K$). Of the 17 BV group respondents, median annual income was \$175K ($M = \$163K, SD = \$87.9K$); however, two BV group members reported incomes \geq \$500K, making it impossible to determine precisely their actual income. These two, high-earning respondents were not included in the analysis; therefore, the true mean income of the BV group is likely higher than the data indicate. The median annual income reported by NBV group respondents was \$125K ($M = 131K, SD = \$109.7K$), although one individual in the NBV group declined to respond to this item and was excluded from the analysis. Reported income of all study respondents is summarized in Table 4.3.

Table 4.3

Study Respondents' Reported Income at Study Participation, by Offender Group

	Annual Income (in thousands of dollars)											
	0-49	50-74	75-99	100-149	150-199	200-249	250-299	300-349	350-399	400-449	450-499	500+
BV	2	—	2	2	5	1	2	1	—	—	—	2
NBV	4	4	—	4	1	1	1	1	1	—	—	—
Total:	6	4	2	6	6	2	3	2	1	—	—	2

Problems reported at residential treatment intake. All of the 35 study respondents reported they were treated for sex addiction during their residential stay at the designated facility. However, many respondents reported they also received treatment for problems with alcohol, amphetamines, cannabis, cocaine, opioids, sedatives, or anxiolytics. The median number of reported presenting problems at treatment intake was two for respondents in both the BV group ($M = 1.65$, $SD = 0.70$) and the NBV group ($M = 1.56$, $SD = 0.51$). Most respondents reportedly remained in residential treatment for approximately three months; the median length of stay reported by the 35 respondents was 91 days ($M = 110.4$, $SD = 55.1$). Respondents in the BV group reported an average length of stay ($M = 100.3$, $SD = 42.5$) slightly briefer than those in the NBV group ($M = 118.0$, $SD = 62.5$). Respondents' reported number of presenting problems is tabulated in Table 4.4; reported length of stay is summarized in Table 4.5.

Occupational Data

The majority of respondents in both the BV and NBV groups reported that they were working as physicians when they were admitted to residential treatment. However, other respondents reported they were dentists, counselors, attorneys, nurses, teachers, and clergypersons prior to treatment. Table 4.6 summarizes the reported occupations of study

Table 4.4

Number of Respondents Reporting Specific Problems at Treatment Intake, by Offender Group

Group	Presenting Problem								Total
	Sex Add.	Alcohol	Amph	Cannabis	Cocaine	Sed/Anx	Eat Dsrdr	Opioid	
BV	17	5	2	—	—	2	—	1	27
NBV	18	4	2	1	3	0	1	—	29
Total:	35	9	4	1	3	2	1	1	56

Note. Rows do not sum to $N = 35$ because many respondents reported more than one presenting problem.

Table 4.5

Respondents' Reported Length of Stay in Residential Treatment, in Days, by Offender Group and Discharge Year

Discharge Year	Offender Group								
	BV			NBV			Total		
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>
2005	—	—	—	6	114.5	76.0	6	114.5	76.0
2006	4	153.8	51.6	4	164.0	70.1	8	160.4	62.2
2007	4	79.5	28.2	4	99.9	47.2	8	90.5	39.5
2008	5	90.1	32.0	2	95.3	18.8	7	92.2	26.8
2009	4	90.2	23.7	2	73.3	19.5	6	85.4	21.8
Total	17	100.3	42.5	18	118.0	62.5	35	110.4	55.1

respondents at the time they presented for residential treatment at the designated facility.

License and employment status at study participation. Many professionals treated at the designated facility are referred for treatment by their licensing boards after complaints have been lodged against them either by other professionals or by patients or clients. Respondents were not asked whether, at the time they presented for residential treatment, they were being investigated

Table 4.6

Reported Respondent Occupation at Admission to Residential Treatment, by Offender Group

Group	Reported Admit Profession							Total
	Physician	Dentist	Counselor	Attorney	Nurse	Clergy	Teacher	
BV	15	1	1	—	—	—	—	17
NBV	11	—	—	3	1	1	2	18
Total	26	1	1	3	1	1	2	35

by their licensing boards. However, at the time they completed the survey, 77.1% of respondents reported they were licensed to practice their professions either outright or with restrictions; 22.9% indicated their license was suspended, surrendered, or revoked. No respondents reported being under mandatory supervision at the time of study participation. BV group respondents were 27.3% less than NBV group respondents to report being currently licensed. Respondents' license status at time of study participation, organized by offender group, appears in Table 4.7.

Table 4.7

Reported License Status at Study Participation, by Offender Group

Group	Fully Licensed		Restricted License		Supervised Practice		Suspended License		Surrendered/Revoked		Total	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>N</i>	%
BV	9	52.9	3	7.6	—	—	2	11.8	3	17.6	17	100
NBV	14	77.7	1	5.5	—	—	1	5.5	2	11.1	18	100
Total	23	65.7	4	11.4	—	—	3	8.6	5	14.3	35	100

Additionally, respondents were asked whether they continued to be employed in the same, general profession as they were before presenting for residential treatment. Of the 12

respondents in the BV group who reportedly had retained their professional licenses, 11 stated they remained practicing in their fields; one reported working in a related field without direct patient contact. Of the five BV group respondents who were reportedly no longer licensed to practice, three were reportedly still employed and two were not. The three unlicensed respondents reported occupations of portfolio manager, surgical assistant, and teacher/administrator at his former practice where he no longer provided direct patient care. Of the two unlicensed but not employed respondents in the BV group, one was reportedly retired and one stated he had initially returned to practice but was placed on leave-of-absence and his license suspended after receiving a new licensing board complaint.

Of the 15 respondents in the NBV group who reportedly retained their licenses at the time of study participation, 13 were reportedly still working in their professions and two were working in other professions: retail management and restaurant management, respectively. None of the three respondents in the NBV group who stated their licenses had been surrendered, suspended, or revoked at the time of the study reported being employed. These three respondents stated that, at that time, they were on leave-of-absence, unemployed, and retired, respectively.

Perceived change in job status and satisfaction. Respondents were asked to rate any change they perceived in: (a) the status of the job they had at the time of study participation and (b) the satisfaction they derived from it, compared to the job they had before they came to treatment. Respondents could choose from a range of ratings between -5 and +5. For example, persons who responded -5, +5, or 0 to the Current Job Status/Satisfaction item were indicating that the status of the job they held at time of study participation, or the satisfaction they derived from it, was much lower, much higher, or unchanged, respectively, compared to the job they had prior to treatment.

Respondents in the BV group reported a median decrease of -2.0 ($M = -1.0, SD = 3.9$) in the status of the job they held at time of study participation; however, their reported satisfaction with their job increased by a median score of +1.0 ($M = -0.3, SD = 3.8$). Respondents in the NBV group reported that their job status at study participation had decreased only slightly, as indicated by the median score of -0.5 ($M = -0.3, SD = 3.7$); however, they reportedly a median increase in job satisfaction of +2.0 ($M = 1.9, SD = 3.4$). Respondents' reported: (a) occupation at the time of study participation and (b) ratings of perceived change in job status and satisfaction are presented in Table 4.8.

Table 4.8

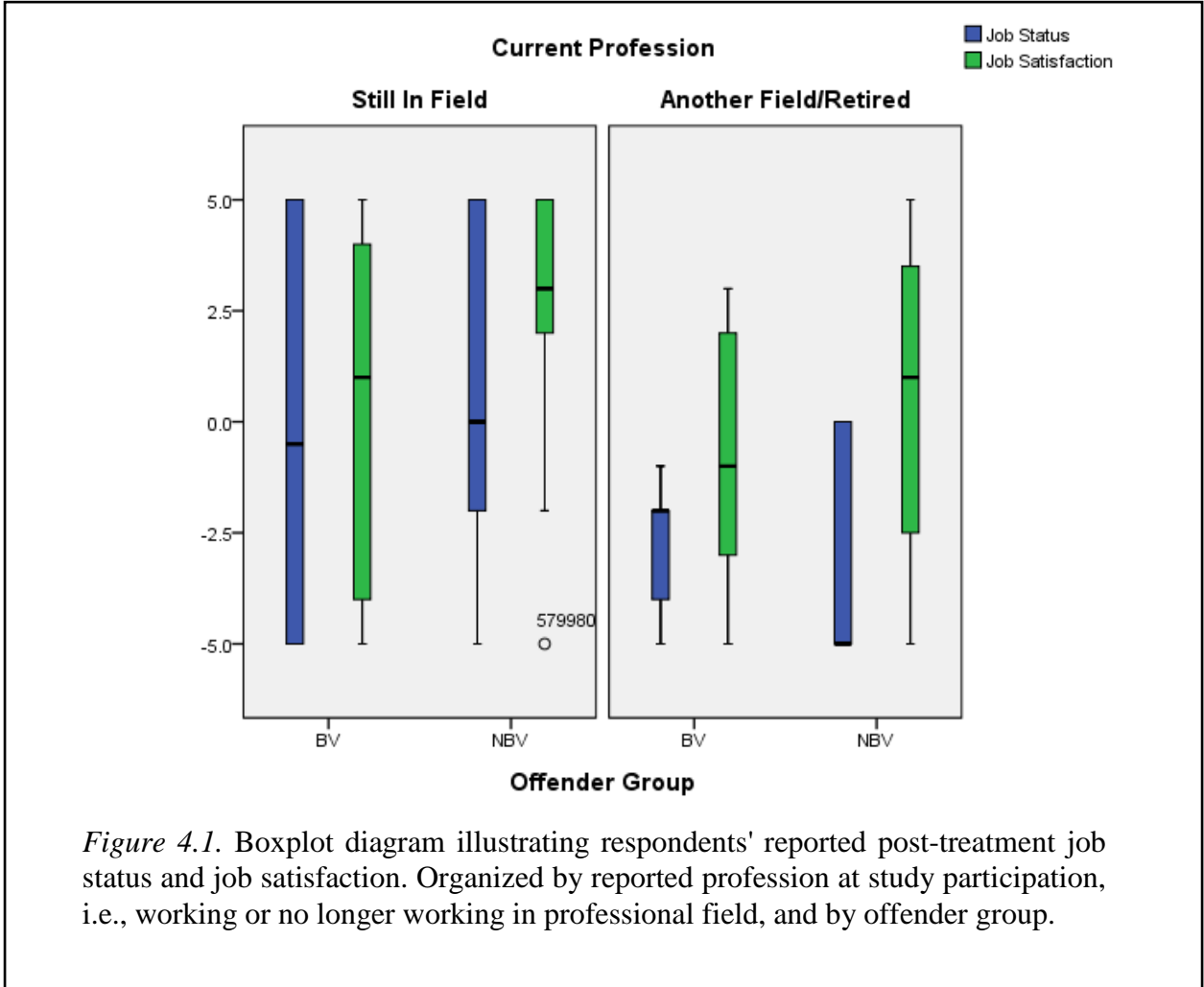
Employment and Ratings of Perceived Changes in Job Status and Job Satisfaction Reported at Time of Study Participation, by Offender Group

Group	Employment			Job Status Change			Job Satisfaction Change		
	In Prof	Other Prof	Unempl/Ret	<i>M</i>	<i>Mdn</i>	<i>SD</i>	<i>M</i>	<i>Mdn</i>	<i>SD</i>
BV	11	4	2	-1.0	-2.0	3.9	-0.3	1.0	3.8
NBV	13	2	3	-0.3	-0.5	3.7	1.9	2.0	3.4
Total	24	6	5	-0.6	-1.1	3.7	0.9	1.5	3.6

Note. "In Prof" = reported employment in the same, general professional field at time of study participation as at, or shortly, before intake to residential treatment. "Other Prof" = employment at time of study participation in some profession other than the one reported at or shortly before intake to residential treatment. "Unempl/Ret" = reported unemployment, leave-of-absence, or retirement at time of study participation.

Respondents' reported perceptions of their current job status and satisfaction varied not only by offender group but also by whether they were still working in their professions. For example, satisfactorily treated professionals who had not crossed sexual boundaries with patients, clients, or staff and who were still working in their field reportedly: (a) returned to jobs with similar or even slightly higher status, and (b) were moderately more satisfied with their jobs

at the time of study participation than prior to treatment. Conversely, professionals who violated sexual boundaries and who were no longer employed in their pre-treatment professions reported the greatest decrease in job status. However, similar to respondents in the other groups, taken as a whole, even these professionals reported feeling somewhat more satisfied with their jobs at the time of study participation than before treatment. A boxplot illustrating the rather complex interaction of all these factors—job status, job satisfaction, profession at time of study participation, and offender group—is provided in Figure 4.1.



Subsequent licensing board complaints. Respondents were asked whether or not any new complaints of misconduct had been lodged against them since completing residential treatment and returning to practice. Participants were informed that: (a) their responses did not constitute an admission of misconduct and (b) a complaint need not have been justified, investigated, adjudicated, or have warranted disciplinary action to be reported in the survey. Furthermore, respondents were instructed to consider only those complaints related to actions or behaviors alleged to have occurred after they discharged from residential treatment.

Many researchers have found that licensing board complaints were not the most accurate indication of the true frequency of professional misconduct (Beecher, 2005; Bouhoutsos et al., 1983; Strasburger et al., 1992). However, study respondents were asked whether they had received new complaints rather than whether they had actually engaged in misconduct because licensing complaints are typically public knowledge. In other words, I wished to gauge the extent to which satisfactorily discharged professionals in the study reported continuing problems with professional misconduct upon returning to practice. However, to preserve respondents' confidentiality, they were not asked to admit to behaviors not already known.

Of the 26 of satisfactorily discharged professionals who returned to practice, four respondents, two each in the BV and NBV groups, reported receiving at least one new board complaint, a rate of 15.4%. One BV group respondent reported he received two new complaints since returning to practice, whereas the other three stated they had received only one complaint each. Two respondents reportedly remained employed in their professions at the time they completed the survey, including the individual who reported receiving two complaints; the two remaining respondents reportedly were on leave-of-absence or unemployed, respectively. Respondents' reported new licensing board complaints is summarized in Table 4.9.

Table 4.9

Returning Professionals' Reported New Licensing Board Complaints by Offender Group

	BV Group		NBV Group		Total	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Total Respondents	17	100	18	100	35	100
Respondents Who Returned to Practice	12	71	14	78	26	74
Practicing Respondents with New Complaints	2	17	2	14	4	15
Respondents Working After New Complaint	1	8	1	7	2	8

Post-discharge Therapeutic Interventions

Of the 35 study respondents, 97.1% reportedly received some type of additional treatment, medication, counseling, and/or recovery support after discharge from residential treatment. Based upon post-hoc categorization, I report these various post-discharge interventions as two broad types: sustained and time-limited. Sustained interventions refer to types of treatment that could conceivably be continued indefinitely, such as personal counseling, psychotropic medication, and participation in recovery-oriented support groups. Conversely, time-limited interventions refer to modes of treatment that typically continue for only a limited period of time, such as additional courses of residential or outpatient treatment, accommodation in a transitional living facility, or continuing education in the maintenance of professional boundaries.

Respondents were asked to provide their best estimate of the raw number of counseling sessions and/or support group meetings they had attended and to estimate the total number of days they used psychotropic medications multiplied by types of medication(s) per day. However, because some respondents had discharged from treatment as many as five years ago, I was not able to compare accurately one respondent's reported number of counseling sessions, support

group meetings, and psychotropic medications to another's. For example, a hypothetical respondent who discharged one year ago and who took five different medications per day since then would have reported a total of 1,825 medication-days since discharge. However, another hypothetical respondent discharged five years ago and who took only one medication per day would obtain the same raw score for this variable. In a similarly vein, respondents could potentially have seen a number of different counselors or have belonged to several different support groups and have participated in each or any of these activities monthly, weekly, or even daily. As with days and types of medication use, it would not be accurate to compare raw data on these variables respondent-by-respondent, when each may have had as many as five additional years in post-discharge recovery.

Therefore, to obtain a figure comparable across all groups, I divided each respondent's total number of reported so-called sustained interventions by the number of years since discharge, data to which I had access and which I took into consideration when assigning respondents to their groups. In so doing, I obtained a “medication-days-per-year” variable, a “counseling-sessions-per-year” variable, and a “support-group-meetings-per-year” variable. These "per-year" variables provide a broad, quantitative measure of reported medications taken, counseling sessions attended, and support group meetings attended that are comparable across groups of respondents.

Sustained interventions. Since their discharge from treatment, 62.9% of study respondents reported having taken prescribed psychopharmaceuticals, 94.3% reported having received counseling or psychotherapy, and 94.1% reported having attended a recovery-oriented support group meeting. Following, I briefly describe the characteristics of study respondents regarding these so-called sustained interventions.

Psychopharmaceuticals. Respondents in the BV group (64.7%) and the NBV group (61.1%) were statistically equally likely to have taken psychopharmaceuticals since discharge, Yates-corrected $\chi^2 (1, n = 35) = .000, p = 1.000, \phi = .037$. The median number of medication-days-per-year since discharge was 360 for the BV group ($M = 416.6, SD = 294.1$), and 395 for the NBV group ($M = 316.8, SD = 174.0$). In other words, in the course of a typical year, respondents in the BV group took an average of 416.6 doses of psychotropic medication, a rate of 1.14 per day, whereas the average respondent in the NBV group took 316.8 doses per year, or 0.87 per day. As evidenced by the rather large standard deviation, I recorded tremendous variation on this variable; some respondents took several daily medications consistently whereas others took only one or two medications sporadically.

Counseling, psychotherapy, and recovery-oriented support groups. Of the 35 study respondents, 33 reported having participated in some form of counseling or psychotherapy since discharge from treatment. Respondents in both the BV and the NBV groups were equally likely to have reported counseling, 94.1% and 94.4% respectively, Yates-corrected $\chi^2 (1, n = 35) = .000, p = 1.000, \phi = -.007$. The median number of reported counseling-sessions-per-year since discharge was 20 for respondents in the BV group ($M = 30.8, SD = 35.6$) and 30 in the NBV group ($M = 42.2, SD = 27.1$). However, respondents reported a great deal of variation on this variable, as well. Some respondents reported over 100 sessions of counseling per year and others only 10 or 15.

Finally, of the 35 respondents in my study, 91.4% reported that they had attended at least one meeting of a recovery-oriented support group since discharge from residential treatment. By offender group, 88.2% of respondents in the BV group reported support group meeting attendance, whereas 94.4% of respondents in the NBV group stated they had done so. The

median number of support group meetings attended per year since discharge was 120 for the BV group ($M = 148.9, SD = 119.4$) and 100 for the NBV group ($M = 162.2, SD = 146.0$).

Respondents in the BV group reported they attended a mean of 2.2 different support groups, whereas NBV group respondents reported having attended a mean of 2.6 different groups.

Reported participation in various recovery-oriented support groups is presented in Table 4.10;

Respondent data for all the so-called sustained interventions is summarized in Table 4.11.

Table 4.10

Reported Recovery-Oriented Support Group Meeting Attendance by Offender Group

Group	AA		NA		SA		SAA		SCA		SLAA		Other 12-Step		Non-12-Step	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
BV	10	59	2	12	4	24	8	47	1	16	4	24	2	12	6	35
NBV	10	56	5	28	7	39	10	56	—	—	5	28	5	28	5	28
Total	20	57	7	20	11	31	18	51	1	3	9	26	7	20	11	31

Note. Rows total to more than 100% because most respondents reported attending several different groups. AA = Alcoholics Anonymous; NA = Narcotics Anonymous; SA = Sexaholics Anonymous; SAA = Sex Addicts Anonymous; SCA = Sexual Compulsives Anonymous; SLAA = Sex & Love Addicts Anonymous. "Other 12-Step" = some other group based on The 12 Steps of Alcoholics Anonymous; "Non-12-Step" = some other group not based on The 12 Steps of Alcoholics Anonymous.

Time-limited interventions. In addition to the various forms of treatment that a respondent could conceivably have continued indefinitely, many respondents reported having participated in post-treatment interventions that typically last only a limited time. Such interventions could include a subsequent course of residential or outpatient treatment, a stay in a transitional living facility, or a continuing-education course on the maintenance of professional boundaries. Unlike sustained intervention data, I did not compensate for years since discharge

Table 4.11

Sustained Post-Discharge Interventions per Year, by Offender Group

	BV Group	NBV Group	Total
Psychopharmaceuticals			
Respondents Reporting Use (<i>n</i>)	11	11	22
Respondents Reporting Use (%)	64.7	61.1	62.9
Mean Med-Days/Year Post Discharge	416.6	316.8	366.7
Standard Deviation Med-Days/Year	294.1	174.0	241.3
Counseling/Psychotherapy			
Respondents Reporting Participation (<i>n</i>)	16	17	33
Respondents Reporting Participation (%)	94.1	94.4	94.3
Mean Sessions/Year Post Discharge	30.8	42.2	36.7
Standard Deviation Sessions/Year	35.6	27.1	31.5
Recovery-Oriented Support Groups			
Respondents Reporting Participation (<i>n</i>)	15	17	32
Respondents Reporting Participation (%)	88.2	94.4	91.4
Meetings/Year Post Discharge	148.9	162.2	156.0
Standard Deviation Meetings/Year	119.4	146.0	132.2

when conducting statistical analyses on time-limited interventions; as no respondents reported participating in these interventions for more than one year, data are comparable across groups as recorded.

Of the 35 study respondents, only one reported that he presented for an additional course of residential treatment after having been discharged from the designated facility, and his reported length of stay for this second course of treatment was 11 days. However, nine respondents, seven from the BV and two from the NBV group, reportedly they continued to receive treatment on an outpatient basis after their discharge from residential treatment. The reported median number of days of post-discharge outpatient treatment was 72 for the BV group ($M = 82.3$, $SD = 52.9$) and 81 for the NBV group ($M = 81$, $SD = 69.3$).

Some study respondents reportedly lived for a time in a transitional living (TL) facility,

sometimes informally referred to as a "half-way house," after discharging from residential treatment but before returning home. Of the study's 35 respondents, one member of the BV group indicated he had resided in TL for 95 days, whereas three members of the NBV group reported stays in TL of 45, 90, and 270 days, respectively. The median number of days of transitional living reported by these four respondents was 92.5 ($M = 125$, $SD = 99.2$).

Finally, many respondents reported they had earned Continuing Medical Education (CME) units in the maintenance of appropriate professional boundaries either while in residential treatment or sometime thereafter. Of the respondents in the BV group, 82.4% reported having earned CMEs in professional boundaries, whereas 72.2% of NBV group respondents indicated they had done so. Respondents in the BV group reportedly earned a median of 24.5 hours of boundary training ($M = 26.2$, $SD = 10.9$) compared to a median of 20.0 hours ($M = 19.8$, $SD = 8.9$) of boundary training for the NBV group. Respondents' reported participation in so-called time-limited, post-discharge treatment and recovery support is summarized in Table 4.12. Additionally, boxplot diagram illustrating the data distribution for five of the most commonly reported post-discharge interventions, whether sustained time-limited, is provided in Figure 4.2.

Accommodations for Missing Data and Defensive Responding

Incomplete Response Sets

In studies involving people, researchers rarely obtain a complete data set from every respondent (Pallant, 2007). Missing data can occur completely at random or can reflect a variety of unmeasured personal, cultural, or situational factors (Gelman & Hill, 2007). Researchers must use their best judgment to determine whether such missing data occur completely at random – a rare occurrence in research involving people – or whether the missing data are the result of other factors (Gelman & Hill, 2007).

Table 4.12

Time-Limited Post-Discharge Interventions, by Offender Group

	BV Group	NBV Group	Total
Subsequent Outpatient Treatment			
Respondents Reporting (<i>n</i>)	7	2	9
Respondents Reporting (%)	41.2	11.1	25.7
Mean Days of Treatment	82.3	81.0	82.0
Standard Deviation, Days of Treatment	52.9	69.3	51.9
Transitional Living			
Respondents Reporting (<i>n</i>)	1	3	4
Respondents Reporting (%)	5.9	16.6	11.4
Mean Days of Transitional Living	95.0	101.3	100.0
Standard Deviation, Days of Trans Liv	0.0	118.3	102.5
Continuing Medical Education, Boundaries			
Respondents Reporting (<i>n</i>)	14	13	27
Respondents Reporting (%)	82.4	72.2	77.1
Mean CME Hours Earned	26.2	20.0	23.1
Standard Deviation, CME Hours Earned	10.3	8.9	10.3

The simplest approach to the problem of missing data is to discard incomplete cases altogether (Gelman & Hill, 2007). However, in studies with many variables, researchers who discard all data from a respondent who did not provide a complete data set typically find they have very few complete cases to analyze. Therefore, researchers commonly utilize a variety of techniques to "fill in" or impute missing values. Gelman and Hill (2007) provided a variety of statistical methods for imputing data, perhaps the most expedient of which is to replace each missing value with the mean of the values obtained by the other respondents for that item. Replacing missing values with the item mean introduces a degree of error, but the results of this method can usually yield reasonable and statistically meaningful results (Gelman & Hill, 2007).

Of the 35 respondent in the study, 21 submitted fully completed questionnaires. The

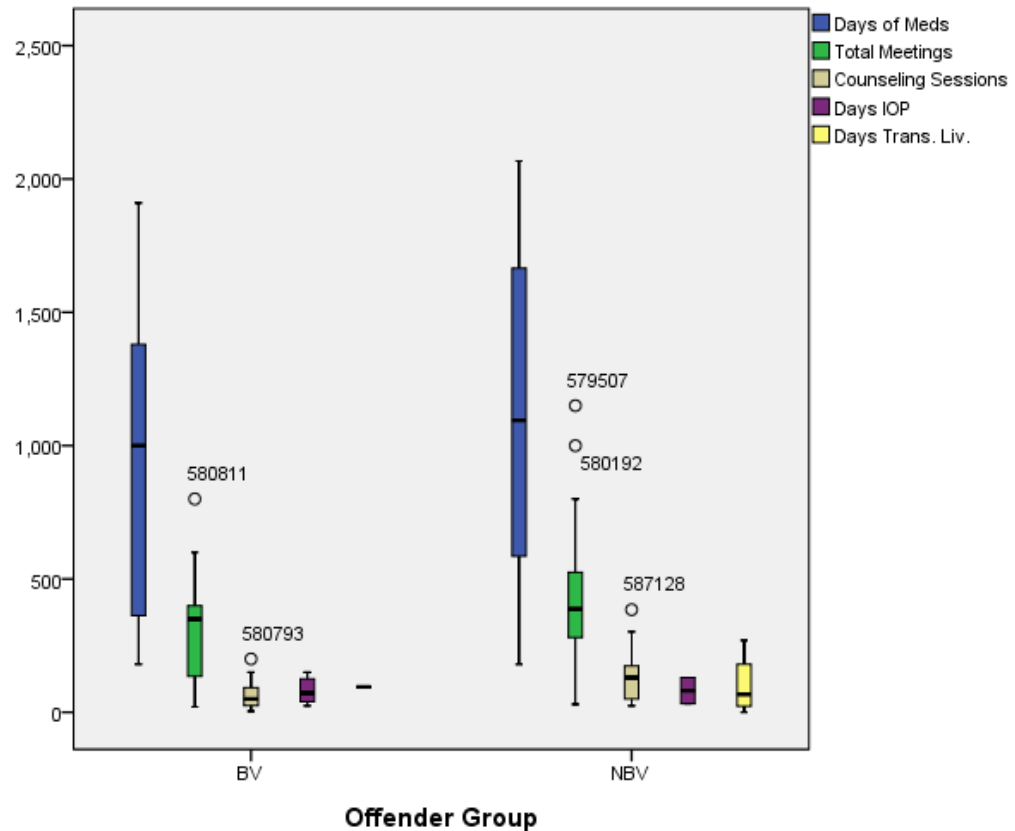


Figure 4.2. Boxplot diagram illustrating distribution of data for five, commonly-reported post-discharge treatment interventions, by Offender Group. Days of Meds = reported number of all days of all psychotropic medication use. Total Meetings = reported number of all meetings of all support groups attended. Counseling Sessions = reported number of all counseling sessions attended. Days IOP = reported number of days of Intensive Outpatient treatment. Days Trans. Liv. = reported days of residence in a transitional living facility.

remaining 14 respondents, eight from the BV group and six from the NBV group, skipped 49 of a possible 2,095 individual survey items. Most respondents who submitted incomplete surveys skipped only one or two items; the median number of skipped items among these 14 respondents was 1.5 ($M = 3.6, SD = 4.7$). However, nearly half of the 49 missing responses were attributable to two participants: one who did not respond to any of the S-SAS items in the context of his post-

treatment experiences, and the other who did not respond to any of the S-SAS items in the context of his retrospective pre-treatment experiences. The remaining 25 missing items were accounted for by 13 respondents and were distributed throughout the questionnaire.

Little deliberation was required when deciding how to handle the 24 missing data points from the two respondents who completely skipped the S-SAS items at either one or the other observation point; their data was simply recorded as it was reported by the respondent. That is to say, these respondent's S-SAS scores were tallied and analyzed at the observation point for which data were provided. However, these two individuals' responses were not included in any analysis that required a pair of scores, i.e., both a post-treatment and a retrospective pre-treatment score, on the S-SAS. As for the remaining respondents who provided incomplete questionnaires, I used my judgment in attempting to discern whether the skipped responses reflected random error or some other, unmeasured characteristic.

I cannot know why a particular respondent may have skipped a certain item; however, I suspect that much of the missing data are a result of some unaccounted-for factor, namely, "defensiveness." I arrived at this conclusion by analyzing the content of each item skipped, the group assignments of the respondents who skipped that item, and whether or not the skipped item reflected the respondents' experiences at the time of study participation. Individuals in both the BV and NBV groups skipped items relating to both their pre-treatment and their post-treatment experiences. However, in general, most missed items can be attributed to respondents in the BV group who skipped items relating to their present experiences of either: (a) CSB symptoms as measured by the S-SAS, or (b) SBV risk factors as measured by the BVI.

I chose to impute values for these missing data by replacing the skipped item with the mean score obtained by the other respondents to that item. However, in order to compensate for

the determination that the missing data reflected respondent defensiveness, the mean of the observed scores for the item was rounded up to the nearest whole number. For example, three respondents, in the context of their current experiences, skipped the BVI item, "I have made exceptions for patients, e.g., scheduling, benefits, and/or fees, because I found the patient attractive, appealing, or impressive." Participants could choose to respond, "Never," "Rarely," "Sometimes," or "Often" and be assigned a score of "0", "1", "2", or "3", respectively. The mean score reported by the 25 persons who responded to this item was .08. However, rather than imputing the actual mean of .08, I rounded up to the nearest whole number, "1". In effect, I made the judgment that if an individual had truly never made exceptions for attractive patients, he would likely not have skipped the item. So rather than imputing the mean score for that value, which would be statistically equivalent to the respondent having answered "never," I entered the mean score rounded up to the nearest whole number, "1", which is interpreted as "rarely." I applied the same logic and methodology to all of the 25 missing values in the BVI and S-SAS portions of the questionnaire. Utilizing imputed values that compensate for responsive defensiveness introduces error into the data. However, as a percentage of total responses to BVI and S-SAS items, the number of imputed responses is relatively small, no more than 1.4% of all responses on any one instrument at any given observation point. A summary of items for which imputed scores were entered in place of missing data is presented in Tables 4.13 and 4.14. Imputed values as a percentage of total items for each instrument and observation point are presented in Table 4.15.

Observed Scores Perceived to be Defensive

In addition to the 14 individuals who submitted incomplete questionnaires, four participants (11.4%) responded in a manner that I have interpreted as defensive despite the fact that they

Table 4.13

Content Analysis of Missing S-SAS Data for Which Imputed Values Were Entered, by Observation Point and Offender Group

Item	Respondents Skipped (<i>n</i>)				<i>M</i>	Imp Val	Item Text
	BV Group		NBV Group				
	Pre	Post	Pre	Post			
S-SAS-2	—	—	1	—	5.2	6	[This week] how many times did you [have] urges to engage in problematic sexual behaviors?
S-SAS-4	—	1	—	—	1.2	2	[This week] how much were you able to control your urges?
S-SAS-5	1	—	—	—	5.6	6	[This week] how often did thoughts about engaging in problematic sexual behaviors come up?
S-SAS-7	1	—	—	—	5.4	6	[This week] how much were you able to control your thoughts of problematic sexual behaviors?
S-SAS-7	—	1	—	—	1.8	2	[This week] how much were you able to control your thoughts of problematic sexual behaviors?
S-SAS-8	—	2	—	—	1.1	2	[This week] how much total time did you spend engaging in problematic sexual behaviors?
S-SAS-12	—	1	—	—	1.2	2	[This week] how much personal trouble... has your problematic sexual behavior caused you?
Total	2	5	1	—			

Note. *M* = mean of all observed scores for that item; Imp Val = Imputed Value, i.e., score entered in place of the missing value.

submitted a complete response set. These four persons responded “0” to every item on the S-SAS in both the post-treatment and the retrospective pre-treatment contexts. Stated another way, these four respondents reported that they experienced no symptoms of CSB as measured by the S-SAS at either observation point. As with many brief, self-report instruments, neither the BVI nor the

Table 4.14

Content Analysis of Missing BVI Data for Which Imputed Values Were Entered, by Observation Point and Offender Group

Item	Respondents Skipped (<i>n</i>)				<i>M</i>	Imp Val	Item Text
	BV Group		NBV Group				
	Pre	Post	Pre	Post			
BVI-04	—	1	—	1	0.3	1	I have... [compared] the gratifying qualities... in a patient with the less gratifying qualities in my [partner].
BVI-05	—	1	—	—	0.04	1	I have thought that my patient's problem would be helped if he/she had a romantic involvement with me.
BVI-07	—	—	1	—	1.2	2	I have felt... excitement/ longing when I think of a patient or anticipate [a] visit.
BVI-09	—	—	1	—	1.5	2	When a patient has acted [seductively] I have experienced this as [due to] my own sex appeal.
BVI-10	—	—	—	1	0.04	1	I have [had] a personal relationship with a patient [during] or after treatment.
BVI-14	1	—	—	—	1.4	2	I have... [talked] about my personal life or problems with patients.
BVI-19	—	1	—	—	0.04	1	I have [made] business deals w/ patients.
BVI-20	1	—	—	—	0.3	1	I have solicited gifts or favors from patients for personal benefit....
BVI-22	1	—	—	—	1.5	2	I have found myself fantasizing or daydreaming about a patient.
BVI-23	—	3	—	—	0.08	1	I have made exceptions for patients... because I found [them] attractive...
BVI-25	1	—	—	—	1.1	2	I have sought social contact w/patients.
Total	4	6	2	2			

Note. *M* = mean of all observed scores for that item; Imp Val = Imputed Value, i.e., score entered in place of the missing value.

Table 4.15

Percentage of All Missing Data Replaced With Imputed Scores, by Instrument, Offender Group, and Observation Point

	BV Group	NBV Group	Total
BVI Pre			
Instrument Items	25	25	25
Respondents	14	13	27
Total Possible Items	350	325	675
Number of Items Skipped	4	2	6
Percentage of Skipped items	1.1%	0.6%	0.9%
BVI Post			
Instrument Items	25	25	25
Respondents	14	14	28
Total Possible Items	350	350	700
Number of Items Skipped	7	2	8
Percentage of Skipped items	2.0%	0.6%	1.1%
S-SAS Pre			
Instrument Items	12	12	12
Respondents	12	18	30
Total Possible Items	144	216	360
Number of Items Skipped	3	2	4
Percentage of Skipped items	2.1%	0.9%	1.1%
S-SAS Post			
Instrument Items	12	12	12
Respondents	13	17	30
Total Possible Items	156	204	360
Number of Items Skipped	5	0	5
Percentage of Skipped items	3.2 %	0%	1.4%
Total			
Total Possible Items	1000	1095	2095
Number of Items Skipped	19	6	25
Percentage Skipped Items	1.9%	0.5%	1.1%

Note. *M* = mean of all observed scores for that item; Imp Val = Imputed Value, i.e., score entered in place of the missing value.

S-SAS includes a mechanism for measuring and compensating for test-taking attitudes such as defensiveness, resentment, or deceitfulness. Therefore, I have no means of determining whether the responses from these four participants reflect their true experiences or some other factor. However, based upon my clinical familiarity with this population, I made the presumption

that these four individuals' responses were likely not representative of their true experiences, and none of the S-SAS data they provided was recorded. As an aside, I noted that, because these same four individuals reported that they had not had any patient/client contact at either post-treatment or retrospective pre-treatment observation point, they were instructed to skip the BVI completely. These four participants, however, did provide what appeared to be face-valid responses to items concerning their demographic information, license status, and job status and satisfaction, as well as to items concerning their post-discharge medication, counseling, treatment, and/or recovery support. I included these respondents' face-valid data in my analyses.

Analyses of Research Questions

Research Question 1: Among all professionals who presented for residential treatment at the designated facility, does treatment type, i.e., sex addiction treatment or other addiction treatment, predict discharge status, i.e., satisfactory/completed or unsatisfactory/not completed?

Using de-identified patient intake and discharge information from treatment facility records, I organized data from the 200 professionals discharged from residential addiction treatment between January 1, 2005 and December 31, 2009 into two dichotomous categories: Treatment Type and Discharge Status. After confirming that each cell in the analysis contained five or more cases, the assumed minimum count, a chi-square test for independence (with Yates Continuity Correction) yielded no significant association between treatment type and discharge status, $\chi^2(1, n = 84) = 2.751, p = 0.097, \phi = -.128$. The effect measure of this analysis, ϕ , indicated that 1.64% of the variance in discharge status of these 200 individuals can be explained by treatment type, a small effect. Although non-significant, for practical purposes, professionals in sex addiction treatment were slightly more likely to complete it than those in other types of addiction treatment. Discharge rates by treatment type are presented in Table 4.16.

Table 4.16

Discharge Rates of Patients in the Impaired Professionals Program at the Designated Treatment Facility between January 1, 2005 and December 31, 2009, by Type of Treatment

Treatment Type	Discharge Status		Total
	Satisfactory	Unsatisfactory	
Sex Addiction			
Count	65	19	84
% within Treatment Type	77.4%	22.6%	100%
% within Discharge Status	46.1%	32.2%	42.0%
% of Total	32.5%	9.5%	42.0%
Non-Sex Addiction			
Count	76	40	116
% within Treatment Type	65.5%	34.5%	100.0%
% within Discharge Status	53.9%	67.8%	58.0%
% of Total	38.0%	20.0%	58.0%
Total			
Count	141	59	200
% within Treatment Type	70.5%	29.5%	100.0%
% within Discharge Status	100.0%	100.0%	100.0%
% of Total	70.5%	29.5%	100.0%

Research Question 2: Among all professionals discharged from residential sex addiction treatment, does offender group, i.e., sexual boundary violator or non-violator, predict discharge status, i.e., satisfactory/completed or unsatisfactory/not completed?

Using de-identified patient intake and discharge information from treatment facility records, data from the 84 professionals discharged from residential sex addiction treatment between January 1, 2005 and December 31, 2009 was organized into two dichotomous categories: Offender Group and Discharge Status. Each cell in the analysis contained five or more cases, the assumed minimum count. A chi-square test for independence (with Yates Continuity Correction) demonstrated no significant association between offender group and

discharge status, $\chi^2 (1, n = 84) = 1.474, p = 0.23, \phi = .140$. Although not statistically significant, the ϕ coefficient of this analysis indicates that 1.96% of the variance in the discharge status of these 84 individuals can be explained by Offender Group, a small effect (Cohen, 1988, pp. 79-81). Although non-significant, this result indicates that professionals who reportedly violated sexual boundaries were, for practical purposes, slightly more likely to have completed treatment than those who did not. Discharge rates by offender group are summarized in Table 4.17.

Table 4.17

Discharge Rates of Impaired Professionals Who Received Residential Sex Addiction Treatment at the Designated Facility between January 1, 2005 and December 31, 2009, by Offender Group

Offender Group	Discharge Status		Total
	Satisfactory	Unsatisfactory	
BV Group			
Count	33	6	39
% within Offender Group	84.6%	15.4%	100%
% within Discharge Status	50.8%	31.6%	46.4%
% of Total	39.3%	7.1%	46.4%
NBV Group			
Count	32	13	45
% within Offender Group	71.1%	28.9%	100.0%
% within Discharge Status	49.2%	68.4%	53.6%
% of Total	38.1%	15.5%	53.6%
Total			
Count	65	19	84
% within Sex Addiction	77.4%	22.6%	100.0%
% within Discharge Status	100.0%	100.0%	100.0%
% of Total	77.4%	22.6%	100.0%

Research Question 3: Among respondents satisfactorily discharged from residential sex addiction treatment, how are reported CSB symptoms related to reported SBV risk both at post-treatment,

i.e., at-time-of-study-participation, and at retrospective pre-treatment?

Pearson product-moment correlation coefficient was used to assess the relationship between respondents' reported severity of symptoms of CSB, as measured by the S-SAS, and frequency of risk factors for SBV, as measured by the BVI. Respondent data was collected in the context of their experiences in two time periods: (a) retrospective, pre-treatment, and (b) at time of study participation, i.e., "post-treatment." The correlation coefficient was calculated twice, once for each observation period. Results of preliminary analyses ensuring that the data met the assumptions of normality and homoscedasticity are provided in Table 4.18; a scatter plot illustrating data linearity is provided in Appendix F, Tables F.1 through F.6.

Table 4.18

Tests Demonstrating Normality and Homogeneity of Error Variance of BVI, S-SAS, and BVI-change and S-SAS-change Scores

Instrument	Observation	Kolmogorov-Smirnov ^a			Levene's Test ^c			
		Statistic	df	p ^b	F	df1	df2	p ^d
S-SAS	Pre-treatment	.157	30	.058	0.213	1	27	.648
S-SAS	Post-treatment	.121	30	.200	2.02	1	27	.166
BVI	Pre-treatment	.139	27	.193	2.967	1	19	.101
BVI	Post-treatment	.200	28	.006*	1.569	1	19	.226
S-SAS Change	N/A	.145	28	.137	1.233	1	26	.277
BVI Change	N/A	.156	21	.197	7.833	1	19	.011*

Note. ^aTests the assumption of normality; ^bp > .05 indicates normal distribution of scores; ^cTests the assumption of homogeneity of error variance, i.e., homoscedasticity; ^dp > .05 indicates homogeneity of error variance; * = assumption not met.

Analysis yielded no significant correlation with no effect at pre-treatment ($r = 0.090$, $n = 24$, $p = 0.674$) and no significant correlation with medium effect at post-treatment ($r = 0.386$, $n = 25$, $p = 0.057$). Thus, among this sample of professionals who successfully completed

residential sex addiction treatment, retrospectively reported symptoms of sex addiction were not correlated to retrospectively reported risk of boundary violation in the months prior to treatment. However, at post-treatment, i.e., at time of study participation, the direct relationship between the two phenomena, though not statistically significant, was moderate for practical purposes.

As my study is investigational in nature, I examined these data by offender group, as well, in an attempt to determine where differences in correlations between the two phenomena might be found. Among the respondents in the BV group, analysis yielded no statistically significant correlation with a medium effect both at retrospective pre-treatment ($r = .361, n = 11, p = 0.276$) and at time of study participation ($r = .304, n = 11, p = 0.363$). Among respondents in the NBV group, results indicated no significant correlation with a small effect at pre-treatment ($r = 0.135, n = 13, p = 0.660$) and no significant correlation with a medium effect at post-treatment ($r = 0.426, n = 14, p = 0.128$). Although none of these results reached statistical significance, they suggest that, prior to treatment, the direct relationship between retrospectively reported pre-treatment CSB symptoms and SBV risk was, as a practical matter, more than twice as strong for respondents who reportedly violated professional sexual boundaries than for those who reportedly did not. Furthermore, at the time of study participation, the direct relationship between CSB symptoms and SBV risk was, for practical purposes, moderate for both offender groups. A scatter-plot of these correlations at both observation points, categorized by offender group, is provided in Figure 4.3.

To further explore these data, in addition to investigating the correlations between pairs of continuous scores, I attempted chi-square analysis to determine if elevated SBV risk was associated with elevated CSB symptom severity at either or both observation(s). However, to do so, the study sample needed to be categorized into (a) High- and Low-SBV-Risk groups and (b)

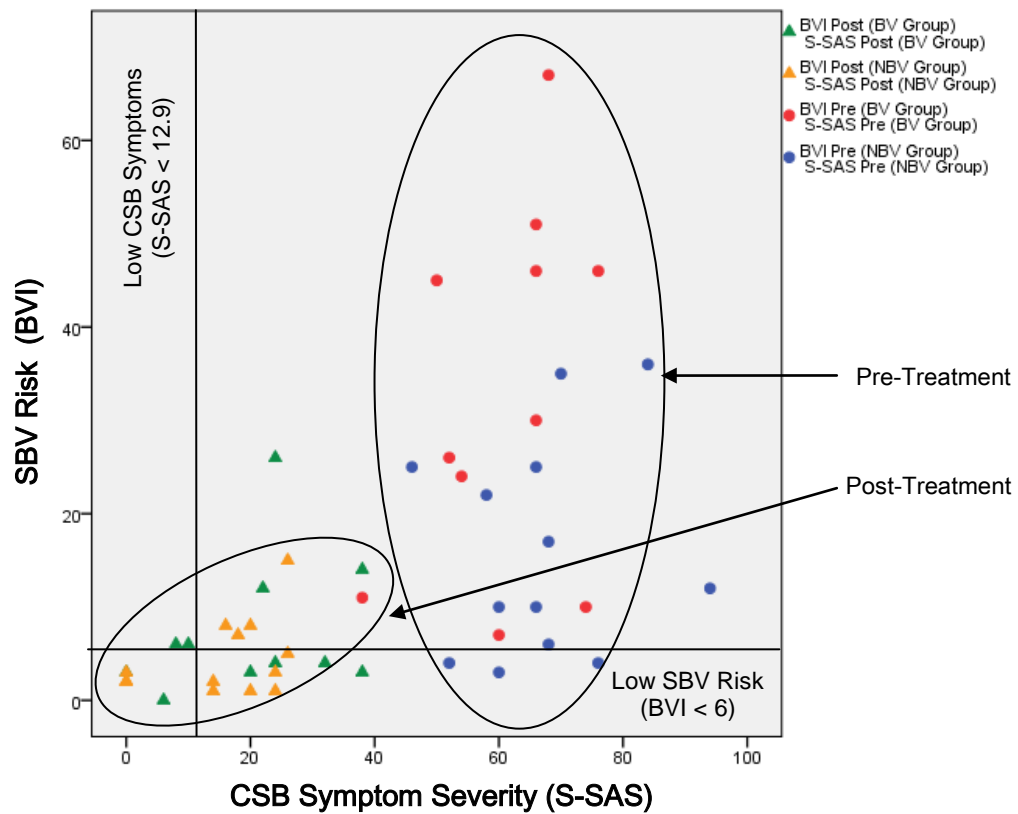


Figure 4.3. Correlations between CSB symptom severity and SBV risk at both retrospective pre-treatment and at time of study participation, by offender group.

High- and Low-CSB-Symptom groups. Swiggart et al. (2008) suggested a BVI score of 6 or higher as an appropriate threshold to discriminate individuals at high risk for SBV from those at low risk. However, as the S-SAS is not a screening instrument, Raymond et al. (2007) did not suggest a similar, discriminating threshold. In the S-SAS validation study, the only published report of data collected with the instrument, Raymond et al. (2007) stated that their sample of 35 men, drawn from a population of 55 persons attending out-patient, group therapy for CSB, obtained mean scores of 12.4 ($SD = 9.6$) at Week 1 and 13.4 ($SD = 9.9$) at Week 2. Intuitively, I chose the mean of these two scores, 12.9, as a preliminary threshold to discriminate “High,” i.e.,

clinically significant, CSB symptom severity from “low” severity. For increased visual clarity, Table 4.3 includes a line of demarcation at each of these High/Low thresholds.

At retrospective pre-treatment, 24 respondents provided both SAS and BVI data; all 24 obtained S-SAS scores ($M = 64.1, SD = 16.2$) greater than my admittedly arbitrary threshold of 12.9. Concurrently, 21 of these 24 respondents obtained BVI scores ($M = 26.7, SD = 17.6$) higher than Swiggart et al.’s (2008) threshold of 6. A chi-square test for independence was not mathematically possible with this data set because pre-treatment CSB symptom severity was constant. However, the cross-tabulation of pre-treatment High-/Low-SBV-risk and High-/Low-CSB-symptoms, summarized in Table 4.19, indicated that, although the two scores were not mathematically correlated, nearly 90% of respondents who reported elevated CSB symptoms at pre-treatment were also at high risk of SBV.

At post-treatment, i.e., at time of study participation, 25 respondents provided both S-SAS and BVI data. Of these respondents, 17 reportedly continued to experience elevated CSB symptoms ($M = 23.5, SD = 7.1$) and eight did not ($M = 3.0, SD = 4.28$). Of these 25 respondents, nine reportedly remained at high risk of SBV ($M = 11.4, SD = 6.46$) and 16 were reportedly at low risk ($M = 2.38, SD = 1.41$). A chi-square test for independence revealed no significant association with a small effect between SBV risk and CSB symptom severity at time of study participation, Yates-corrected $\chi^2(1, n = 25) = .115, p = 0.432, \phi = .157$. Although not significant, the ϕ coefficient of the analysis indicated that 2.46% of the variance in SBV risk was explained by CSB symptom severity, a small effect. However, because two of the cells in the analysis contained fewer than 5 cases, Fisher’s Exact Test was conducted to confirm that the association between the phenomena at post-treatment was not significant, $p = .661$.

The cross-tabulation of High-/Low-SBV-risk and High-/Low-CSB-symptoms provided

Table 4.19

Cross-tabulation of High/Low SBV Risk and High/Low CSB Symptom Severity, as Measured Respectively by BVI Scores ≥ 6 and S-SAS Scores ≥ 12.9 , at Retrospective Pre-Treatment Observation and at Time of Study Participation, i.e., Post-Treatment Observation

SBV Risk	CSB Symptom Severity				
	Pre-Treatment		Post-Treatment		
	High	Low	High	Low	Total
High					
Count	21	0	7	2	9
% within SBV Risk	100%	0%	77.8%	22.2%	100%
% within CSB Symp. Sev	87.5%	0%	41.2%	25.0%	36.0%
% of Total	87.5%	0%	28.0%	8.0%	36.0%
Low					
Count	3	0	10	6	16
% within SBV Risk	100%	0%	62.5%	37.5%	100.0%
% within CSB Symp. Sev.	12.5%	0%	58.8%	75.0%	64.0%
% of Total	12.5%	0%	40.0%	24.0%	64.0%
Total					
Count	24	0	17	8	25
% within SBV Risk	100%	0%	68.0%	32.0%	100.0%
% within CSB Symp. Sev.	100%	0%	100.0%	100.0%	100.0%
% of Total	100%	0%	68.0%	32.0%	100.0%

Note. To be included in this table, respondents need only have provided both an S-SAS score and a BVI score at either observation. Most respondents provided paired BVI/S-SAS data at both observations. However, respondents providing data at post-treatment are not necessarily the same respondents providing data at pre-treatment and vice versa. Therefore, this table does not indicate change over time but only how pairs of BVI and S-SAS scores were related at two different observations.

in Table 4.19 indicated that, at time of study response, most respondents (64%) were reportedly at low risk of SBV. However, of these 16 persons at low SBV risk, 10 reported they continued to experience "high," i.e., clinically significant, symptoms of CSB as indicated by S-SAS score greater than 12.9. This result suggests that, as a practical matter, although both phenomena decreased over time, lower CSB symptom severity was only moderately correlated to lower SBV risk. In other words, SBV risk was reduced to "low" levels more frequently than CSB

symptomatology was reduced to “low”, i.e., non-clinical levels.

Research Question 4: Among respondents satisfactorily discharged from residential sex addiction treatment, do sexual boundary violators and non-violators differ in CSB symptom severity reported at post-treatment, i.e., at time of study participation, when compared to recollections of their pre-treatment CSB symptom severity?

I first conducted tests to confirm that the assumptions underlying ANOVA were met, including normality and homoscedasticity, the results of which were presented previously in Table 4.18. Additionally, I confirmed that my data met the assumption of linearity (See Tables F.1 and F.2 in Appendix F), the assumption of homogeneity of covariance matrices, Box's $M = 2.699$, $F(3, 36899.706) = .824$, $p = .480$, and the assumption of sphericity utilizing Greenhouse-Geisser's correction, $\epsilon = 1.00$. I then conducted a split plot ANOVA to determine whether: (a) respondents reported a statistically significant difference in CSB symptoms over time, as measured by their post-treatment versus retrospective pre-treatment S-SAS scores; and (b) respondents who violated professional sexual boundaries differed from respondents who did not violate such boundaries in any reported CSB symptom change. The number of respondents' scores utilized in this analysis ($n = 29$) was less than the number of completed surveys received ($n = 35$) because several respondents either: (a) did not provide a pair of pre- and post-treatment S-SAS scores, or (b) submitted responses I interpreted as defensive and did not include in the data set.

ANOVA produced a small but statistically non-significant interaction effect between offender group and mean S-SAS score, Wilks's $\lambda = .974$, $F(1, 27) = 0.716$, $p = .405$, partial $\eta^2 = .026$. This result indicated that, although the rates of change were not statistically significantly different between the groups, reported rate of decrease in CSB symptom severity as measured by

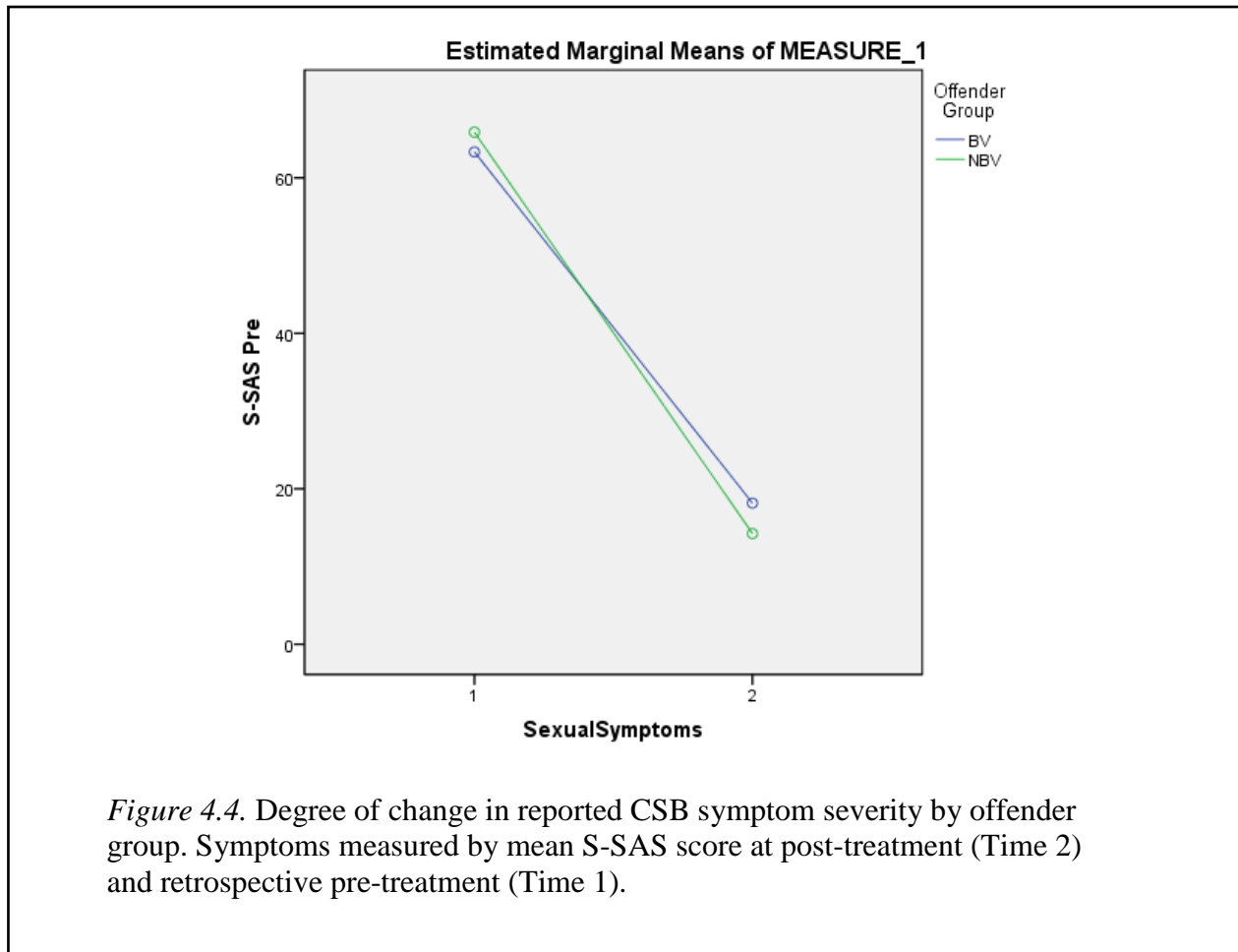
the S-SAS was, as a practical matter, slightly greater for the NBV group than for the BV group. However, the ANOVA revealed a substantial and statistically significant main effect for time, Wilks's $\lambda = .144$, $F = (1, 27) = 159.9$, $p < .0005$, partial $\eta^2 = .856$, indicating that 85.6% of the variance in S-SAS scores was accounted for by observation point, i.e., Time 1 to Time 2, a very large effect. For contextual purposes, in addition to partial η^2 , I calculated effect size in standard deviation units, Cohen's d . The main effect in standard deviation units, Cohen's $d = 3.57$, revealed that for the respondent group as a whole, CSB symptom severity decreased by more than 3.5 standard deviations, a very large degree of change in CSB symptom severity over time.

Finally, the main effect comparing the two groups to each other was not significant and resulted in a negligible effect, $F(1, 27) = 481.994$, $p = .852$, partial $\eta^2 = .001$, indicating that, at both observations the two groups reported statistically equivalent CSB symptom severity as measured by the S-SAS. Changes in mean S-SAS score from Time 1 to Time 2, as revealed by this ANOVA, are summarized in Table 4.20 and represented graphically in Figure 4.4.

Table 4.20

Reported Change in CSB Symptom Severity as Measured by Mean S-SAS Score at Post-Treatment and Retrospective Pre-Treatment Observations, by Offender Group

Offender Group	S-SAS (pre-treatment)			S-SAS (post-treatment)			Cohen's d
	n	M	SD	n	M	SD	
BV	12	63.3	13.7	12	18.2	13.1	3.36
NBV	17	65.8	18.0	17	14.2	9.8	3.71
Total	29	64.8	16.2	29	15.9	11.3	3.57



CSB symptoms among cohorts categorized by discharge year. Because I found that the very large reduction in sexual symptoms was shared statistically equally by both offender groups, I conducted the ANOVA a second time using a different grouping variable to investigate where a difference, if any, might be found. Intuitively, I investigated whether the five cohort groups who discharged from residential treatment in 2005, 2006, 2007, 2008, and 2009, respectively, reported significant differences in CSB symptom severity as measured by the S-SAS. I found a small but statistically non-significant interaction effect between Years Since Discharge and mean S-SAS score, Wilks's $\lambda = 0.961$, $F = (4, 24) = 0.240$, $p = .913$, partial $\eta^2 = .039$. This result indicated that, although non-significant, as a practical matter, a small degree of

difference in S-SAS score was observed in groups discharging from treatment in different years.

As with ANOVA using offender group as the grouping variable, this analysis yielded an extremely large and statistically significant main effect for time, Wilks's $\lambda = .144$, $F = (1, 24) = 142.88$, $p < .0005$, partial $\eta^2 = .856$. However, the main effect comparing the five groups to each other was moderate but not statistically significant, $F(1, 24) = .647$, $p = .634$, partial $\eta^2 = .097$, indicating that the rate of change in S-SAS scores Time 1 to Time 2 was moderately, although not statistically significantly, different for cohort groups discharged in different years. Mean differences between cohort groups revealed by this ANOVA are summarized in Table 4.21. This moderate difference between the five cohort groups, although not significant, could suggest instability of effect over time; however, the difference could also reflect other, unmeasured factors not related to passage of time. To ascertain whether the degree of reported change in CSB symptom severity was correlated to years post discharge, Pearson product-moment correlation was calculated between the two variables. Results yielded no significant correlation and negligible effect between change in CSB symptom severity and years post discharge, $r = .042$, $n = 28$, $p = .832$. This result suggests that the moderate but not significant difference between the cohort groups revealed by ANOVA likely reflected other, unmeasured factors unrelated to the passage of time.

CSB symptoms and new licensing board complaints. Because of the investigational nature of my study, I explored whether reported CSB symptom severity differed for respondents who reported new licensing board complaints compared to those who did not. Results of split-plot ANOVA yielded no significant interaction between New Licensing Complaints and mean S-SAS score, Wilks's $\lambda = 0.9981$, $F = (1, 20) = 0.045$, $p = .833$, partial $\eta^2 = .002$. This result constituted a negligible effect that was not statistically significant, indicating that respondents

Table 4.21

Reported Change in CSB Symptom Severity as Measured by Mean S-SAS Score at Post-Treatment and Retrospective Pre-Treatment, by Years post discharge

Years post discharge	S-SAS (pre-treatment)			S-SAS (post-treatment)			Cohen's <i>d</i>
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	
Five	6	63.3	27.2	6	19.0	5.2	2.74
Four	6	69.3	11.4	6	17.0	12.9	4.29
Three	8	64.5	14.9	8	12.5	13.8	3.63
Two	4	60.5	16.4	4	9.0	9.3	4.01
One	5	65.2	10.0	5	21.6	10.9	4.18
Total	29	64.8	14.8	29	16.8	11.3	4.08

reported statistically equivalent rates of reduction in CSB symptom severity, as measured by the S-SAS, regardless of whether or not they reported new licensing board complaints.

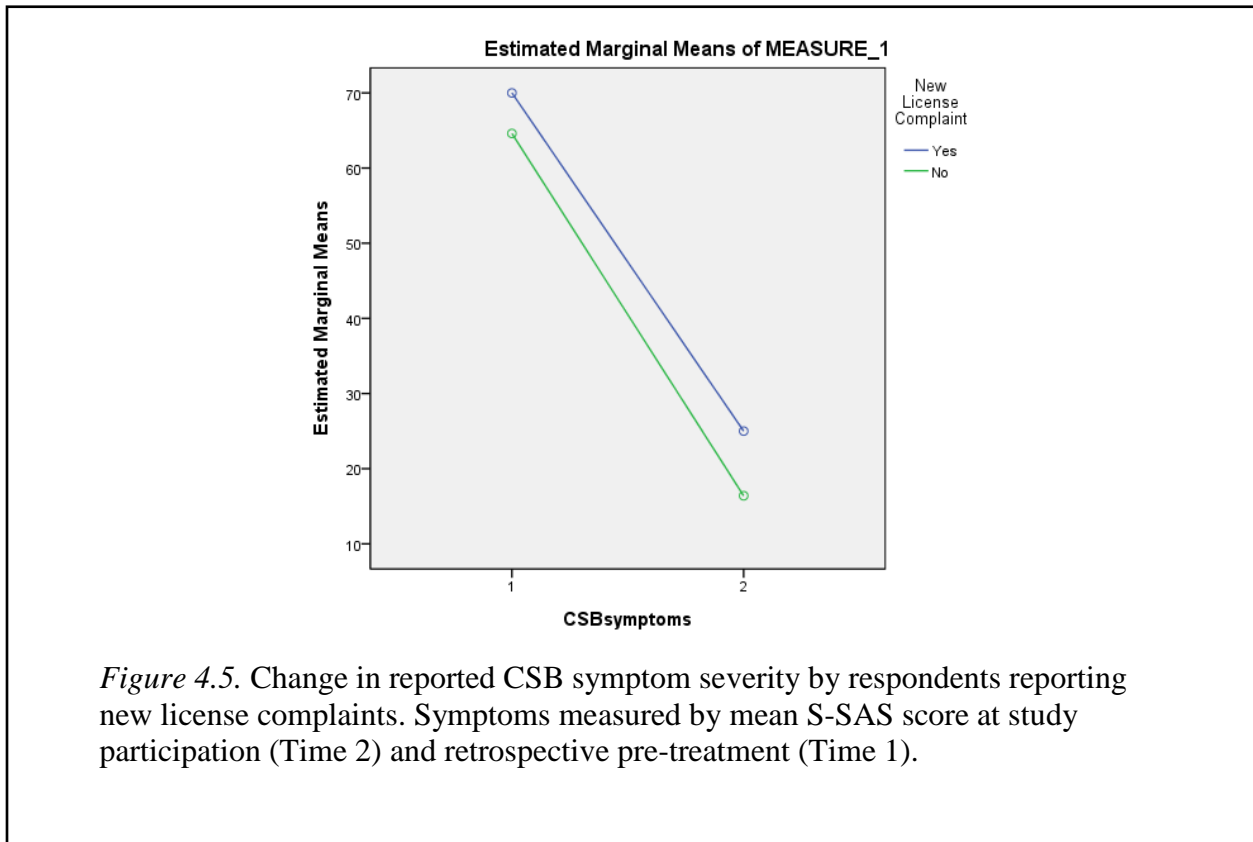
Analysis yielded a very large and statistically significant main effect for time, Wilks's $\lambda = .342$, $F(1, 20) = 142.88$, $p < .0005$, partial $\eta^2 = .658$, indicating the 65.8% of the variance in S-SAS scores was explained by observation point, i.e., Time 1 to Time 2. This result demonstrated that respondents as a group reported a large and statistically significant decrease in CSB symptom severity as measured by the S-SAS. The main effect comparing the two groups to each other was small but did not reach statistical significance, $F(1, 20) = .880$, $p = .359$, partial $\eta^2 = .042$. This result indicated that, although statistically non-significant, CSB symptom severity as measured by the S-SAS was slightly higher for respondents who reported new license complaints than for those who did not. Results of this ANOVA are summarized in Table 4.22 and represented graphically in Figure 4.5.

Research Question 5: Among respondents satisfactorily discharged from residential sex addiction treatment, do sexual boundary violators and non-violators differ in frequency of SBV risk factors

Table 4.22

Reported Change in CSB Symptom Severity as Measured by Mean S-SAS Score at Retrospective Pre-Treatment and at Study Participation, i.e., Post-Treatment, by New Licensing Complaints

New Complaints	S-SAS (pre-treatment)			S-SAS (post-treatment)			Cohen's <i>d</i>
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	
Yes	2	70.0	33.9	2	25.0	1.4	2.83
No	20	64.5	15.2	20	16.4	11.7	3.57
Total	22	65.1	16.3	22	17.2	11.4	3.45



reported at post-treatment, i.e., the time of study participation, compared to recollections of their pre-treatment SBV risk factor frequency?

The assumptions underlying ANOVA, including normality, homoscedasticity (see Table

4.18), and linearity (see Tables F.3 and F.4, Appendix F), were tested and confirmed to have been met. Additionally, the assumption of homogeneity of covariance matrices was met, Box's $M = 5.708$, $F(3, 99783.919) = 1.685$, $p = .168$, and sphericity was preserved using Greenhouse-Geisser's correction, $\epsilon = 1.00$. Split-plot ANOVA was conducted to investigate whether: (a) respondents reported a statistically significant difference in SBV risk over time, as measured by their post-treatment versus retrospective pre-treatment BVI scores; and (b) mean BVI scores differed depending upon whether respondents reportedly had or had not violated professional sexual boundaries. The number of respondents' data used in this analysis ($n = 21$) was less than the total number of completed surveys received ($N = 35$) because 14 respondents reported that they had not had contact with patients or clients either "in the past 6 months" or "in the 6 months before [their] compulsive sexual behavior became known by others." Individuals who did not provide a pair of BVI scores, one for each observation point, were excluded from this analysis.

ANOVA yielded a statistically significant interaction effect between Offender Group and mean BVI score, Wilks's $\lambda = 0.786$, $F(1, 19) = 5.164$, $p = .035$, partial $\eta^2 = .214$, an indication that 21.4% of the variance in BVI score was be accounted for by Offender Group, a large effect. In other words, respondents in the BV group reported a greater decrease in SBV risk factor frequency as measured by the BVI than did NBV group respondents, a large difference that reached statistical significance.

I found a substantial and statistically significant main effect for time, Wilks's $\lambda = .382$, $F(1, 19) = 30.7$, $p < .0005$, partial $\eta^2 = .620$, an indication that 62% of the variance in BVI score was accounted for by observation point, i.e., Time 1 to Time 2, a large effect. In addition, for contextual purposes, this effect was calculated in standard deviation units, Cohen's $d = 1.60$, indicating that SBV risk as measured by the BVI was reduced by nearly one-and-two-third

standard deviations over time, a very large and statistically significant decrease.

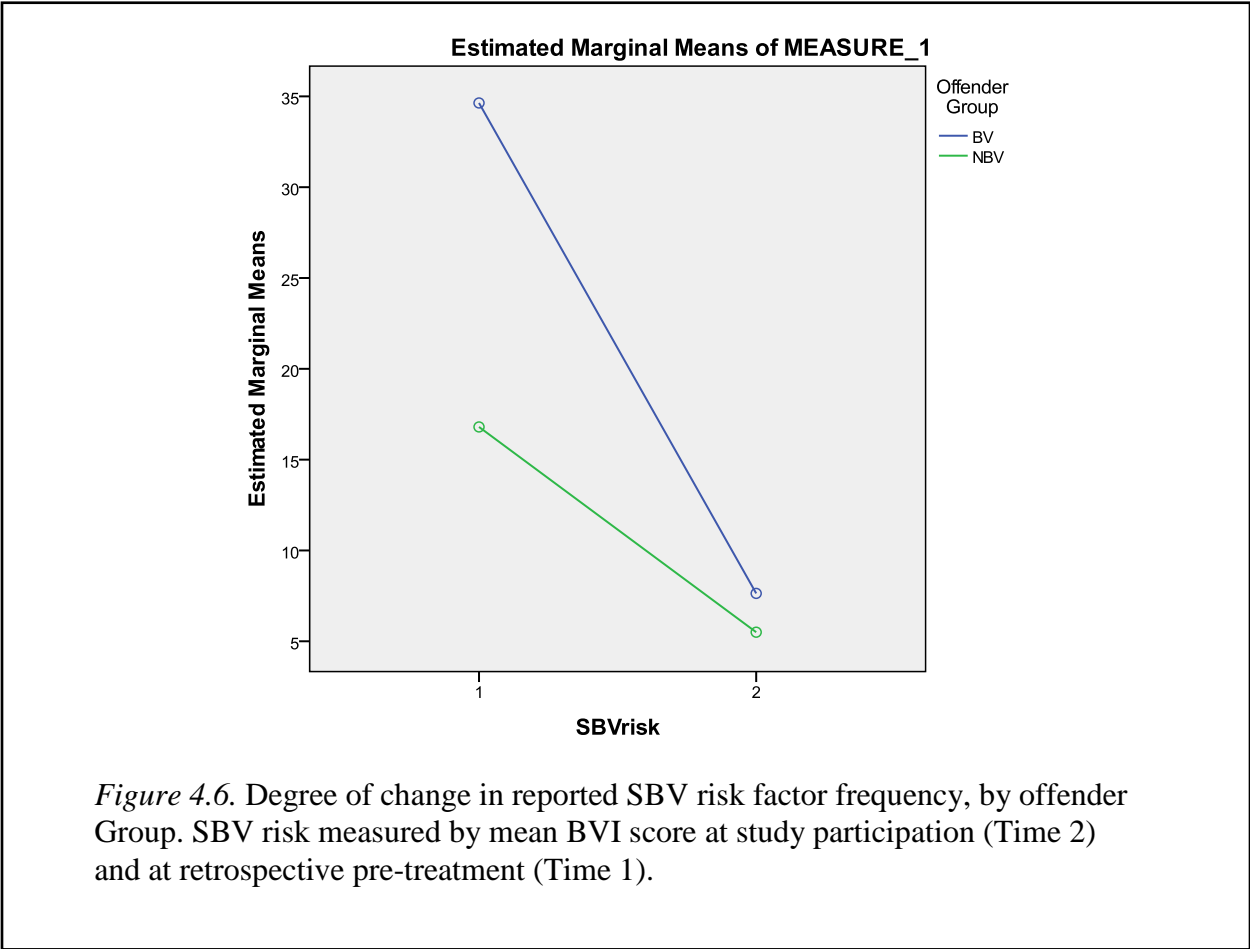
The main effect comparing the two offender groups' BVI scores was significant, $F(1, 19) = 5.38, p = .032$, partial $\eta^2 = .221$, revealing that 22.1% of the variance in scores was accounted for by offender group, a large effect. This result indicated that reductions in SBV risk as measured by the BVI were statistically significantly greater for respondents in the BV group than for those in the NBV group. However, most of this difference was observed at retrospective pre-treatment. At post-treatment, i.e., at time of study participation, although the BV group's scores remained slightly higher than the NBV group's, this difference was not significant, $t(19) = .932, p = .360, \eta^2 = .039$. Results of this ANOVA are summarized in Table 4.23 and represented graphically in Figure 4.6.

Table 4.23

Reported Change in SBV Risk Factor Frequency as Measured by Mean BVI Score at Post-Treatment and Retrospective Pre-Treatment, by Offender Group

Offender Group	BVI (pre-treatment)			BVI (post-treatment)			Cohen's <i>d</i>
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	
BV	11	34.6	20.0	11	7.6	7.3	1.98
NBV	10	16.8	12.4	10	5.5	4.1	1.37
Total	21	26.1	18.8	21	6.6	6.0	1.60

SBV risk factors among other classifications of respondents. Because I found that respondents in both the BV and NBV groups reported a large reduction in risk factors for SBV, I investigated this difference further to determine if some other, potentially confounding factor, such as passage of time or Continuing Medical Education (CME) units in professional boundary



maintenance, could explain the difference between groups. First, however, I was curious whether the percentage of respondents reporting CMEs in professional boundaries differed by offender group. Fourteen of the 17 respondents in the BV group, or 82.4%, reported having earned CMEs in professional boundary maintenance either during residential treatment or sometime thereafter. Similarly, 13 NBV group respondents, or 72.2%, reported earning these CME units. Because the data violated the minimum cell count assumption for chi-square analysis, I conducted Fisher's Exact Probability Test, results of which indicated that the probability that the BV and NBV groups differed in their reported earning of CME units in professional boundaries was $p = .691$. This probability, greater than my desired significance level ($\alpha = .05$), confirmed that the two groups were statistically equivalent in their reported earning of CMEs in boundary maintenance.

Two additional split-plot ANOVAs were then performed to investigate where potential differences could be found.

BVI Change and passage of time. I first investigated whether the five cohort groups organized around discharge year reported significant differences in SBV risk factor frequency as measured by the BVI. I found a statistically significant interaction effect between years since discharge and mean BVI scores, Wilks's $\lambda = 0.502$, $F(4, 16) = 3.974$, $p = .020$, partial $\eta^2 = .498$. This result indicated that degree of change in SBV risk was statistically significantly different for the five cohort groups, a large effect that accounted for 49.8% of the variance in SBV risk.

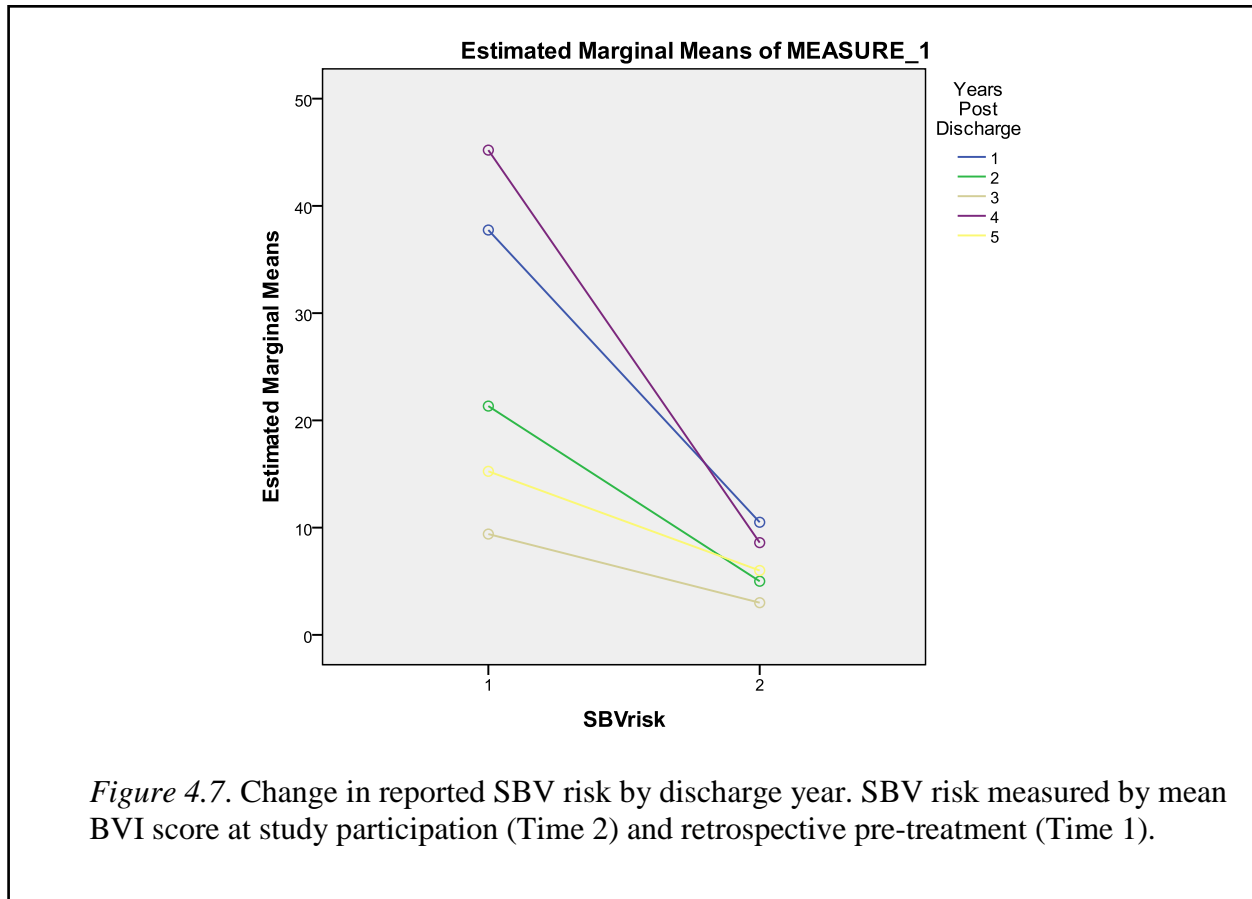
ANOVA revealed a substantial main effect for time, Wilks's $\lambda = .289$, $F(1, 16) = 39.314$, $p < .0005$, partial $\eta^2 = .711$, revealing that 71.1% of the total variance in the five cohorts' BVI scores was explained by observation point, i.e., Time 1 to Time 2. This result indicated that the respondents as a group reported a very large reduction in frequency of risk factors for SBV over time, as measured by mean BVI score.

The main effect comparing the five groups to each other was significant, $F(4, 16) = 6.167$, $p = .002$, partial $\eta^2 = .623$, a large effect indicating that cohort groups discharged from treatment in different years reported large and statistically significant differences in SBV risk as measured by the BVI. Results are summarized in Table 4.24 and graphed in Figure 4.7. Group differences revealed by this ANOVA could suggest instability over time, but could also reflect other, unrelated factors. To investigate whether these group differences were related to passage of time, Pearson product-moment correlation was calculated between years since discharge and BVI-change score. Results yielded a small but statistically non-significant correlation between the variables, $r = 0.100$, $n = 21$, $p = 0.666$. In other words, although the ANOVA using data from respondents grouped by Years Since Discharge indicated that the cohorts were statistically

Table 4.24

Reported Change in SBV Risk Factor Frequency as Measured by Mean BVI Score at Post-Treatment and Retrospective Pre-Treatment, by Number of Years post discharge

Years post discharge	BVI (pre-treatment)			BVI (post-treatment)			Cohen's <i>d</i>
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	
Five	4	15.3	5.4	4	6.0	2.4	2.38
Four	3	45.2	15.1	3	8.6	5.6	3.54
Three	5	9.4	9.7	5	3.0	1.0	1.20
Two	6	21.3	21.5	5	5.0	6.2	1.18
One	5	37.8	12.3	4	10.5	10.5	2.39
Total	21	26.1	18.8	21	6.6	6.0	1.57



significantly different, this difference likely reflects some factor other than simply the passage of time because the two variables were not correlated.

BVI Change and CME units in boundary maintenance. The third ANOVA yielded a medium but statistically non-significant interaction effect between BVI score and reported CMEs in professional boundary maintenance, Wilks's $\lambda = 0.935$, $F(1, 19) = 1.317$, $p = .265$, partial $\eta^2 = .065$. This result indicated that 6.5% of the variance in BVI scores was attributable to CMEs in professional boundary maintenance, a medium effect that, although statistically non-significant, suggested that respondents who reportedly earned CMEs in professional boundary maintenance reported a greater rate of decrease in SBV risk than respondents who reportedly did not earn CMEs in boundary maintenance.

As with previous analyses of BVI scores Time 1 to Time 2, I found a substantial main effect for time, Wilks's $\lambda = .566$, $F(1, 19) = 14.582$, $p = .001$, partial $\eta^2 = .434$, indicating that 43.4% of the variance in BVI score was explained by observation point. This result indicated that study respondents as a whole showed a very large and statistically significant reduction over time in SBV risk as measured by the BVI.

The main effect comparing respondents who reportedly had earned CMEs in professional boundaries with those who reportedly had not was, although statistically non-significant, moderately greater for those reporting CMEs in boundary maintenance, $F(1, 19) = 1.107$, $p = .326$, partial $\eta^2 = 0.051$. In other words, 5.1% of the variance in decreased SBV risk was explained by CMEs in professional boundary maintenance, a result that approached a medium effect. However, most of this difference was due to the two groups being unequal at retrospective pre-treatment, as mean BVI score at study participation was statistically equal ($t(26) = -.392$, $p = .698$ [two-tailed]) for the 23 respondents who reportedly earned CMEs in boundary

maintenance and the five respondents who reportedly did not. Results of this third split-plot ANOVA are summarized in Table 4.25 and represented graphically in Figure 4.8.

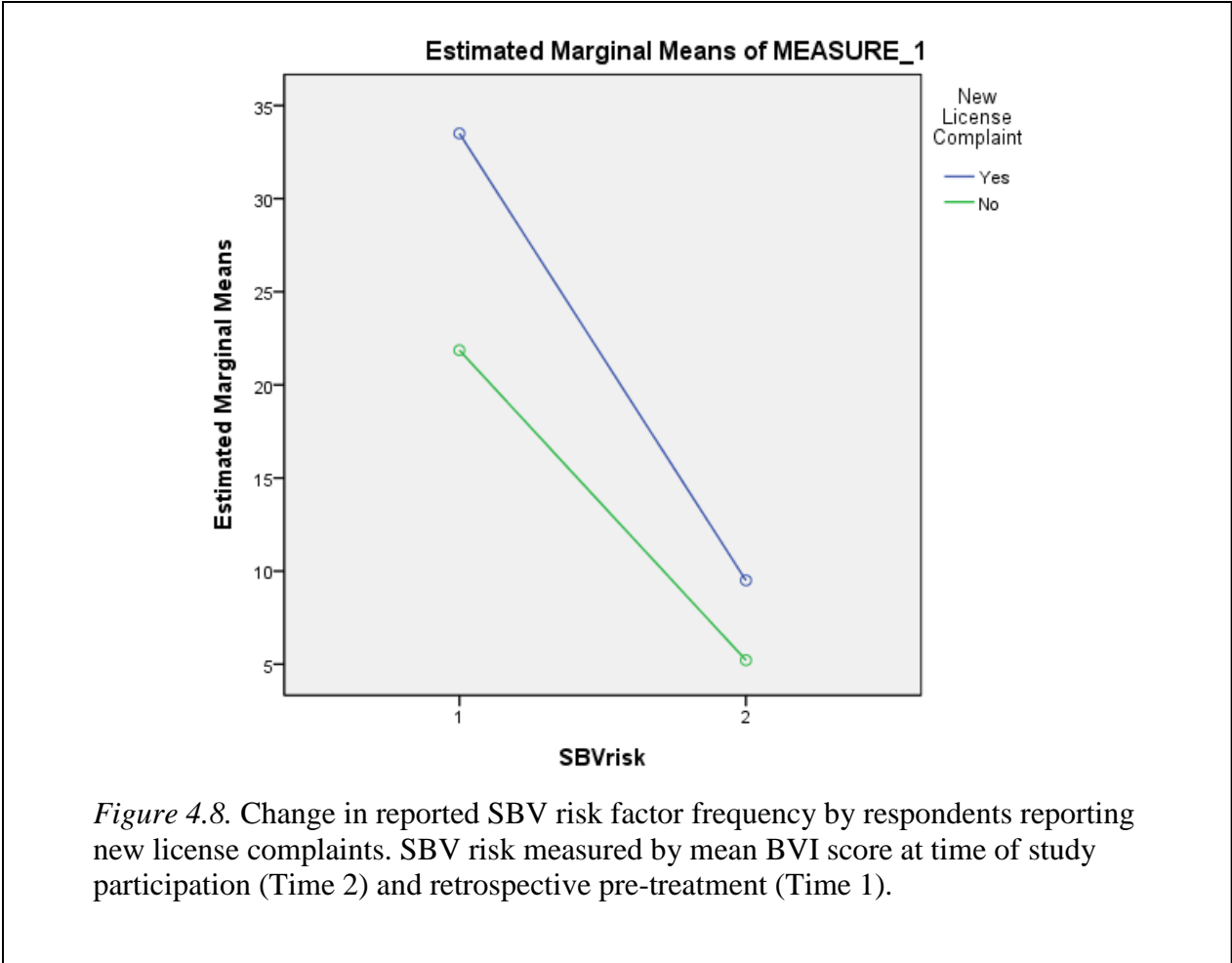
Table 4.25

Reported Change in SBV Risk Factor Frequency as Measured by Mean BVI Score at Post-Treatment and Retrospective Pre-Treatment, by Reported CMEs in Professional Boundaries

Boundary CMEs	BVI (pre-treatment)			BVI (post-treatment)			Cohen's <i>d</i>
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	
Earned	16	28.7	19.2	16	6.8	6.6	1.70
Not Earned	5	18.0	16.3	5	6.2	3.8	1.17
Total	21	26.1	18.8	21	6.6	6.0	1.58

SBV risk and new licensing board complaints. Because of the investigational nature of my study, I explored whether reported SBV risk factor frequency differed for groups of respondents who reportedly had or had not received new licensing board complaints. Results of split-plot ANOVA yielded a small but statistically non-significant interaction effect between New Licensing Complaints and mean BVI score, Wilks's $\lambda = 0.970$, $F = (1, 14) = 0.437$, $p = .519$, partial $\eta^2 = .030$. This result suggested that BVI scores of respondents reporting new complaints were, although non-significantly different, as a practical matter, slightly greater among those not reporting new license complaints.

Analysis yielded a large and statistically significant main effect for time, Wilks's $\lambda = .512$, $F = (1, 14) = 13.34$, $p < .003$, partial $\eta^2 = .488$, indicating that 48.8% of the variance in S-SAS scores was explained by observation point, i.e., Time 1 to Time 2. This very large effect indicated that the respondent group as a whole reported a substantial decrease over time in SBV

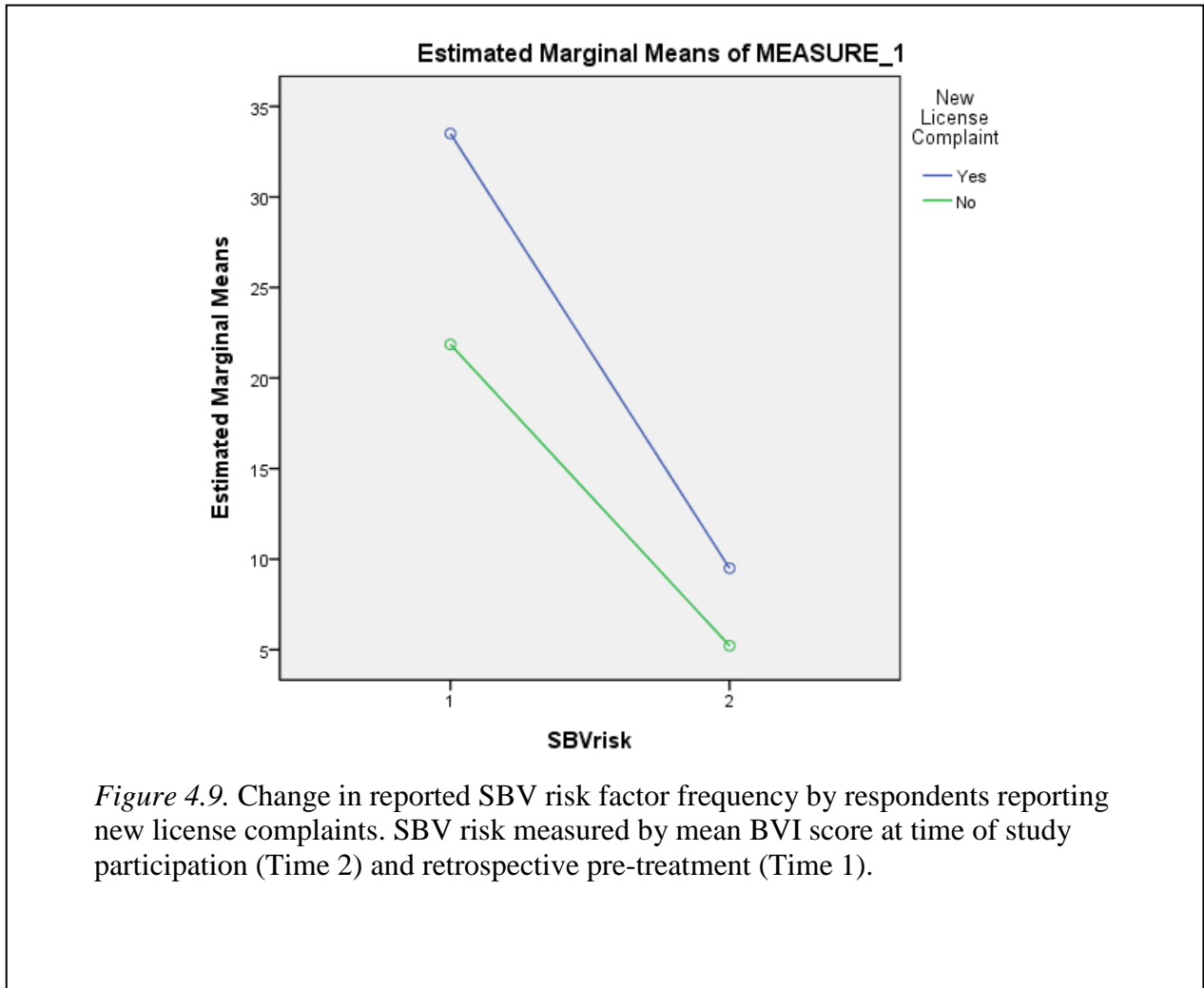


risk as measure by the BVI. Finally, although not reaching statistical significance, the main effect comparing the two groups to each other was moderate, $F(1, 14) = 1.323, p = .269$, partial $\eta^2 = .086$. The mean differences revealed by this ANOVA, summarized in Table 4.26 and represented graphically in Figure 4.9, indicated that, although non-significant, SBV risk as measured by the BVI was moderately higher for respondents who reported new licensing board complaints than for those who did not, although much of this difference was attributable to pre-treatment differences.

Table 4.26

Reported Change in SBV Risk as Measured by Mean BVI at Post-Treatment and Retrospective Pre-Treatment, by New Licensing Board Complaints

New Complaints	BVI (pre-treatment)			BVI (post-treatment)			Cohen's <i>d</i>
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	
Yes	2	33.5	30.4	2	9.5	6.4	1.30
No	14	21.9	14.5	14	5.2	3.6	1.84
Total	16	22.3	16.1	16	5.8	4.0	1.74



Research Question 6: Among respondents satisfactorily discharged from residential sex addiction treatment, do sexual boundary violators and non-violators differ in the reported status of their professional licenses at the time of study participation?

To answer this question, a chi-square test for independence was performed using two dichotomous, categorical variables: Offender Group, i.e., boundary violator vs. non-boundary violator, and License Status at Study Participation, i.e., full/restricted licensed vs. license suspended, surrendered, or revoked. Results of this test (with Yates Continuity Correction) yielded a small and statistically non-significant association between offender group and license status at study participation, $\chi^2(1, n = 35) = .763, p = 0.383, \phi = -.213$. The ϕ coefficient, an effect size measure comparable to Pearson's correlation coefficient and interpreted similarly, i.e., .10 = small effect, .30 = medium effect, .50 or greater = large effect (Pallant, 2007), indicated that, although statistically non-significant, 21.3% of the variance in license status was explained by offender group, a small effect. However, because one cell in the analysis contained fewer than five cases, violating the assumed minimum count for chi-square tests, the results of Fisher's Exact Test, $p = .264$, were used to corroborate the chi-square analysis that the license status of the two groups were not statistically significantly different. Cross-tabulation of Offender Group and License Status at time of study participation is provided in Table 4.27.

Research Question 7: Among respondents satisfactorily discharged from residential sex addiction treatment, what are meaningful predictors of change in CSB symptom severity, controlling for passage of time and degree of intake pathology?

Hierarchical multiple regression was performed to discover which factors, if any, were most responsible for degree of reported decrease in CSB symptom severity as measured by S-SAS-change, a variable discussed previously in this chapter. Passage of time data was

Table 4.27

Cross-tabulation of Offender Group and License Status Reported at Time of Study Participation

Offender Group	License Status		Total
	Licensed, Full or Restricted	Suspended, Surrendered, or Revoked	
BV Group			
Count	11	6	17
% within Offender Group	64.7%	35.3%	100%
% within License Status	42.3%	66.7%	48.6%
% of Total	31.4%	17.1%	48.6%
NBV Group			
Count	15	3	18
% within Offender Group	83.3%	16.7%	100.0%
% within License Status	57.7%	33.3%	51.4%
% of Total	42.9%	8.6%	51.4%
Total			
Count	26	9	35
% within Offender Group	74.3%	25.7%	100.0%
% within License Status	100.0%	100.0%	100.0%
% of Total	74.3%	25.7%	100.0%

extrapolated from respondents' group assignments which indicated their discharge year; pre-treatment pathology data was inferred by number of reported problems at treatment intake. The various predictor variables were at least minimally, although non-significantly, correlated with S-SAS Change. Because lower S-SAS Change scores indicated greater improvement, variables correlated to therapeutic growth were represented by inverse, i.e., negative, relationships. A summary of the correlation matrices between the control and predictor variables in this multiple regression is presented in Table 4.28.

Preliminary analyses were conducted to ascertain that the data met the assumptions of normality and homoscedasticity, reported previously in Table 4.18, linearity (see Figures F.5 –

Table 4.28

Matrix of Correlation Coefficients for Variables Entered in Hierarchical Multiple Regression Equations Predicting Change in CSB Symptom Severity over Time

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
S-SAS Change (1)	1.00	.042	.116	-.174	.026	.124	-.017	.181
Years post discharge (2)		1.00	-.021	.430*	-.438**	-.179	-.519*	-.333**
Total Problems (3)			1.00	.145	-.295	.460*	.084	-.128
Days of IP & OP (4)				1.00	-.464**	-.193	-.335	-.067
Med-Days/Year† (5)					1.00	.216	.235	.393
Counseling Sessions/Year† (6)						1.00	.320**	.071
Support Meetings/Year† (7)							1.00	.061
CME Boundary Hours (8)								1.00

Note. All correlations are statistically non-significant, $p \geq .10$, unless otherwise indicated. †"Per Year" = raw number of reported medication days, counseling sessions, or support group meetings attended, divided by the number of years post discharge.
* $p < .01$. ** $p < .05$.

F.13, Appendix F), and multi-collinearity, as indicated by inter-correlation between independent variables less than $r = .700$ (Howell, 2002), demonstrated in Table 4.28. Although the dependent variable, S-SAS Change, met these assumptions, all of the predictor variables violated the assumption of normality. A summary of these tests for the various predictor and control variables is provided in Table 4.29.

Researchers who attempt multiple regression using data sets that violate these assumptions typically obtain results with an increased probability of Type I and Type II error (Osborne & Waters, 2002). However, for exploratory purposes, I continued with the analysis. Results indicated that the control variables explained 1.5% of the variance in decreased CSB symptom severity; however, this value, $R^2 = .015$, did not reach statistical significance, $p = .904$, an indication that the control variables had no effect on S-SAS-change. After entering the remaining independent variables in Step 2, the model as a whole explained 14.1% of the total

Table 4.29

Tests of Normality and Homoscedasticity of Control and Predictor Variables Utilized in Hierarchical Multiple Regression of S-SAS-change and BVI-change Equations

Variable	Type	Kolmogorov-Smirnov ^a			Levene's Test ^c			
		Statistic	df	p ^b	F	df1	df2	p ^d
Years post discharge (control)		.162	35	.020*	0.849	1	33	.364
Total Presenting Problems (control)		.297	35	.000*	2.344	1	33	.135
Days of IP & IOP Treatment		.187	35	.003*	0.742	1	33	.395
Med-Days Per Year†		.203	22	.019*	0.839	1	20	.371
Sessions Per Year†		.234	33	.000*	0.138	1	31	.713
Meetings Per Year†		.224	32	.000*	0.330	1	30	.570
Hours Boundary CME		.206	27	.005*	0.567	1	25	.459

None. †“Per Year” = raw number of reported days of medication use, counseling sessions attended, or recovery-oriented support group meetings attended divided by the number of years post discharge.

^aTests the assumption of normality. ^b $p > .05$ indicates normal distribution of scores. ^cTests the assumption of homogeneity of error variance, i.e., homoscedasticity. ^d $p > .05$ indicates homogeneity of error variance. * = assumption not met.

variance in S-SAS-change, however this effect failed to reach statistical significance, $R^2 = .141$, $F(5, 8) = .188$, $p = .980$. The result of Step 2 of the regression indicated that, taken as a group, the five predictor variables explained 12.6% of the variance in CSB symptom severity reduction after the two control variables were accounted for, R^2 change = .126, F change (5, 8) = .234, $p = .937$. This effect, although non-significant, indicated that the confluence of the five predictor variables had, for practical purposes, a medium effect on reductions in CSB symptom severity.

In the final model, two of the five predictor variables were meaningful and unique—although statistically non-significant—contributors to S-SAS Change: (a) days of inpatient and outpatient treatment, $\beta = -.323$; and (b) hours of boundary CMEs, $\beta = .294$. The β -coefficient is a standardized effect measure mathematically related, and interpreted similarly, to Pearson's correlation coefficient (Howell, 2002). Results of this model indicated that when Days of inpatient and outpatient treatment increased by one standard deviation, S-SAS Change score

decreased, i.e., changed in the direction of greater therapeutic improvement, by 0.323 standard deviations. Although non-significant, this change constituted a medium effect. Conversely, when Hours of CME boundary training increased by one standard deviation, S-SAS Change also increased, i.e., changed in the direction of less therapeutic improvement, by .294 standard deviations. Although non-significant, this medium effect indicated that respondents who reportedly received boundary training reported a smaller decrease in CSB symptom severity as measured by the S-SAS than respondents who did not report such training. Results of this multiple regression are summarized in Table 4.30.

Table 4.30

Hierarchical Multiple Regression Predicting Degree of Change in Reported CSB Symptoms as Measured by the Difference in Pre-Treatment/Post-Treatment S-SAS Mean Scores, Controlled for Time Since Discharge and Degree of Pre-Treatment Pathology

Predictor	Degree of Change in Reported CSB Symptoms			
	ΔR^2	β^b	t^c	p
Step 1	.015			.904
Control Variables ^a				
Step 2	.126			.937
Days of IP and OP Treatment		-.323	-.803	.445
Med-Days per Year [†]		-.089	-.197	.849
Counseling Sessions per Year [†]		.035	.083	.936
Support Group Meetings Year [†]		-.025	-.061	.953
Hours of Boundary Training		.294	.782	.457

Note. ^a Control variables include: (a) years since discharge from residential treatment as extrapolated from respondent group assignment, and (b) degree of pre-treatment pathology as inferred from respondents' reported number of problems at treatment intake. ^b Standardized beta coefficient. ^c Un-standardized Beta coefficient divided by standard error. [†] "Per Year" = raw number of reported days of medication use, counseling sessions attended, or recovery-oriented support group meetings attended divided by the number of years post discharge.

Research Question 8: Among respondents satisfactorily discharged from residential sex addiction treatment, what are meaningful predictors of change in SBV risk factor frequency, controlling for passage of time and degree of intake pathology?

Hierarchical multiple regression was performed to discover which factors, if any, were most responsible for the degree of reported decrease in SBV risk as measured by BVI-change score, after controlling for the possible influence of passage of time and degree of intake pathology, factors discussed previously in this chapter. The various predictor variables were at least minimally, although non-significantly, correlated with BVI-change; however, because lower BVI-change scores indicated greater improvement, variables correlated to therapeutic growth were represented by inverse, i.e., negative, relationships. A summary of the correlation matrices between the control and predictor variables in this multiple regression is presented in Table 4.31.

Table 4.31

Matrix of Correlation Coefficients for Variables Entered in Hierarchical Multiple Regression Equations Predicting Change in SBV Risk Factor Frequency over Time

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
BVI Change (1)	1.00	.100	-.070	-.536*	.054	-.191	-.202	-.306
Years post discharge (2)		1.00	-.021	.430*	-.438**	-.179	-.519*	-.333**
Total Problems (3)			1.00	.145	-.295	.460*	.084	-.128
Days of IP & OP (4)				1.00	-.464**	-.193	-.335**	-.067
Med-Days/Year† (5)					1.00	.216	.235	.393
Counseling Sessions/Year† (6)						1.00	.320**	.071
Support Meetings/Year† (7)							1.00	.061
CME Boundary Hours (8)								1.00

Note. All correlations are statistically non-significant, $p \geq .10$, unless otherwise indicated.

† Variable indicates the raw number of reported days of medication use, counseling sessions attended, or recovery-oriented support group meetings attended divided by the number of years post discharge.

* $p < .01$. ** $p < .05$.

Preliminary analyses revealed that dependent variable data met the assumptions of normality and homoscedasticity, reported previously in Table 4.18, linearity (See Tables F.6 – F.13, Appendix F), and multi-collinearity, indicated by inter-variable correlations $r < .700$

(Howell, 2002) and reported in Table 4.31. However, all the predictor variables violated the assumption of normality, as reported previously in Table 4.29. Nevertheless, I continued with this analysis for exploratory purposes, aware that the violation of these underlying assumptions increased the probability of Type I and Type II error (Osborne & Waters, 2002).

Results yielded a statistically significant and large correlation between one of the independent variables in the model and BVI Change: Days of Inpatient/Outpatient Treatment ($r = -.536, n = 21, p = .006$). This result indicated that longer stays in sex addiction treatment were associated with greater reductions in SBV risk, a large degree of correlation that was statistically significant. Each of the other predictor variables in the model were at least minimally correlated to BVI Change, although these other correlations did not reach statistical significance. A table of correlation coefficients between the control, predictor, and dependent variables for this model is provided in table 4.31.

The control variables, Years post discharge and Total Presenting Problems, were entered in Step 1 of the multiple regression, explaining 1.5% of the variance in SBV risk reduction. However, this value, $R^2 = .015$, did not reach statistical significance, $p = .929$, an indication that the control variables did not exert a significant influence on SBV risk. After entering the remaining independent variables, the model as a whole explained 62.4% of the total variance in BVI Change scores, $R^2 = .624, F(7, 5) = 1.186, p = .441$, a large although statistically non-significant effect.

Results of Step 2 of the regression indicated that, as a group, the five predictor variables explained 61% of the variance in SBV risk reduction after controlling for years post discharge and degree of intake pathology, R^2 change = .610, F change (5, 5) = 1.621, $p = .304$. This result indicated that, although not statistically significant, the confluence of the five predictor variables

had, as a practical matter, a large effect on reductions in SBV risk after controlling for the negligible effect of passage of time and intake pathology.

The final model revealed several meaningful and unique, although statistically non-significant, contributors to SBV risk reduction: (a) days of inpatient and outpatient treatment, $\beta = -.785$, (b) counseling sessions per year, $\beta = -.303$, (c) support group meetings per year, $\beta = -.292$, and (d) hours of boundary CMEs earned, $\beta = -.259$. The β -coefficient, a standardized effect size measure, indicated that when days of inpatient and outpatient treatment increased by one standard deviation, BVI Change score decreased, i.e., changed in the direction of therapeutic improvement, by .785 standard deviations. Although statistically non-significant, this effect was, as a practical matter, very large and suggested that the longer respondents remained in residential and outpatient sex addiction treatment, the greater was their reported SBV risk.

Similarly, the β -coefficient of the other predictors in the model indicated that an increase of one standard deviation in number of counseling sessions, support group meetings, and hours of CMEs in boundary maintenance was correlated to reductions in SBV risk of $-.303$, $-.292$, and $-.259$ standard deviations, respectively. Although statistically non-significant, these results suggest that on-going counseling, recovery support, continuing education had a medium effect in reductions in SBV risk as measured by BVI Change. Results of this analysis are summarized in Table 4.32.

Research Question 9: Among respondents satisfactorily discharged from residential sex addiction treatment, do decreases in reported CSB symptom severity predict reported professional license status at time of study participation?

Discriminant analysis was performed to explore the predictive power of one continuous independent variable, change in CSB symptom severity as measured by S-SAS-change score, on

Table 4.32

Hierarchical Multiple Regression Predicting Degree of Change in Reported SBV Risk Factors, as Measured by the Difference in Pre-Treatment/Post-Treatment BVI Mean Scores, Controlled for Time Since Discharge and Degree of Intake Pathology

Predictor	Degree of Change in Reported SBV Risk			
	ΔR^2	β^b	t^c	p
Step 1	.015			.904
Control Variables ^a				
Step 2	.610			.304
Days of IP and OP Treatment		-.785	-2.336	.067
Med-Days per Year [†]		.062	.164	.876
Counseling Sessions per Year [†]		-.303	-.856	.431
Support Group Meetings Year [†]		-.292	-.860	.492
Hours of Boundary Training		-.259	-.825	.447

Note. ^a Control variables = (a) years since discharge from residential treatment as extrapolated from respondent group assignment, and (b) degree of intake pathology as inferred from respondents' reported total presenting problems. ^b Standardized. ^c Un-standardized Beta coefficient divided by standard error. [†] Per Year = total reported days of medication use, counseling sessions attended, or recovery-oriented support group meetings attended divided by the number of years post discharge.

one categorical dependent variable: reported license status at time of study participation. Tests were performed to confirm that none of the assumptions underlying discriminant analysis, e.g., normality, homogeneity of covariance, and heterogeneity of group means, were violated. Results indicated that the degree of change in CSB symptoms was normally distributed (Kolmogorov-Smirnov Statistic = .145, $df = 28$, $p = .137$), and that the covariance of the two factors was equivalent, Box's $M = .514$, $F(1, 1095) = .488$, $p = .485$. However, the data failed to meet the assumption of heterogeneity of group means, (Wilks's $\lambda = .984$, $F = [1, 26] = .427$, $p = .519$).

In other words, the decrease in CSB symptom severity as measured by the S-SAS was not statistically significantly different for the 21 professionals who retained their licenses ($M = -49.6$, $SD = 18.6$) and those eight professionals who did not ($M = -54.0$, $SD = 17.8$). Therefore, results of the discriminant analysis were not significant and left 98.4% of the variation in license

status unaccounted for, Wilks's $\lambda = .984$, $\chi^2(1, n = 28) = 0.416$, $p = 0.519$). This result indicates that respondents who reportedly lost their professional licenses reported reductions in CSB symptom severity that were statistically equal to respondents who reportedly retained their professional licenses, suggesting that S-SAS-change was not a reliable discriminator for license status at time of study participation.

Exploring CSB symptom change by license status. Because mean S-SAS-change scores were not significantly different for respondents who reportedly were or were not licensed at time of study participation, I explored this reduction in CSB symptom severity by license status using split-plot ANOVA. First, however, tests were conducted to confirm that none of the assumptions underlying ANOVA were violated, including normal distribution of scores and equality of error variance, reported previously in Table 4.18. The assumption of homogeneity of covariance matrices was met, Box's $M = 11.452$, $F(3, 2953.171) = 3.384$, $p = .017$, and sphericity was preserved by using Greenhouse-Geisser's correction, $\epsilon = 1.00$.

ANOVA revealed a small but statistically non-significant interaction effect between license status and mean S-SAS score, Wilks's $\lambda = .975$, $F(1, 27) = 0.678$, $p = .417$, partial $\eta^2 = .025$. Although non-significant, this result indicated that respondents who lost their professional licenses after treatment reported a slightly greater rate of reduction in CSB symptom severity as measured by the S-SAS than respondents who retained their licenses.

As with other ANOVAs of CSB symptom severity, this test revealed a substantial and statistically significant main effect for time, Wilks's $\lambda = .159$, $F(1, 27) = 143.25$, $p < .0005$, partial $\eta^2 = .841$, indicating that 84.1% of the variance in S-SAS scores was accounted for by observation point, i.e., Time 1 to Time 2, a very large effect. Additionally, for contextual purposes, effect size was calculated in standard deviation units, Cohen's $d = 3.57$, indicating that

indicating that the respondent group as a whole reported a very large reduction in CSB symptom severity over time, a change equal to more than 3.5 standard deviations.

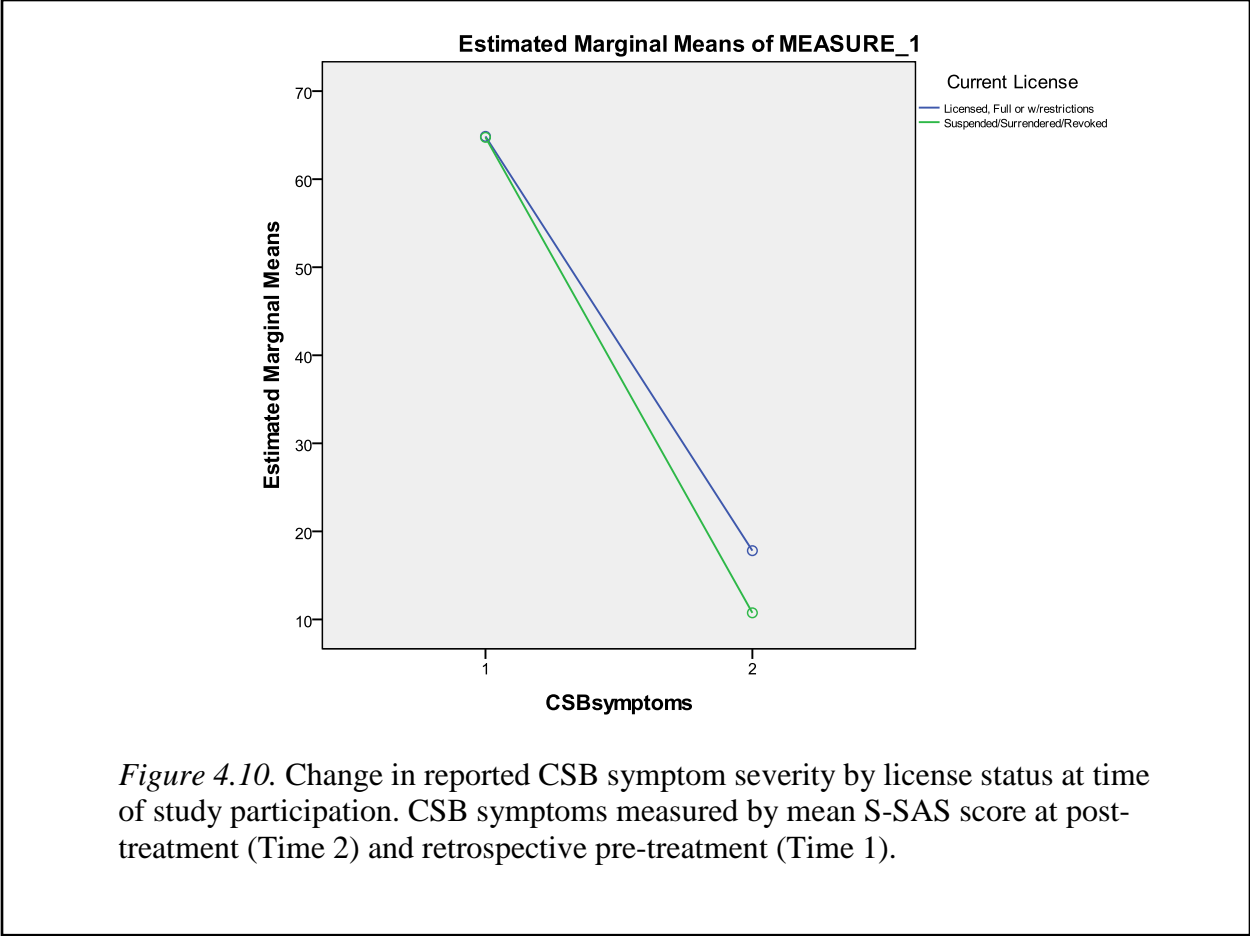
Finally, the main effect comparing the two groups to each other was small but statistically non-significant, $F(1, 27) = .803, p = .378$, partial $\eta^2 = .029$, indicating that 2.9% of the variance in S-SAS scores was explained by license status, a small effect. In other words, although non-significant, respondents who reportedly no longer had their professional licenses obtained lower S-SAS scores—and reported nearly double the rate of CSB symptom reduction in standardized units—than respondents who had reportedly retained their licenses. The mean differences revealed by this ANOVA are summarized in Table 4.33 and represented graphically in Figure 4.10.

Table 4.33

Reported Change in CSB Symptom Severity as Measured by Mean S-SAS Score at Post-Treatment and Retrospective Pre-Treatment, by License Status at Study Participation

License Status	S-SAS (pre-treatment)			S-SAS (post-treatment)			Cohen's <i>d</i>
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	
Full/Restricted	21	64.9	18.7	21	17.8	10.9	3.18
Surrendered/Revoked	8	64.8	6.7	8	10.8	11.3	6.00
Total	29	64.8	16.2	29	15.9	11.3	3.57

Correlation of CSB symptom change to subjective occupational measures. Because my study is exploratory in nature, I investigated not only the relationship of CSB symptomatology to objective measures of occupational status, such as rates of professional licensure, but also to other, subjective occupational measures: perceived changes in job status and job satisfaction. As described previously, respondents could rate the status of, and their satisfaction with, the jobs



they held at time of study participation compared to their jobs prior to treatment. As previously mentioned, median change in job status reported by respondents overall was -1.0 ($M = -0.64$, $SD = 3.7$), indicating that, as a group, study respondents returned to jobs they perceived to be of slightly lower status than the job they had before treatment. The median change in post-treatment job satisfaction was +1 ($M = -0.30$, $SD = 3.8$), indicating that study respondents as a group returned to jobs from which they gleaned a slightly higher degree of satisfaction than prior to residential treatment.

Pearson product-moment correlation was calculated between S-SAS-change and perceived change in job status, measured as described above. Preliminary analyses were performed to ensure no violation of the assumptions of normality and homoscedasticity, as

summarized in Table 4.34, or linearity (See Figures F.5, F.14 and F.15, Appendix F). Results revealed a negligible and statistically non-significant correlation between S-SAS Change and change in perceived job status, $r = -.044$, $n = 27$, $p = .827$. This result indicated that, as a group, respondents returned to jobs of similarly decreased status regardless of the degree to which their reported CSB symptom severity was reduced.

Table 4.34

Tests of Normality and Homoscedasticity of Perceived Change in Job Status and Job Satisfaction

Variable	Kolmogorov-Smirnov ^a			Levene's Test ^c			
	Statistic	df	p ^b	F	df1	df2	p ^d
Job Status Change	.146	33	.073	0.053	1	31	.819
Job Satisfaction Change	.168	31	.026*	1.651	1	29	.209
S-SAS Change	.145	28	.137	1.233	1	26	.277
BVI Change	.156	21	.197	7.833	1	19	.011*

Note. ^aTests the assumption of normality. ^b $p > .05$ indicates normal distribution of scores. ^cTests the assumption of homogeneity of error variance, i.e., homoscedasticity. ^d $p > .05$ indicates homogeneity of error variance. * = assumption not met.

Similarly, to explore whether changes in CSB symptom severity were related to perceived occupational satisfaction, Pearson product-moment correlation was calculated between S-SAS-change and change in job satisfaction, measured as described above. Analysis yielded no statistically significant correlation and no effect between the CSB symptom change and job satisfaction change, $r = -.067$, $n = 26$, $p = .745$. This result indicated that, although respondents reportedly returned to jobs from which they derived slightly more satisfaction, increases in job satisfaction were not statistically significantly correlated to decreases in CSB symptom severity.

Research Question 10: Among respondents satisfactorily discharged from residential sex addiction treatment, do decreases in reported SBV risk predict reported professional license

status at time of study participation?

Discriminant analysis was performed to explore the predictive power of one continuous independent variable, change in SBV risk as measured by BVI-change score, on one categorical dependent variable: reported license status at time of study participation. Tests were performed to confirm that none of the assumptions underlying discriminant analysis, e.g., normality, homogeneity of covariance, and heterogeneity of group means, were violated. Results indicated that the degree of change in SBV risk as measure by BVI-change was normally distributed (Kolmogorov-Smirnov Statistic = .156, $df = 21$, $p = .197$) and that the covariance of the factors was equivalent, Box's $M = 3.219$, $F = (1, 229) = 2.916$, $p = .089$. However, the data failed to meet the assumption of heterogeneity of group means, (Wilks's $\lambda = .938$, $F = (1, 19) = 1.262$, $p = .275$).

Said another way, the decrease in reported SBV risk as measured by the BVI was not statistically significantly different for the 17 professionals who reportedly retained their licenses ($M = -17.5$, $SD = 14.2$) and the 4 who reportedly did not ($M = -28.3$, $SD = -28.5$). Therefore, results of the discriminant analysis were not significant and left 93.8% of the variation in license status unaccounted for, Wilks's $\lambda = .938$, $\chi^2 (1, n = 21) = 1.190$, $p = 0.275$. This result indicated that respondents who reportedly had lost their professional licenses reported reductions in SBV risk that were statistically equal to respondents who reportedly retained their licenses. Therefore, BVI-change was not a reliable discriminator for license status at time of study participation.

Exploring change in SBV risk by license status. Because mean BVI-change scores were not significantly different for respondents who reportedly were or were not licensed at time of study participation, reduction in SBV risk was explored using split-plot ANOVA. First, however, tests were conducted to confirm that none of the assumptions underlying the ANOVA

were violated, including normal distribution of scores and equality of error variance, reported previously in Table 4.34. The assumption of homogeneity of covariance matrices was met, Box's $M = 4.677$, $F(3, 373.329) = 1.160$, $p = .325$, and sphericity was preserved by using Greenhouse-Geisser's correction, $\epsilon = 1.00$.

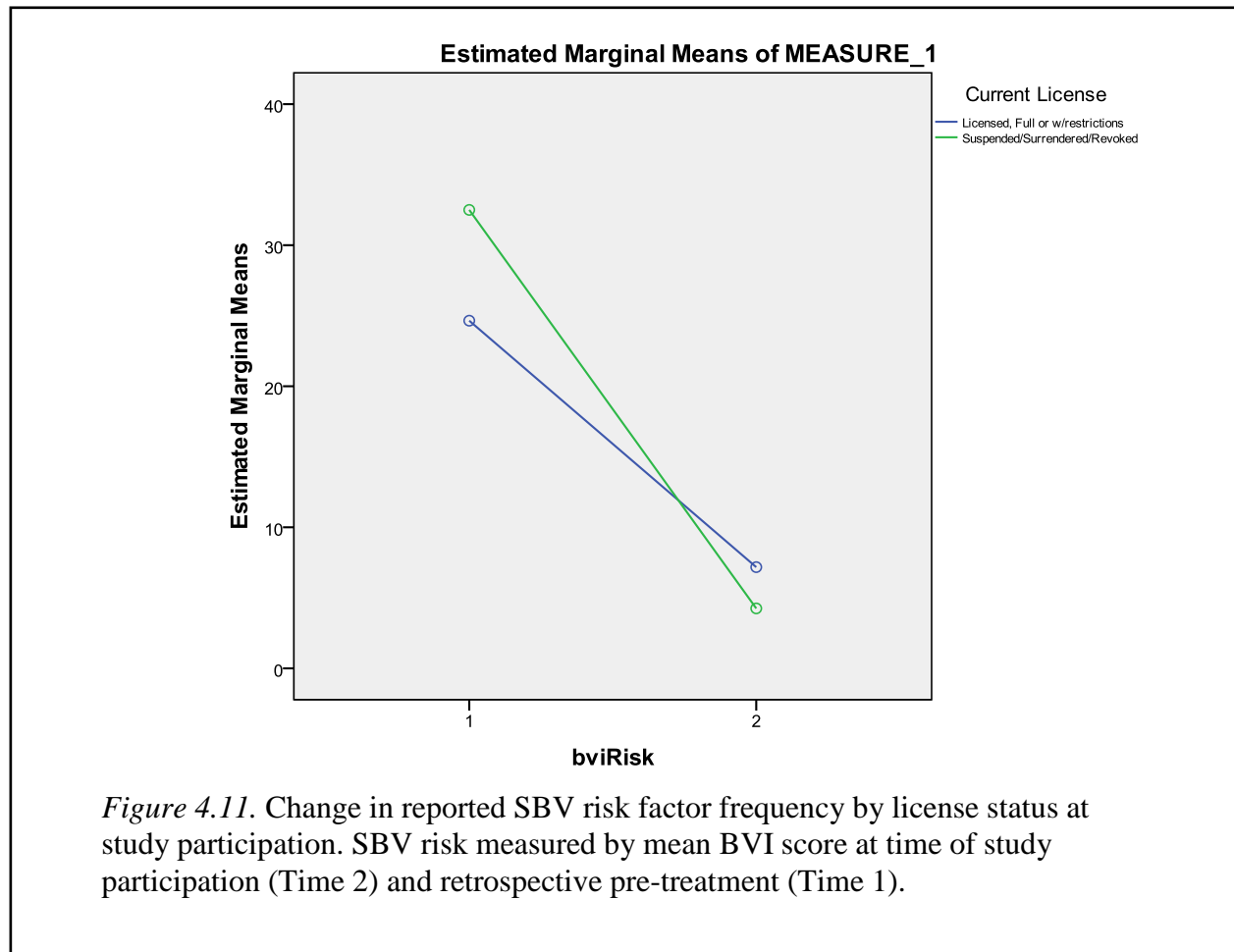
ANOVA revealed a medium but statistically non-significant interaction effect between license status and mean BVI score, Wilks's $\lambda = .938$, $F(1, 19) = 1.262$, $p = .275$, partial $\eta^2 = .062$. Although non-significant, this result indicated that respondents who reportedly lost their professional licenses after treatment reported a moderately greater rate of reduction in SBV risk than those who reportedly had retained their licenses. ANOVA revealed a substantial and statistically significant main effect for time, Wilks's $\lambda = .456$, $F(1, 19) = 22.702$, $p < .0005$, partial $\eta^2 = .544$, indicating that 54.4% of the variance in BVI scores was accounted for by observation point, i.e., Time 1 to Time 2. This change constituted a very large effect which, for contextual purposes, was also calculated in standard deviation units. The main effect of this ANOVA in standard units, Cohen's $d = 1.57$, produced an effect greater than 1.5 standard deviations, an indication that the respondent group as a whole reported a very large degree of change in SBV risk factor frequency over time.

Finally, the main effect comparing the two groups to each other was not significant and resulted in a negligible effect, $F(1, 19) = 39.294$, $p = .694$, partial $\eta^2 = .008$. In other words, although not significant, when compared to respondents who had reportedly retained their licenses, respondents who indicated they had lost their licenses reported moderately higher SBV risk at pre-treatment and statistically equivalent SBV risk at post-treatment. Mean differences revealed by this ANOVA are summarized in table 4.35 and presented graphically in Figure 4.11. As with CSB symptom severity in Research Question 9, the relationship between SBV risk and

Table 4.35

Reported Change in SBV Risk as Measured by Mean BVI Score at Study Participation, i.e., Post-Treatment, and Retrospective Pre-Treatment, by License Group

License Group	BVI (pre-treatment)			BVI (post-treatment)			Cohen's <i>d</i>
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	
Full or Restricted	17	24.7	16.4	17	7.2	6.4	1.54
Surrendered/Revoked	4	32.5	29.0	4	4.3	3.5	1.74
Total	21	26.1	18.8	21	6.6	6.0	1.57



certain, subjective occupational measures such as perceived changes in job status or satisfaction was investigated. After ensuring that the data met the assumptions of normality,

homoscedasticity, and linearity, reported previously in Table 4.33 and in Tables F.6, F.14, and F.15, Appendix F, respectively, Pearson product-moment correlation was calculated for BVI-change and perceived change in job status. Analysis yielded a strong, statistically significant, direct correlation between reduction in SBV risk and change in perceived job status, $r = .509$, $n = 20$, $p = .022$. The direction of this correlation may be misleading however, because lower BVI-change scores indicate improvement over pre-treatment conditions. Therefore, the large, positive correlation coefficient between the two factors indicated that greater decreases in SBV risk were strongly correlated to lower ratings of current job status, a relationship that reached significance.

Similarly, Pearson product-moment correlation was calculated for BVI-change and perceived change in job satisfaction. Analysis yielded a medium but statistically non-significant correlation between SBV risk reduction and job satisfaction change, $r = .379$, $n = 18$, $p = .121$. As before, because lower BVI-change scores indicate improvement over pre-treatment conditions, the medium, positive correlation between the variables suggested that, although non-significant, greater reductions in SBV risk were, as a practical matter, moderately correlated to lower ratings of job satisfaction at time of study participation.

CHAPTER 5

DISCUSSION

In this study, I investigated the reported post-treatment disposition of professionals who had satisfactorily discharged from residential sex addiction treatment between one and five years prior to study participation. Approximately half of these professionals had reportedly violated sexual boundaries with patients, clients, or staff in the course of their compulsive sexual behavior. Following, I discuss my findings in five broad areas: (a) demographic data from this group of respondents and how it may compare to similar data from other studies, (b) reductions in both CSB symptom severity and SBV risk factor frequency over time, (c) relationship between CSB symptoms and SBV risk factors, (d) predictors of change in both phenomena, and (e) objective and subjective impact of these changes on occupation. I conclude by discussing limitations of this study, directions for future research, and clinical and professional implications of this study.

Demographic Data from Study Respondents

Respondents to this study were demographically similar to respondents in other studies of sexually addicted and/or boundary violating professionals: All participants in my study were male, 89% were White, and most were between 40 and 54 years of age. I was gratified at the rate of response to my study, especially considering that symptoms of sex addiction and risk factors for boundary violation tend to be stigmatized phenomena. I believe the high response rate, 60.3%, was most likely due to my decision to survey only satisfactorily treated professionals, many of whom were involved in 12-step recovery programs that emphasize both “rigorous honesty” and the responsibility to “give back” to other recovering persons. Potential study participants were informed that their responses could be of help to other recovering individuals,

and I suspect that respondents' sense of duty to these other persons was one of the more powerful incentives for study participation.

During my investigation, I collected de-identified demographic data on all 200 professionals who discharged from residential treatment at the designated facility between January 1, 2005 and December 31, 2009, the study window. I utilized these data to investigate rates of satisfactory discharge by: (a) treatment type, i.e., sex addiction treatment versus treatment for addictive disorders unrelated to sexual behavior; and (b) offender group, i.e., respondents who reported sexual boundary violation versus those who did not. Additionally, of the 35 persons responding to my study questionnaire, all of whom had satisfactorily completed residential sex addiction treatment, I inquired about other several pertinent demographic factors, including professional license status, continuing license complaints, perceived job status, and perceived job satisfaction. Following, I discuss those findings.

Rates of Satisfactory Treatment Discharge

In Research Question 1, I found that among the 200 professionals treated for any behavioral health issue at the designated facility during the study window, patients completed or did not complete the treatment at a statistically equivalent rate regardless of whether they presented for sex addiction treatment or for some other behavioral disorder. This finding tends to support Carnes's (1992) and Irons and Schneider's (1994) assertions that sexually compulsive individuals are as responsive to treatment as persons with other addictive disorders, e.g., alcohol or substance dependence. The finding that these two groups were statistically equivalent may be misleading, however, because a chi-square test yielded a small effect that may be of practical, if not statistical, significance. Specifically, among my sample of 35 respondents, professionals treated for sex addiction were actually 18.2% more likely to complete treatment than those

treated for other addictive disorders.

I suspect that part of this difference in discharge rates could be explained by the increased risk of physiological dependence inherent in many substance-related disorders, a factor that may tend to complicate recovery for alcohol- and chemically-dependent individuals. Some authors (Berlin, 2008; Washton, 1989) have suggested that persons addicted to sex could become physiologically dependent upon endogenously-produced opioids, stimulants, or other neurotransmitters released with sexual activity. However, more research is needed to test my surmise that sexually addicted persons may complete treatment at higher rates than substance-dependent persons because they are not as likely to experience physiological dependence in the course of their addiction.

In Research Question 2, analysis revealed that, among the 84 professionals who presented for sex addiction treatment at the designated facility during the study window, reported incidences of SBV were not, in themselves, predictive of whether or not respondents completed treatment satisfactorily. In fact, among these 84 professionals, those reporting a history of sexual boundary violation prior to treatment were 19% more likely to have completed treatment successfully than those not reporting such a history. Although not significant, this finding may indicate that professionals who had reportedly violated professional boundaries (successful discharge rate = 84.6%) were somewhat more amenable to, or were perhaps more motivated to complete, sex addiction treatment than professionals who reportedly had not violated boundaries (71.1%). This finding lends empirical support to Irons and Schneider's (1994, 1999) and Abel and Osborn's (1999) assertions that professionals accused of sexual misconduct are at least as responsive, and perhaps slightly more so, to sex addiction treatment as those not so accused. As a matter of conjecture, I wonder if perhaps patients reporting a history of SBV had increased

motivation to complete treatment due to feelings of shame that their secretive sexual behavior had intersected with their professional lives despite their best efforts to “control” it. However, it is also possible that these professionals were more likely to have had license complaints and, being at greater risk of losing their professional licenses, potentially more motivated to complete treatment. However, more research would be required to test these intuitive conjectures.

Objective Occupational Measures

In reviewing the existing scholarly literature, I found data on two objective ratings of occupational status for sexually compulsive and/or boundary transgressing professions: (a) rates of continued licensure after sexual problems (Abel et al., 1998; & Osborn, 1999; Dehlendorf & Wolfe, 1998; Morrison & Wickersham, 1998) and (b) rates of recidivism (Abel & Osborn, 1999). For example, Dehlendorf and Wolfe (1998) found that only 29.3% of physicians retained their licenses after receiving board complaints of sexual misconduct warranting disciplinary action. Similarly, Morrison and Wickersham (1998) reported that 59% of physicians in their sample remained licensed after similar complaints and board action. Of the 35 satisfactorily treated professionals in this study, 77.1% were reportedly still licensed at the time they took the survey. This result suggests that professionals who satisfactorily completed residential treatment retained their licenses at a higher rate than has been reported in previous studies.

However, neither Dehlendorf and Wolfe (1998) nor Morrison and Wickersham (1998) indicated whether any of these disciplined professionals had received treatment of any kind; their studies were comparisons of raw, publically available data, i.e., number of license suspensions/revocations/surrenders compared to number of board-adjudicated cases. The finding in this present study that more than three-quarters of successfully treated professionals reportedly retained their licenses to practice may provide licensing boards an additional remediation option

when adjudicating cases. In other words, licensing boards, which typically make licensing decisions based more on societal or professional pressures than on an evaluation of continuing risk (Abel et al., 1998), could consider a licensee's response to, and degree of therapeutic change after, residential treatment when making disciplinary determinations.

Abel et al. (1998) and Abel and Osborn (1999), authors of the only two published reports on license status of successfully treated boundary-violating professionals, reported, respectively, that 47.7% and 52% of physicians referred to their sex addiction program both completed the treatment and returned to practice. However, some extrapolation is required before comparing the data collected in my study to Abel et al.'s (1998) and Abel and Osborn's (1999) findings. For example, as previously reported, 77.4% of professionals treated for sex addiction at the designated facility successfully completed the treatment. Of the 35 respondents to my study, all drawn from that population, 77.1% were reportedly licensed at the time of study participation. On the assumption that the 35 study respondents are representative of all the professionals who satisfactorily completed sex addiction treatment at the designated facility, it can be extrapolated that 59.7% of professionals referred to sex addiction treatment at the facility both completed it and returned to practice, a rate comparable to, and even somewhat higher than, the rates Abel and his co-authors have previously reported. Nevertheless, my findings corroborate these previous findings that successfully treated professionals tend to retain their licenses at higher rates than professionals for whom treatment was not specified.

In contrast to data on license status of offending professionals, data on recidivism rates of professionals accused of SBV is nearly non-existent. In the only published account of which I am aware, Abel et al. (1998) reported that "identified recidivism in the last 7 years has been less than 1%" (p. 334), a figure reiterated in Abel and Osborn (1999, p. 245). However, the authors did not

specify what they considered “recidivism” to entail. In my study, 15.4% of respondents who returned to practice reported having received a subsequent licensing board complaint, a rate statistically equal for respondents in both the BV and NBV group. This percentage seems unacceptably high, and I wonder whether the fact that none of the study respondents reported being under the supervision of another professional at the time they completed the study was a contributing factor to their subsequent licensing complaint. Perhaps the finding that, in the absence of monitoring and supervision, a substantial number of professionals reported continuing misconduct complaints even after satisfactory treatment adds support to other writers’ admonition that licensing boards strengthen their regime of mandated post-treatment assessment and monitoring of returning professionals (Abel & Osborn, 1999; Celenza & Gabbard, 2003).

Subjective Occupational Measures

No previously published studies have investigated impaired professionals’ perceptions of their job status and satisfaction after successful completion of treatment. Results of this study indicated that respondents reported everything from the greatest possible decrease to the greatest possible increase in job status and/or satisfaction after treatment. However, as a whole, the respondent group reportedly returned to jobs of slightly lower status but from which they gleaned a slightly higher degree of satisfaction. Respondents who reportedly violated professional boundaries endorsed the greatest decrease in job status upon returning to work, however, even these respondents reported being somewhat more satisfied with their jobs at the time they completed the survey than prior to treatment.

This result suggests that sex addicted professionals, regardless of whether or not they violated boundaries in the course of their compulsive behavior, can return to productive and satisfactory employment after successful treatment. Even among respondents who reportedly left

their professional fields as a result of their problems, boundary violators and non-violators alike were, on the whole, about as satisfied, and perhaps even somewhat more satisfied, with their jobs at the time of study participation than their jobs prior to treatment. These factors may provide hope to other professionals with similar problems: the possibility that their behavioral health issues and/or ethical breaches need not end their occupational prospects. Such hope for the future could help them persevere through the grueling and often emotionally painful process of sex addiction treatment and recovery.

Reductions in CSB Symptoms and SBV Risk over Time

CSB Symptom Severity

This study is the only empirical exploration I uncovered during my review of scholarly literature that was designed to measure changes in CSB symptom severity over time, and the changes I found were dramatic. Analysis revealed reductions in CSB symptomatology greater than 3.5 standard deviations among the 29 respondents providing S-SAS data at both observations. This substantial reduction in symptom severity was statistically equal ($t [26] = .499, p = .622$ [two-tailed], $\eta^2 = .009$) for the 11 respondents who reportedly violated professional boundaries ($M = -47.8, SD = 19.8$) and the 17 who reportedly did not ($M = -51.65, SD = 19.8$). These results indicated that sexual boundary violators reported retrospective, pre-treatment CSB symptoms as severe as boundary non-violators, and that their symptoms decreased by the same, very large degree after residential treatment and post-discharge continuing care. This finding tends to support both Carnes's (1992) and Irons and Schneider's (1994, 1999) hypothesis that boundary violation can be one of several potential manifestations of the disorder of sex addiction, and provides evidence that symptom severity can be reduced equally for both groups of respondents.

Furthermore, these reductions in CSB symptom severity were statistically significantly stable over time, up to five years post-discharge, a result that I suspect was likely impacted by the fact that 97.1% of study respondents reported having participated in some form of post-discharge treatment or recovery support. The finding of stability of these reductions in CSB symptom severity may be of interest to licensing boards when making licensing decisions. Members of various states' boards of examiners, who have the duty both to ensure public safety and to provide due process for licensees, can take from these findings that therapeutic change, at least among respondents to this study, was long-lasting. This finding may provide contrary evidence to the assumption of many members of both the public and the various professions that impaired professionals are irredeemably predatory, psychotic, and immune to treatment (Celenza & Gabbard, 2003).

Finally, although not statistically significant, respondents who reported new licensing board complaints reported pre-treatment CSB symptoms 8.5% more severe than respondents not reporting new complaints. Rates of CSB symptom decrease over time were statistically equivalent for the two groups, suggesting that respondents reporting new complaints were as receptive to treatment as those not reporting them. However, at time of study participation, CSB symptomatology of respondents reporting new complaints remained substantially greater than those not reporting complaints. These results indicate that regular assessment of the severity of returning professionals' CSB symptoms could identify those at risk for continuing misconduct complaints. Perhaps, then, the S-SAS could become a tool to assist: (a) recovering persons monitor their continuing CSB symptoms and (b) licensing boards and PHPs periodically assess ongoing CSB symptomatology that could predict future complaints. However, more research with

a larger sample population is needed to confirm not only the predictive power of the S-SAS on licensing board complaints but also the potential future uses of the S-SAS as a monitoring tool.

SBV Risk Factor Frequency

As with changes in CSB symptom severity, I found that reported SBV risk factor frequency also decreased substantially over time, by a factor of more than 1.5 standard deviations among the 21 respondents providing BVI data at both observations. Respondents in the BV group reported a decrease more than twice as great as those in the NBV group; however, this difference was likely due to the fact that the mean BVI score at retrospective pre-treatment of the BV group was more than twice the score of the NBV group. The reduction in SBV risk over time was so large, in fact, that, at post-treatment, i.e., the time of study participation, the mean score obtained by the 21 respondents providing data at both observations was 6.6, within one point of what Swiggart et al. (2008) have defined as low risk. Furthermore, this score was statistically equivalent for both BV and NBV group respondents.

If one accepts Swiggart et al.'s (2008) preliminary determination that a BVI score ≥ 6 is an appropriate threshold for differentiating high risk from low risk, the result from this study suggests that satisfactorily treated professionals, all of whom were at high risk of SBV prior to treatment and many of whom reportedly had already crossed professional boundaries, can reduce their reported risk for future boundary violations to a level that is very nearly low risk. This result offers evidence supporting the clinical observations of Irons and Schneider (1994, 1999) that successful sex addiction treatment and post-discharge continuing care is associated with reductions in SBV risk. Furthermore, similar to reduction in CSB symptom severity, reduction in SBV risk factor frequency was stable over time, up to five years post discharge, as degree of SBV risk reduction was not correlated to years post discharge. This result adds empirical

support to Celenza and Gabbard's (2003) assertion that many professionals at high risk for boundary violation at one point in time are not fated to remain so inalterably.

Continuing Education and Future Risk of Boundary Violation

Curiously, at time of study participation, the 23 respondents who reportedly earned CMEs in boundary maintenance were at statistically equal SBV risk as measured by the BVI as were the five respondents who reportedly did not. The large, overall reduction in SVB risk over time was, although not significant, moderately greater for respondents who reportedly earned CMEs than for those who reportedly did not (partial $\eta^2 = .065$). However, this difference in the rate of change was largely due to the two groups being unequal at retrospective pre-treatment. For example, respondents who reportedly earned CMEs in boundary maintenance obtained scores 59.2% higher on the BVI at retrospective pre-treatment than those who did not. It is possible that, during treatment, clinicians working with these professionals may have identified certain individuals as being at higher SBV risk and recommended they participate in a CME course in boundary maintenance in addition to sex addiction treatment to address their greater risk. However, no data were collected to either support or refute this hypothesis.

Nevertheless, the finding that, at time of study participation, respondents who reported CMEs in boundary maintenance were statistically equivalent in their SBV risk to respondents who did not report them could suggest that a short-term intervention such as a CME course in boundary maintenance may not have been the factor most responsible for change in SBV risk. If so, one might expect that the group who reportedly earned boundary CMEs would be at lower SBV risk at post-treatment than those who reportedly did not earn them. Conversely, however, because both groups were not equal in SBV risk at retrospective pre-treatment, it could also be said that the addition of a boundary course may have been the factor that reduced the two groups'

SBV risk to equivalent levels at post-treatment.

Results of multiple regression that were performed in Research Question 8 tended to support the former hypothesis, that the CME course was not the factor most responsible for change in SBV risk. Results of this regression analysis are discussed in more detail later in this chapter. Although an evaluation of treatment effectiveness between the various interventions, sex addiction treatment, CMEs, counseling, recovery support, etc., cannot be conducted based upon the data collected for this present writing, an investigation of this type would be fertile ground for future research.

Results of this study also indicated that the BVI could be used to predict risk of future boundary violations after treatment. For example, respondents reporting new licensing board complaints obtained a BVI score nearly double that of respondents not reporting new complaints. Additionally, the two respondents who reported new licensing complaints and who provided post-treatment BVI data scored above Swiggart et al.s' (2008) "high-risk" threshold of 6, whereas the 20 respondents not reporting new complaints obtained a mean BVI score more than 2 points below that threshold. However, the fact that some respondents without new licensing complaints scored like the two respondents with new complaints suggests that higher scores alone are not infallibly predictive.

Nevertheless, this result suggests that the BVI, similar to the S-SAS, may be useful in helping to identify professionals who may continue to have trouble maintaining professional boundaries even after satisfactory sex addiction treatment. The BVI could likely be incorporated into a broader regime of post-treatment professional supervision and monitoring, as suggested is necessary by several commentators (Abel & Osborn, 1999; Celenza & Gabbard, 2003). The BVI also could be useful as a self-monitoring tool for recovering professionals as they return to

practice. More research with a larger sample population is needed to confirm not only the power of the BVI to predict licensing board complaints, but also its potential use as both a professional and personal monitoring tool.

Correlations between CSB Symptoms SBV Risk

In Research Question 3, I explored whether CSB symptom severity was correlated to SBV risk as measured by the S-SAS and BVI, respectively. Although the two phenomena were not correlated at pre-treatment, results indicated a medium correlation that approached statistical significance at post treatment. Furthermore, although not significant, the correlation between retrospectively reported, pre-treatment CSB symptoms and SBV risk was 2.7 times greater for respondents who had violated professional boundaries than for those who had not. At post-treatment, i.e., at time of study participation, the correlation of reported CSB symptoms and SBV risk was, although non-significant, practically moderate for both the BV group ($r = .304$, $n = 11$, $p = 0.363$) and the NBV group ($r = 0.426$, $n = 14$, $p = 0.128$). These results add preliminary empirical data to the clinical observations of Irons and Schneider (1994, 1999), who have asserted that sex addiction and sexual boundary violation are correlated phenomena. However, the results of this study suggest that the relationship may be a complex one.

Pre-treatment Correlation

I was surprised to find no significant correlation and very small effect between CSB symptom severity and SBV risk at retrospective pre-treatment; prior to conducting the study, I had assumed their relationship would have been greatest at that observation. However, by investigating the distribution of scores on the BVI and S-SAS at that observation, perhaps statistical correlation between these scores may not be the most informative method of investigating the relationship of CSB and SBV. Rather, it appears that an analysis of association

between High-/Low-SBV-Risk groups and High-/Low-CSB-Symptoms groups might better explain the interaction.

At retrospective pre-treatment, 100% of study respondents reported experiencing a high degree of CSB symptom severity ($S-SAS > 12.9$, as discussed in Chapter 4). At the same observation point, 87.5% of study respondents were also at high risk of SBV ($BVI \geq 6$). This increased risk of boundary violation was similar for respondents in both offender groups. For example, 100% of the 14 BV group respondents providing BVI data at retrospective pre-treatment were at high risk for SBV, as were 76.3% of the 13 NBV-group respondents. Only three respondents reported retrospective pre-treatment BVI scores indicating they were at low risk for SBV, and all three of these individuals were in the NBV group.

This similarity in elevated SBV risk between offender groups indicates that, although a direct correlation may not exist between severity of CSB symptoms and frequency of SBV risk factors at pre-treatment, sex addicted professionals are generally at increased risk for SBV regardless of whether or not they had actually crossed boundaries at the time they presented for treatment. In other words, the finding that pre-treatment CSB symptom severity was only weakly correlated to SBV risk factor frequency indicates that the relationship between the phenomena may not be linear, i.e., greater symptom severity leads to greater SBV risk. Nevertheless, the finding that nearly 90% of respondents to my study both: (a) reportedly experienced clinically significant CSB symptoms at retrospective pre-treatment and (b) were also at high risk for SBV supports Irons and Schneider's (1994, 1999) clinical observation of an association between the two phenomena. It is left to future investigators to determine what other factors, either independent of or in conjunction with CSB symptomatology, may predict incidences of professional sexual boundary violation.

Post-treatment Correlation

At time of study participation, i.e., in the context of respondents' reported post-treatment experiences, I found a medium correlation between CSB symptoms and SBV risk that approached statistical significance. This result indicated that the greatly-reduced CSB symptom severity reported at post-treatment was moderately correlated to frequency of SBV risk factors at post-treatment, which had also been substantially reduced. Even though this correlation was not statistically significant, the fact that it approached significance with such a relatively small sample of respondents suggests that the medium correlation may be practically significant. However, as with the attempt to correlate the two phenomena at pre-treatment, investigating the relationship between High-/Low-SBV-Risk and High-/Low-CSB-Symptoms may be helpful in better understanding the possible association of the phenomena at post-treatment.

At time of study participation, 68% of respondents providing data reported they continued to experience elevated CSB symptoms ($S-SAS > 12.9$), a 32% reduction compared to the 100% of respondents who reported elevated CSB symptoms at retrospective pre-treatment. By contrast, at time of study participation, only 36% of respondents remained at high risk for SBV, a 41.5% reduction compared to the 87.5% reportedly at high risk prior to treatment. This result suggests that SBV risk can be decreased to "low risk" levels at a higher rate than CSB symptoms can be reduced to non-clinically significant levels, even though both SBV risk and CSB symptoms decreased dramatically over time. Stated another way, 64% of respondents providing data were at low SBV risk at time of study participation, even though 62.5% of them reported they continued to experience clinically significant CSB symptomatology. This result suggests that, even though many professionals may still struggle with clinically significant symptoms of sex addiction after treatment, most can nevertheless learn to monitor their

professional behaviors and attitudes such that they are not at high risk of crossing professional boundaries.

Factors Predicting Change in Symptomatology and Risk

Decreases in CSB Symptom Severity

In Research Question 7, I attempted to identify which factors might be responsible for the decrease in CSB symptom severity as measured by S-SAS-change: days of sex addiction treatment, post-discharge counseling or psychotherapy; use of prescribed psychopharmaceuticals; support group meeting participation; and CME units in professional boundary maintenance. I was surprised to find that: (a) none of the five predictors tested were more than weakly, and statistically non-significantly, correlated to CSB symptom reduction; and (b) only one predictor was a meaningful contributor to those reductions. For example, only days of inpatient/outpatient treatment was found to contribute meaningfully to decreases in CSB symptom severity, and this relationship was only moderate and not statistically significant. Initially, I suspected that these results could reflect Type II error because the predictor variables were not normally distributed. However, as I investigated these findings further, I noticed that all of the predictor variables were quantitative in nature, i.e. number of years since discharge, number of presenting problems, days of treatment, number of sessions or support group meetings attended, etc. Perhaps these quantitative variables do not adequately measure the qualitative change in respondents over time.

For example, perhaps it was the confluence of other, unmeasured factors, e.g., readiness for change, willingness to accept responsibility, commitment to personal growth, ability to tolerate and work through emotional pain, openness to feedback, or other personal, cultural, or situational factors that was actually responsible for the dramatic reduction in CSB symptom

severity. I suspect that many of these traits are shared by most successfully treated professionals, and that it was these unmeasured factors that were, in fact, predictive of both: (a) quantitative measures such as length of stay in treatment, number of counseling sessions or support group meetings attended, etc.; and (b) decreases in CSB symptom severity. More research utilizing different instruments designed to measure these qualitative factors would be useful in investigating which factors may have been most responsible for CSB symptom change.

Decreases in SBV Risk

In question eight I attempted to identify factors that might be responsible for the degree of decrease in SBV risk factor frequency as measured by BVI-change. In contrast to predictors of CSB symptom reduction, most predictor variables tested were, although non-significantly, at least moderately correlated to SBV risk factor reduction. However, one of the variables, days of inpatient/outpatient treatment, demonstrated a large degree of correlation with SBV risk factor reduction that, in fact, reached statistical significance. This result indicated that the longer respondents spent in inpatient and outpatient sex addiction treatment, the greater was the reported decrease in their SBV risk. The relationship between these two factors constituted a large effect that explained 28.7% of the variance in SBV risk.

Days of treatment was a meaningful and unique contributor to reductions in SBV risk, as well. Although failing to reach statistical significance, the β -coefficient, which approached significance notwithstanding the small sample, indicated that a one-standard-unit increase in days of treatment resulted in a .785-standard-unit reduction in SBV risk, a very large effect (Cohen, 1988, pp. 79-81). This finding provides evidence suggesting a relationship between number of days in sex addiction treatment and reductions in risk of sexual boundary violation. Other meaningful, although statistically non-significant, unique contributors to SBV risk

reduction were number of counseling sessions per year ($\beta = -.303$), support group meetings per year ($\beta = -.292$), and Hours of Boundary Training ($\beta = -.259$). Counseling sessions per year was a moderate predictor of SBV risk reduction; the other two variables exerted a small, approaching medium, effect on SBV risk (Cohen, 1988, pp. 79-81).

Although non-significant, these results indicated that the other interventions were associated with a degree of impact on SBV risk reduction that was at least practically significant. However, as with reductions in CSB symptomatology discussed in Research Question 7, it is possible that other, unmeasured personal, situational, and/or cultural factors were associated with both the decrease in SBV risk and in degree of participation in therapeutic interventions. Therefore, it remains for future researchers to determine which factors may be responsible for decreases in SBV risk; however, the finding of a strong association between: (a) sex addiction treatment, continuing care, and recovery support; and (b) SBV risk reduction provides empirical justification for such research.

Curiously, however, hours of boundary training was the least meaningful of the tested predictors of SBV risk reduction. This result tends to support the finding in Research Question 5 which revealed that the large reduction in SBV risk over time was only moderately greater for those who had reportedly earned CMEs in boundary maintenance than those who reportedly had not, a difference likely due to differences at pre-treatment. The findings from questions five and eight support a hypothesis that sex addiction treatment and post-treatment continuing care was likely responsible for a greater degree of SBV risk reduction than was a course in boundary training taken in conjunction with such treatment. As stated previously, however, this present study cannot be used to evaluate the relative effectiveness of one treatment over another; it does, however, provide a potential direction for future research.

Occupational Impact of Symptom and Risk Reductions

In Research Question 9, I attempted to determine whether the degree of reported reduction in CSB symptom severity was predictive of current license status. I found that, rather than the former predicting the latter, CSB symptom reduction was statistically equal for both licensed and non-licensed respondents. This finding offers support to Abel et al.'s (1998) assertion that licensing boards may not take into consideration individual growth and therapeutic change, including reductions in sexually compulsive thoughts, feelings, and behaviors as measured by the S-SAS, when deciding whether or not to allow a professional to remain licensed to practice. Perhaps, as the S-SAS is a relatively new instrument, licensing boards are unaware of its potential use for this purpose. Alternately, because the BVI and the S-SAS are self-report instruments with no means of assessing respondent defensiveness or deceptiveness, licensing boards may be hesitant to rely solely upon self-reported changes in these factors. Ironically, although the degree of CSB symptom reduction was not statistically significantly different for those respondents reportedly licensed or not licensed, likely a function of my small sample size, the mean decrease in symptom severity of those not licensed was actually greater than those who were. This finding suggests that many professionals lost their professional licenses despite the fact that they reported decreases in CSB symptom severity that were at least equal to, and potentially actually greater than, professionals who reportedly retained their licenses.

Although CSB symptom reduction was not predictive of license status, an objective occupational measure, I investigated whether reduced CSB symptomatology may have been related to subjective changes in occupation. Analysis yielded no statistically significant correlation with negligible effect between decrease in CSB symptom severity and perceived change in either job status or job satisfaction. This result suggests that respondents reporting

greater reductions in CSB symptom severity do not subjectively experience the status of their post-treatment jobs, or the satisfaction derived from them, to be to be any higher than respondents who reported lesser reduction in CSB symptoms. This finding suggests that the lack of relationship between CSB symptom reduction and objective measures of occupation such as license status is also reflected in subjective measures of this factor.

In Research Question 10, I attempted to determine whether the degree of a respondent's reported change in SBV risk was predictive of license status at time of study participation. Similar to CSB symptom change, SBV risk reduction was not predictive of license status because the degree of reduction was not significantly different for those professionals who retained their licenses and those who did not. This finding suggests that some respondents lost their professional licenses despite reporting an equivalent decrease in SBV risk as those who retained their licenses, suggesting that SBV risk reduction may not have been considered when licensing decisions were made.

This finding is subject to the limitation of small sample size, as only four non-licensed respondents reported BVI scores for both post-treatment and retrospective pre-treatment observations, scores necessary to calculate BVI-change. However, by exploring data from all 29 respondents providing BVI scores at post-treatment, regardless of whether they also provided data at retrospective pre-treatment, SBV risk was actually slightly lower for the six respondents who reportedly lost their licenses ($M = 4.5, SD = 2.8$) than for the 23 who reportedly retained them ($M = 5.5, SD = 6.29$). This difference could be explained by the fact that, having lost their licenses to practice, these six respondents may not have had as much contact with patients or clients and their reported boundary risk reflected their interactions only (or mostly) with coworkers and staff. More research is needed to confirm these findings; however, this initial

result is the first empirical evidence supporting Abel et al.'s (1998) assertion that continuing SBV risk is not taken into consideration by boards making licensing decisions.

As with perceived change in CSB symptom severity, I investigated whether perceived change in SBV risk may be related to changes in subjective reports of job status and/or satisfaction. Pearson product-moment correlation revealed a large and statistically significant correlation between reductions in SBV risk as measured by BVI-change and perceived job status. Similar to the non-significant correlation with CSB symptomology, the positive direction of the correlation suggests that respondents with greater decreases in SBV risk reported working at jobs of lower status than they had prior to treatment. Additionally, analysis revealed no significant correlation but with a medium effect between BVI-change and change in job satisfaction. Although not statistically significant, this moderate correlation suggested that, similar to job status, respondents reporting greater reductions in SBV risk reported they derived less satisfaction from their jobs. These findings suggest that respondents noticed subjectively what they reported objectively: that reduction in SBV risk did not differentiate licensed from non-licensed professionals, and, moreover, that reductions in SBV risk were actually associated with lower subjective ratings of job status and satisfaction.

Limitations

This study is subject to several important limitations that could threaten the validity and generalizability of results. Such limitations include: (a) selection and non-response bias, (b) lack of a control group, (c) questionable accuracy of self-reports, (d) potentially erroneous group assignments, and (e) lack of homogeneity of treatment.

Potential study respondents were drawn from a pool of only those individuals who presented to and successfully completed residential sex addiction treatment at the designated

facility; therefore, the validity of obtained results is threatened by selection bias. Said another way, professionals who otherwise would have met the study criteria but who did not present for treatment at this facility were, in effect, “screened out.” It is impossible to know why one individual may have presented for treatment at this facility and another may not have. Perhaps respondents who did not present for treatment were deemed to be unsuitable candidates by their licensing boards, as Abel and Osborn (1999) found that 32.3% of professionals were. However, respondents may not have received treatment for any number of reasons, including unawareness that such treatment existed, insufficient resources to pay for such treatment, a desire to seek treatment elsewhere, and arrest or incarceration preventing them from getting treatment. Regardless, any form of “pre-screening” of respondents prior to treatment limits the generalizability of the results obtained in this study.

Another limitation to this study lies in the fact that, although rate of response was relatively high, nearly 40% of potential respondents did not participate. It is impossible to determine why one study invitee chose to participate in the study and another did not; perhaps the survey non-response occurred completely at random. However, it is also possible, and I suspect more likely, that the 35 respondents to the questionnaire may have had different experiences than the 23 who did not respond. My surmise is that the most likely commonality between those persons not responding to the study was that these individuals were not functioning as well in recovery as the 35 respondents who provided data. If so, the results obtained in this study may be artificially skewed in the direction of more positive therapeutic outcomes. Additionally of note is the fact that among the individuals who did not participate in the study was the one female respondent who met the study criteria. The lack of a sufficient sample of female respondents is another limitation to the generalizability of these findings.

Additionally, because my available resources allowed me to work with only the designated treatment facility, the pool of potential respondents and thus the obtained sample was relatively small. I am very gratified to have received usable data from the 35 respondents who participated, especially considering the stigmatized nature of the subject matter. However, the small sample of respondents was likely the primary reason some analyses yielded statistically non-significant results. Additionally, some analyses, especially multiple regression, require larger samples to produce results of satisfactory statistical power. In other words, multiple regressions testing three or more predictor variables are typically not recommended for small samples such as mine. Therefore, the validity of the results obtained is threatened by the size of the sample. However, as this study was both exploratory and, as far as I could determine, unprecedented, I believe that the potential benefits of having undertaken the study outweighed the limitation introduced by the small sample.

The fact that all respondents had satisfactorily completed treatment introduced another limitation: The lack of data from a control group of respondents who either did not receive or did not successfully complete treatment. Abel et al. (1998) conceded that controlled outcome studies of boundary violating professions would be problematic if not impossible, because allowing a control group of known boundary violators to continue practicing during data collection would be unethical on its face. However, even if the control group was not made up of practicing boundary violators, patient and/or defendant confidentiality could pose another problem in identifying a suitable control group. When planning this study, I considered inviting all individuals discharged from residential sex addiction treatment during the study window to participate, regardless of whether they had or had not successfully completed it. However, I was informed that the vast majority of person who leave treatment prior to satisfactory completion do

not consent to be contacted by the facility afterward. As such, the facility was ethically bound not to contact these persons, even if only to invite them to participate in a study. Similarly, I considered contacting various malpractice attorneys and members of state licensing boards to ask if they would forward a study invitation letter to appropriate clients and/or licensees. However, after investigating the logistics of such an endeavor, I determined that to do so was beyond my available resources. Therefore, it will be for future researchers to survey a suitable control group of respondents.

This study is also subject to several limitations regarding the accuracy of data collected, including recall bias, the lack of mechanisms to assess or compensate for test taking attitudes, and respondents' prerogative to skip certain items, factors potentially exacerbated by the compensation offered to respondents submitting a survey. Perhaps the primary limitation in regard to recall bias lies in the very retrospective nature of assessing pre-treatment conditions in lieu of a true pre-test. For example, respondents were asked to recall and rate themselves up to as many as five years prior to the time of study participation, recollections which may not be accurate. Such inaccuracies could reflect a tendency for respondents to remember themselves as either more or less disturbed than they actually were, potentially resulting in either over- or under-reporting, respectively, of CSB symptoms and SBV risk. However, it is also possible that, because test-taking attitudes such as defensiveness or deceptiveness were unmeasured and unaccounted for, respondents with accurate recollections may have simply not reported their true experiences.

Ironically, the \$100 appreciation gift offered to each participant and the decision to allow respondents to skip items they deemed to be "too sensitive," while likely increasing study response, may have also introduced error into the data. For example, in order to claim an

appreciation gift, respondents may have had incentive to either: (a) skip items they did not wish to answer or (b) respond defensively merely to meet the requirement that they submit a survey. However, as this study was exploratory in nature, it was determined that the potential benefit of a higher response rate justified the possible risk of incomplete data or defensive responses, and I attempted to compensate for these factors in a manner that was both clinically and statistically sound, as described previously in this document. Nevertheless, reporting error based upon any of these factors is a limitation of this study.

Another limitation to this study lies in the fact that I relied upon respondent-reported incidences of boundary violation at treatment intake, or the lack thereof, to assign participants to the BV or NBV group. Patients at the designated facility participate in a fairly exhaustive intake process—typically including psychiatric, general medical, and psycho-social intake interviews—during each of which patients describe in detail the circumstances leading to their referral to treatment. Additionally, the facility’s intake counselors have access to communications from patients’ licensing boards that typically indicate if boundary violations were known to have occurred. Based on such data, I am satisfied that respondents assigned to the BV group were almost certainly respondents who had, indeed, violated professional boundaries. However, it is possible that respondents assigned to the NBV group actually had violated professional boundaries but were: (a) not accused of professional sexual misconduct, and/or (b) did not admit such boundary violations at treatment intake. Furthermore, because respondents in both the BV and NBV groups retrospectively reported pre-treatment BVI mean scores at least three times what Swiggart et al. (2008) have determined “high risk,” it is possible that many respondents in the NBV group would have violated a professional boundary if they had not presented for treatment when they did. In other words, respondents in the NBV group, many of whom shared

several important characteristics with respondents in the BV group, may have been assigned to the NBV group simply because they had not violated a sexual boundary "yet." Erroneously assigning respondents to the NBV group for any of these reasons would tend to confound the results of this study and must be counted as a limitation.

Another potential limitation concerns treatment homogeneity. Although treatment protocols at the designated facility are standardized, some patients may have received additional therapeutic experiences. For example, all persons satisfactorily discharged from the facility completed assignments from Steps 1, 2, and 3 of the facility's 12-step-based program of sex addiction treatment. Additionally, successfully discharged persons wrote and presented their sexual life history assignment as well as participated in weekly, and sometimes daily, individual and/or group therapy sessions, various psycho-educational presentations, and recovery support group meetings. However, in addition to these standardized treatments, some patients at the facility may have undergone EMDR therapy; others may have participated in Gestalt/psychodrama therapy, family, and/or couples therapy. Some respondents may have completed assignments from the "Safer Society" workbook, and still others may have received remedial professional boundaries training. Therefore, whereas every study participant in the study satisfactorily completed residential treatment, homogeneity of the specific course of treatment, including length of stay and specific therapeutic interventions administered, was impossible to verify. I deferred to the facility's treatment team's determination that each study participant received the appropriate, individualized treatment to meet the discharge criteria. Lack of homogeneity of treatment, in conjunction with the lack of a "no-treatment" or "treatment-not-completed" control group, is a limitation that precludes one from concluding that the treatment was responsible for the results obtained by this study.

Future Directions

Although this study illuminated many previously uninvestigated areas of SBV risk, CSB symptomatology, and correlations between the two, in many cases the small sample size probably contributed to results that did not reach statistical significance and for which statistical power was lessened. Therefore, I offer the following recommendations for future research:

1. Replication of this study with a larger sample of respondents from other treatment facilities could: (a) confirm, refute, or provide context for the results obtained in this study; (b) increase the generalizability of these findings; and (c) produce more results reaching statistical significance. Additionally, replication including a “no-treatment” or “treatment-not-completed” control group could provide evidence of treatment effectiveness.
2. Future studies could investigate the degree of decrease in CSB symptom severity as compared to degree of decrease in symptomatology of other addictive disorders after successful treatment. In this study, I compared rates of satisfactory discharge from sex addiction treatment to discharge rates for other forms of residential addiction treatment, primarily alcohol and substance dependence, and a future researcher could either confirm or dispute these findings. However, in addition to simply analyzing rates of discharge, a future study could be designed to compare the degree of symptom reduction after sex addiction treatment to the degree of symptom reduction reported by persons who completed residential treatment for other addictive disorders. A finding that rates of symptom decrease were equivalent across addictive disorders would offer additional corroborating evidence to Carnes’ (1992) assertion that compulsive sexuality is a treatable “addiction.”

3. Finally, more study examining the association between CSB symptom severity and SBV risk is needed. This study illuminated the complex relationship between these factors and added empirical evidence to the clinical observation that these phenomena are related. However, in the absence of an agreed-upon threshold score on the S-SAS that would indicate “clinically significant symptom severity,” the association I found between clinically significant CSB symptoms and high risk of SBV must remain preliminary at present.

Implications and Conclusions

Professionals are individuals in whom patients or clients place trust. However, professionals are, like anyone, subject to cognitive, physical, and emotional impairment, potentially including sex addiction. Such impairments, often in conjunction with generally poor interpersonal boundaries or other unmet personal and emotional needs, can contribute to incidences of sexual boundary violation, victimizing persons who contacted the professional seeking help. Much has been written on each of these topics—professional impairment, sex addiction, and boundary violation—and many studies have investigated various aspects of these phenomena. However, no previous researcher of whom I am aware has attempted to investigate empirically the relationship between sex addiction and boundary violation, measure changes in either sexual symptoms or boundary violation risk over time, identify factors that may contribute to such changes, or explore the professional and personal dispositions of professionals who successfully completed sex addiction treatment.

Taken as a whole, the results of this study can be summarized as follows:

1. Professionals successfully complete residential sex addiction treatment at a rate at least equal to completion rates of other addictive disorders.

2. Professionals who have reportedly violated sexual boundaries in the course of their compulsive sexual behavior were as likely to complete residential sex addiction treatment as those who reportedly had not.
3. Symptoms of sex addiction were reduced by 75.5% over time, reductions that were statistically equivalent for respondents who did and did not report boundary violations.
4. Reductions in symptoms of sex addiction over time were, as a practical matter, moderately related to (a) length of stay in residential sex addiction treatment, (b) continuing care, and (c) ongoing recovery support.
5. SBV risk was reduced by 74.7% over time, reductions that were (a) moderately greater for respondents reporting boundary violations, and (b) attributable to differences at retrospective pre-treatment.
6. Reductions in SBV risk over time were, practically speaking, strongly related to length of stay in residential sex addiction treatment and moderately related to post-discharge continuing care, recovery support, and continuing education in boundary maintenance.
7. CSB symptoms and SBV risk, although not correlated at retrospective pre-treatment, were, as a practical matter, moderately correlated at time of study participation.
8. The relationship between CSB and SBV may be better explained non-linearly, as clinically significant CSB symptomatology was related to elevated risk of SBV in 87.5% of respondents at retrospective pre-treatment and in 41.2% of respondents at time of study participation.

9. Nearly two-thirds of successfully treated professionals were reportedly at low risk for SBV at time of study participation, even though slightly more than six in 10 of these persons reported continuing to experience clinically significant, albeit greatly reduced, CSB symptomatology.
10. More than 75% of respondents who completed residential treatment reportedly retained their licenses to practice.
11. BV group respondents were 27.3% more likely than the NBV group to report losing their professional licenses, although the substantial decreases in both CSB symptoms and SBV risk was statistically equal for the two groups.
12. Professionals exhibiting symptoms of sex addiction, including those accused of boundary violations, can return to satisfying employment after treatment; however, the degree of their therapeutic growth over time does not predict whether or not they remain licensed.

Many commentators have written that perhaps the lowest point in a sex-addicted professional's life occurs when his or her previously secretive—and simultaneously shameful yet unstoppable—behavior is discovered by other professionals, licensing bodies, patients, clients, and other significant persons in the professional's life. This study's findings can be used to offer hope to sex-addicted professionals that, upon "hitting bottom," they can finally experience relief from their distressing feelings and compulsive behaviors. Additionally, the results of this investigation can provide those professionals, even ones accused of boundary violation and at risk of losing their livelihoods, the promise of treatment and a potential return to practice. However, even if a return to practice is not possible, this study revealed that most treated professionals can return to jobs that are, on average, at least as satisfying as, and considering the

substantial reduction in their painful feelings and humiliating behaviors, potentially even more satisfying than their pre-treatment occupations.

The results of this study can be utilized by licensing boards and PHPs in their work with impaired professionals. Perhaps such authorities, based upon this study's findings, will (a) offer professionals exhibiting symptoms of compulsive sexuality or accused of sexual boundary violation the option of residential sex addiction treatment and (b) consider reductions in CSB symptomatology and SBV risk when making licensing decisions. Finally, this study's finding that, in the absence of monitoring or supervision, 15% of successfully treated professionals reported new license complaints can encourage licensing boards and PHPs to strengthen their supervision of returning professionals. Such supervision should include regular re-assessments of CSB symptom severity and SBV risk by the professional's supervisor and by the PHP or licensing board itself.

Ultimately, however, I believe that it is the responsibility of recovering professionals to self-monitor these factors with the input of their sponsor and recovery support group as frequently as weekly so they can continue to practice competently and ethically. This study provided evidence that has been absent in the professional literature on the correlation between, reduction in, and consequences of CSB and SBV. However, it is only a preliminary step. Other researchers are free to use this study as a framework for future studies, both quantitative and qualitative, into sex addiction treatment and incidences of boundary violation in professional relationships.

APPENDIX A
THE CLASSICAL HIPPOCRATIC OATH

Following is the complete text of the medical oath, commonly attributed to Hippocrates ca. 400 B.C.E., historically used to swear in medical apprentices. Although not commonly used today for other than ceremonial purposes (Edelstein, Temkin, and Temkin, 1987), medical ethicists and classical scholars have updated the oath various times over the millennia in keeping with contemporary language and culture. Despite not being the most recent revision, Ludwig Edelstein's 1943 translation is still frequently cited because it seems to most aesthetically balance the phrasing of the original Greek with the stylistic, linguistic, and medical terminology of the modern era. Apprenticed physicians were to say:

I swear by Apollo the Physician and Asclepius and Hygieia and Panacea and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art—if they desire to learn it—without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody who asks for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief, and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot. (attr. to Hippocrates, trans. 1943, as cited in Edelstein, Temkin, & Temkin, 1987, p. 6)

APPENDIX B
INSTITUTIONAL REVIEW BOARD APPROVAL

UNT
UNIVERSITY OF
NORTH TEXAS

Discover the power of ideas.

OFFICE OF THE VICE PRESIDENT FOR RESEARCH AND ECONOMIC DEVELOPMENT

January 24, 2011

Research Services

Janice Holden
Department of Counseling and Higher Education
University of North Texas

Re: Human Subjects Application No. 10428

Dear Dr. Holden:

As permitted by federal law and regulations governing the use of human subjects in research projects (45 CFR 46), the UNT Institutional Review Board has reviewed your proposed project titled "The Relationship between Professional Sexual Boundary Violation and Sex Addiction: An Exploratory Study of Post-Treatment and Retrospective Pre-Treatment Dispositions." The risks inherent in this research are minimal, and the potential benefits to the subject outweigh those risks. The submitted protocol is hereby approved for the use of human subjects in this study. **Federal Policy 45 CFR 46.109(e) stipulates that IRB approval is for one year only, January 24, 2011 to January 23, 2012.**

Enclosed is the consent document with stamped IRB approval. Please copy and **use this form only** for your study subjects.

It is your responsibility according to U.S. Department of Health and Human Services regulations to submit annual and terminal progress reports to the IRB for this project. The IRB must also review this project prior to any modifications.

Please contact Shelia Bourns, Research Compliance Analyst, or Boyd Herndon, Director of Research Compliance, at extension 3940, if you wish to make changes or need additional information.

Sincerely,



Patricia L. Kaminski, Ph.D.
Associate Professor
Department of Psychology
Chair, Institutional Review Board

PK:sb

APPENDIX C
INFORMED CONSENT NOTICE

University of North Texas Institutional Review Board
Informed Consent Notice

Before you agree to participate in this research study, it is important that you read and understand the following. In this notice you will receive an explanation of: (a) why the study is being conducted, (b) the study procedures, and (c) any risks and/or benefits involved in your participation in the study.

STUDY TITLE: The Relationship between Professional Sexual Boundary Violation and Sex Addiction: An Exploratory Study of Post-Treatment and Retrospective Pre-Treatment Dispositions.

PRINCIPAL INVESTIGATOR: This study is being conducted by Janice Holden, Ed.D., Professor of Counseling and Chair of the Department of Counseling and Higher Education of the University of North Texas, Denton.

KEY PERSONNEL: The principal investigator is working Bret M. Menassa, M.Ed., doctoral candidate in the Counseling Program, Department of Counseling and Higher Education, University of North Texas.

PURPOSE OF THE STUDY: This study has been designed to investigate the relationship, if any, between (a) severity of symptoms of sex addiction and (b) risk factors for professional boundary violation. The information you provide has the potential to advance our understanding of this relationship, factors that may be associated with changes in such symptoms and risk factors over time, and the effect these changes may have upon your occupational status.

STUDY PROCEDURES: You were selected to participate in this study primarily because you (a) are or were employed as a health, helping, or other professional and (b) successfully completed residential sex addiction treatment at Sante Center for Healing between January 1, 2005 and December 31, 2009. If you choose to participate in this study, you will complete a confidential, internet-based survey wherein you will be asked to: (a) rate the severity of symptoms of sex addiction you experienced in the past and any that you may still experience; (b) describe your thoughts, feelings, attitudes, and behaviors regarding the relationship you maintain with patients or clients; (c) assess in broad strokes the status of your occupation; and (d) describe any post-discharge treatment, recovery support, or licensing complaints you may have received.

RISKS AND DISCOMFORTS: There are no known or reasonably anticipated risks or discomforts associated with your participation in this study. Your participation is completely voluntary, and you may decide to withdraw from the study at any time prior to selecting "Submit Survey" on the final page of the survey website. Survey items have been constructed in such a way that your responses do not constitute an admission of current or past impropriety or misconduct of any kind. The cost of participation is limited to the time it will take you to complete the survey, approximately 30 minutes.

POTENTIAL BENEFITS: By participating in this study, we expect that you will experience a potentially enlightening self-assessment of the current state of (a) your recovery from sex addiction and (b) your experience of the professional relationship. The results of this study are expected to contribute to the scholarly understanding of the relationship between sex addiction and professional boundary violation, and they may provide licensing boards with empirically validated options for dealing with impaired professionals in the future.

RESPONDENT COMPENSATION: All study participants who submit a completed survey and follow the redemption instructions supplied on the final page of the online questionnaire will receive a \$100 American Express Gift Card as a token of the researchers' appreciation

PRODEDURES FOR MAINTAINING CONFIDENTIALITY OF RESEARCH RECORDS: All individual surveys will be coded and data will be analyzed only by group. There is no way your personal identity can be linked to any of your survey responses. All confidential study-related material and any records generated during the course of the study will be kept by the principal investigator in a locked file cabinet on the campus of the University of North Texas, Denton. In compliance with Federal research regulations, study-related material and confidential information will be stored for three years after the completion of the study. The personal identity of study participants, including descriptions of specific treatment referrals that could be potentially identifying, will not be disclosed in any publication or discussion of the results of this study.

QUESTIONS ABOUT THE STUDY: If you have any questions about the study, you may feel free to contact Bret Menassa at [address redacted] or by telephone at [phone number redacted]. Should Mr. Menassa be unable to adequately address your questions or concerns, you are free to contact Dr. Janice Holden at [address redacted].

REVIEW FOR THE PROTECTION OF PARTICIPANTS: This study has been reviewed and approved by the UNT Institutional Review Board (IRB), which insures that research involving people adheres to Federal regulations. The UNT IRB can be contacted at (940) 565-3940 should you have any questions regarding your rights as a research subject.

YOUR CONSENT TO PARTICIPATE: By signing below and submitting a completed questionnaire, you affirm that you have read and understand all of the above and that you hereby give your free and full consent to participate in the study. You are free to decline to participate or to withdraw your consent to participate at any time without penalty or prejudice.

Signature

Date

Printed Name

APPENDIX D

INVITATION LETTERS TO POTENTIAL STUDY RESPONDENTS



Letterhead Obscured for Confidentiality

On behalf of everyone here at [REDACTED] I hope you're experiencing serenity in your recovery. I am contacting you because I wanted to make you aware of a study of recovering professionals being conducted by researchers at the University of North Texas in Denton.


The University research team would like to learn more about how recovering professionals like you adjust, both personally and professionally, after successfully completing residential treatment. The researchers tell me that your participation will likely spark an enlightening self-investigation of your own growth in recovery and that the information you provide has the potential to help other recovering professionals like you in the future.

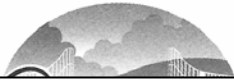
Because they value your time and opinions, the University research team has reserved a **\$100 American Express Gift Card for everyone who completes the survey** as a small token of their appreciation for your responses.

If you are interested in participating in this confidential, anonymous survey, you are invited to go to [www.\[REDACTED\].com](http://www.[REDACTED].com) and complete their online questionnaire before March 15, 2011. It should only take about 20 minutes. Make sure you have the **survey password** and your individual **group code**, listed above.

You can read about the details of the study and the steps the researchers will take to protect your confidentiality before you decide to participate. And if you still have questions, you can email [REDACTED] or [REDACTED] for a personal response before you begin.

Wishing you continued health and wellness,


[REDACTED] LCDC
Clinical Director
[REDACTED]



Letterhead Obscured for Confidentiality

Recently, I wrote to tell you about a study of recovering professionals being conducted by researchers at the University of North Texas.

If you've already submitted your responses to their online survey and followed the redemption instructions at the end of the questionnaire, the researchers wanted me to tell you that **your \$100 American Express Gift Card is on its way**. This gift card is a small token of the researcher's appreciation, and they have reserved a gift card for everyone who responds by the deadline.

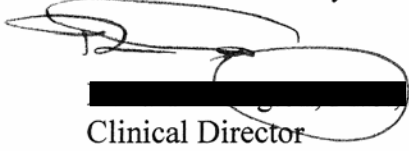
If you haven't gotten a chance to take the survey yet, please be aware that the deadline to do so is March 15, 2011.

Of the more than 2,500 people who've come to [REDACTED] over the past five years, **you are one of only about 60 people who meet the study criteria**—recovering professionals who have successfully completed residential treatment—and the University researchers would really appreciate your personal participation. The confidential survey is conducted online, so you can choose when and where to take it.

By participating, you could not only gain a new perspective of your own growth in recovery but also provide valuable information that could help other recovering professionals like you in the future. Feel free to email [REDACTED] or [REDACTED] for a personal response to any concerns or questions you may have before deciding whether or not to participate.

When you get about 20 minutes, you are invited to go to [www.\[REDACTED\].com](http://www.[REDACTED].com) and complete the questionnaire. When you do, please make sure you have the **survey password** and your **group code**, listed above.

With thanks and my best wishes for your continued health and wellness,


[REDACTED] LCDC
Clinical Director
[REDACTED]



Letterhead Obscured for Confidentiality

If you've already submitted your responses to the online survey of recovering professionals I've written you about, the researchers at the University of North Texas wanted me to extend their thanks and tell you to **be on the lookout for your \$100 American Express Gift Card.**

The University research team understands if you choose not to participate in their survey at this time, **and this is the last time that I will contact you about it.** However, you still have a few days before the deadline of March 15, 2011, to respond if you so choose.

Of the more than 2,500 people who've come to [REDACTED] over the past five years, **you are one of only about 60 people who meet the study criteria**—recovering professionals who have successfully completed residential treatment—and your personal involvement could really make a difference to other recovering professionals like you.

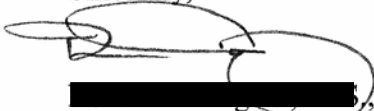
As a small token of their appreciation for your time, the UNT researchers have reserved a **\$100 American Express Gift Card for everyone** who follows the simple redemption instructions at the end of the online questionnaire before the deadline of March 15.

If you can, you are invited to go to [www.\[REDACTED\].com](http://www.[REDACTED].com) and complete the online survey. It should only take about 20 minutes. Make sure you have the **survey password** and your **group code** listed above.

Feel free to email [REDACTED] or [REDACTED] for a personal response to any concerns you may have, including the steps they will take to preserve your confidentiality if you participate.

Regardless of whether you take part in the UNT study or not, we at [REDACTED] wish you continued health in your journey of recovery and hope to see you at a future alumni event.

Sincerely,



[REDACTED], LCDC
Clinical Director
[REDACTED]

APPENDIX E
COMPLETE STUDY QUESTIONNAIRE

Items 13-37 and 69-93 originally appeared in Swiggart, W., Feurer, I. D., Samenow, C., Delmonico, D. L., & Spickard, W. A. (2008). Sexual Boundary Violation Index: A validation study. *Sexual Addiction & Compulsivity, 15*(2), 176-190. doi:10.1080/10720160802055939. © 2008 Taylor & Francis, reprinted by permission.

Items 38-49 and 94-105 originally appeared in Raymond, N. C., Lloyd, M. D., Miner, M. H., & Kim, S. W. (2007). Preliminary report on the development and validation of the Sexual Symptom Assessment Scale. *Sexual Addiction & Compulsivity, 14*, 119-129. doi:10.1080/10720160701310856. © 2007 Taylor & Francis, reprinted by permission.

Thank you for your time! This anonymous survey is being conducted by researchers at the University of North Texas, Denton, in cooperation with (facility name). You will be asked about some aspects of your professional life, any addictive or compulsive symptoms you may still experience, and any addiction treatment or recovery support you may have gotten since you left (name of facility).

Some items will ask about how you're doing today. Other items will ask you to recall how you were doing before you came to (facility name). We know your time is valuable, so we've reserved a \$100 American Express Gift Card for everyone who submits a completed survey by the deadline of March 15, 2011. Just follow the redemption instructions at the end of the questionnaire to claim your appreciation gift.

Please try to complete the survey in one sitting when you have 20-30 minutes to yourself. Your candor and "rigorous honesty" are greatly appreciated; however, you are not required to answer any item you may feel is too sensitive.

Please make a selection below:

- I have read, signed, and will return the enclosed Informed Consent Notice.
- I decline to participate at this time. Please destroy this questionnaire.

1) Please indicate the Group Code listed on the letter you received inviting you to participate in this survey.

- | | |
|--------------------------------|--------------------------------|
| <input type="checkbox"/> VB-05 | <input type="checkbox"/> 25-NB |
| <input type="checkbox"/> VB-06 | <input type="checkbox"/> 26-NB |
| <input type="checkbox"/> VB-07 | <input type="checkbox"/> 27-NB |
| <input type="checkbox"/> VB-08 | <input type="checkbox"/> 28-NB |
| <input type="checkbox"/> VB-09 | <input type="checkbox"/> 29-NB |

2) What is your gender?

- Male Female

3) Which of the following would you say best describes your ethnicity?

- | | |
|---|---|
| <input type="checkbox"/> Asian | <input type="checkbox"/> Native Hawaiian/Pacific Islander |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> White |
| <input type="checkbox"/> Hispanic or Latino/a | <input type="checkbox"/> Other (please specify:_____) |

4) Into which of the following categories does your current age fall?

- | | | | |
|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> 30-34 | <input type="checkbox"/> 45-49 | <input type="checkbox"/> 60-64 | <input type="checkbox"/> 75-79 |
| <input type="checkbox"/> 35-39 | <input type="checkbox"/> 50-54 | <input type="checkbox"/> 65-69 | |
| <input type="checkbox"/> 40-44 | <input type="checkbox"/> 55-59 | <input type="checkbox"/> 70-74 | |

- 5) Into which of the following categories does your individual, annual income fall?
- | | | |
|--|---|---|
| <input type="checkbox"/> \$0 - \$49,999 | <input type="checkbox"/> \$150,000 to \$199,999 | <input type="checkbox"/> \$350,000 to 399,999 |
| <input type="checkbox"/> \$50,000 to \$74,999 | <input type="checkbox"/> \$200,000 to 249,999 | <input type="checkbox"/> \$400,000 to \$449,999 |
| <input type="checkbox"/> \$75,000 to 99,999 | <input type="checkbox"/> \$250,000 - \$299,999 | <input type="checkbox"/> \$450,000 to \$499,999 |
| <input type="checkbox"/> \$100,000 - \$149,999 | <input type="checkbox"/> \$300,000 to \$349,999 | <input type="checkbox"/> \$500,000 or more |

6) How many days did you spend in residential treatment at (facility name)? _____ days.

7) For which of the following behavioral health issues did you receive treatment when you were most recently in residential care at (facility name)? Please select as many as may apply:

- Alcohol abuse or dependence
- Marijuana abuse or dependence
- Cocaine abuse or dependence
- Sexual Addiction/Compulsivity
- Compulsive Gambling
- Eating Disorder (e.g., anorexia or bulimia)
- Amphetamine abuse or dependence (e.g., Adderall, Ritalin, “speed,” “meth,” “crank”)
- Hallucinogen abuse or dependence (e.g., LSD, “mushrooms,” or peyote.)
- Opioid abuse or dependence (e.g., heroin, morphine, Vicodin, Lortab, Oxycontin, or Percocet.)
- Sedative/anxiolytic abuse or dependence (e.g., Xanax, Valium, Klonopin, “reds,” “roofies,” or “ludes.”)
- Compulsive use of non-sexually-oriented Web sites or computer/video games

8) What is the status of your employment as it stands today?

- | | |
|---|---|
| <input type="checkbox"/> Employed full time | <input type="checkbox"/> On extended leave from work |
| <input type="checkbox"/> Employed part-time | <input type="checkbox"/> Unemployed but hoping to work again |
| <input type="checkbox"/> Employed on a contract/as-needed basis | <input type="checkbox"/> Retired / I do not work outside the home |

9) Which of the following categories best describes the occupation you held at the time (or shortly before) you were admitted to residential care at (facility name)_?

- | | |
|--|--|
| <input type="checkbox"/> Physician or P.A. | <input type="checkbox"/> Veterinarian |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Pharmacist / pharmacy technician |
| <input type="checkbox"/> Counselor / psychotherapist | <input type="checkbox"/> Pastor / clergy-person, lay or ordained |
| <input type="checkbox"/> Attorney | <input type="checkbox"/> Educator / teacher |
| <input type="checkbox"/> Nurse / nurse’s aide | <input type="checkbox"/> Other (Please specify: _____) |

- 10) Are you currently employed in that general, professional field today?
- Yes
 - No (Please specify current occupation: _____)
- 11) What is the current status of your state-issued professional license as it stands today?
- Fully licensed to practice, no restrictions or conditions
 - Licensed, but with practice restrictions (e.g., no direct patient/client contact, limited clientele, chaperone, etc.)
 - Licensed, but under the mandatory supervision of another professional
 - Licensed, but with practice restrictions and under mandatory supervision
 - Suspended
 - Voluntarily surrendered
 - Revoked
 - My profession does not require a state-issued license.
- 12) During the past six months, have you had any interaction(s) of any kind with patients, clients, students, parishioners, or other such persons you may serve in the practice of your profession?
- Yes, I have interacted with such persons during the past six months.
 - No, I have not interacted with such persons during the past six months.
(skip to question #38)
 - No, I am no longer a practicing healthcare or other professional.
(skip to question #38)

Professionals interact with their patients or clients in different ways under different circumstances. For this portion of the survey, you'll be asked about your recent experience of the professional relationship. The following items were written for health care professionals. However, feel free to substitute words like patients with "clients", clinic with "office", and treatment procedures with "professional services" if these terms are more appropriate for you.

The items have been constructed so that your responses do not constitute an admission of misconduct or suggest professional impropriety of any kind. There is no way your identity can be linked to any of your responses.

Please consider the following items as you think about any thoughts, feelings, or behaviors you experienced IN THE PAST SIX MONTHS.

Please circle the response that best characterizes your behaviors:

N = Never *R* = Rarely *S* = Sometimes *O* = Often

13) I have told patients personal things about myself to impress them.	N	R	S	O
14) I have accepted social invitations from particular patients outside of scheduled clinic visits.	N	R	S	O
15) I have used language other than clinical language to discuss my patient's physical appearance or behaviors I may consider seductive.	N	R	S	O
16) I have found myself comparing the gratifying qualities I observe in a patient with the less gratifying qualities in my significant other.	N	R	S	O
17) I have thought that my patient's problem would be helped if he/she had a romantic involvement with me.	N	R	S	O
18) I have found myself trying to influence other employees in my workplace over whom I have supervisory influence to support political causes or positions in which I have personal interest.	N	R	S	O
19) I have felt a sense of excitement or longing when I think of a patient or anticipate his/her visit.	N	R	S	O
20) I have found myself talking about my personal life or problems with a patient and expected sympathy.	N	R	S	O
21) When a patient has acted in a manner I consider seductive, I have experienced this as a gratifying sign of my own sex appeal.	N	R	S	O
22) I have engaged in a personal relationship with a patient, either while I was treating him/her, or after treatment was terminated.	N	R	S	O

23) I think about what it would be like to be sexually involved with a patient.	N	R	S	O
24) I have initiated or engaged in a personal relationship with an employee that I supervise.	N	R	S	O
25) I take great pride in the fact that such an attractive, wealthy, powerful, or important patient is seeking my help.	N	R	S	O
26) I have found myself talking about my personal life or problems with patients.	N	R	S	O
27) I have resisted or refused consultation with appropriate professionals, when others have told me I have problems that cause difficulty in my work or personal relationships.	N	R	S	O
28) I have initiated or engaged in a personal relationship with a person over whom I have power, authority, or decision-making ability.	N	R	S	O
29) I have asked one or more patients to do personal favors for me.	N	R	S	O
30) I have found myself trying to influence my patients to support causes, business deals, or positions in which I have personal interest.	N	R	S	O
31) I have initiated business deals with my patients.	N	R	S	O
32) I have solicited gifts, bequests, or favors from patients for personal benefit or to benefit a business with which I am or plan to be involved.	N	R	S	O
33) I have recommended treatment procedures or referrals that I did not believe to be necessarily in my patient's best interests.	N	R	S	O

- | | | | | |
|---|---|---|---|---|
| 34) I have found myself fantasizing or daydreaming about a patient. | N | R | S | O |
| 35) I have made exceptions for patients, e.g., scheduling, benefits, and/or fees, because I found the patient attractive, appealing, or impressive. | N | R | S | O |
| 36) I have made exceptions for patients because I was afraid he/she will otherwise become extremely angry or self-destructive. | N | R | S | O |
| 37) I have sought social contact with patients outside of scheduled clinic visits. | N | R | S | O |
-

You were selected to participate in this survey in part because you satisfactorily completed residential sex addiction treatment while at (facility name).

In the following items, you'll be asked to rate your recent experience of any sexual thoughts, feelings, or behaviors you consider to be problematic, addictive, or compulsive.

The items have been constructed so that your responses do not constitute an admission of misconduct or suggest professional impropriety of any kind. There is no way your personal identity can be linked to any of your responses.

Some items concern problematic sexual urges, others refer to problematic thoughts, and others address problematic behaviors. Please read the questions carefully before you answer.

- 38) If you had urges to engage in problematic sexual behaviors during the past WEEK, on average, how strong were your urges? Please circle the most appropriate number:

None	Mild	Moderate	Severe	Extreme
0	1	2	3	4

- 39) During the past WEEK, how many times did you experience urges to engage in problematic sexual behaviors? Please circle the most appropriate number.

None	Once	Two-to-three times	Several-to-many times	Constant or near constant
0	1	2	3	4

- 40) During the past WEEK, how many hours (add up total hours) were you preoccupied with your urges to engage in problematic sexual behaviors? Please circle the most appropriate number.

None	1 hr or less	1 to 7 hrs	7 to 21 hrs	Over 21 hrs
0	1	2	3	4

41) During the past WEEK, how much were you able to control your urges? Please circle the most appropriate number.

Complete	Much	Moderate	Minimal	No Control
0	1	2	3	4

42) During the past WEEK, how often did thoughts about engaging in problematic sexual behaviors come up? Please circle the most appropriate number.

None	Once	Two-to-three times	Several-to-many times	Constant or near constant
0	1	2	3	4

43) During the past WEEK, approximately how many hours (add up hours) did you spend thinking about engaging in problematic sexual behaviors? Please circle the most appropriate number.

None	1 hr or less	1 to 7 hrs	7 to 21 hrs	Over 21 hrs
0	1	2	3	4

44) During the past WEEK, how much were you able to control your thoughts of problematic sexual behaviors? Please circle the most appropriate number.

Complete	Much	Moderate	Minimal	No Control
0	1	2	3	4

45) During the past WEEK, approximately how much total time did you spend engaging in problematic sexual behaviors? Please circle the most appropriate number.

None	1 hr or less	1 to 7 hrs	7 to 21 hrs	Over 21 hrs
0	1	2	3	4

46) During the past WEEK, on average, how much anticipatory tension and/or excitement did you have shortly before you engaged in problematic sexual behaviors? If you did not actually engage in such behaviors, please estimate how much tension and/or excitement you believe you would have experienced if you had engaged in problematic sexual behaviors. Please circle the most appropriate number.

None	Mild	Moderate	Severe	Extreme
0	1	2	3	4

47) During the past WEEK, on average, how much excitement and pleasure did you feel when you engaged in problematic sexual behaviors? If you did not actually engage in such behaviors, please estimate how much excitement and pleasure you would have experienced if you had. Please circle the most appropriate number.

None	Minimal	Moderate	Much	Extreme
0	1	2	3	4

48) During the past WEEK, how much emotional distress (mental pain or anguish, shame, guilt, or embarrassment) has your problematic sexual behavior caused you? Please circle the most appropriate number.

None	Mild	Moderate	Severe	Extreme
0	1	2	3	4

49) During the past WEEK, how much personal trouble (relationship, financial, legal, job, medical, or health) has your problematic sexual behavior caused you? Please circle the most appropriate number.

None	Mild	Moderate	Severe	Extreme
0	1	2	3	4

After leaving residential treatment, some professionals seek additional mental health treatment, medication, counseling, or psychotherapy and others do not. For this portion of the survey, we'd like to know about any such care you may have received since your most recent discharge from residential care at (facility name). For now, do not consider addiction recovery support groups like Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or Sex Addicts Anonymous (SAA). You will be asked about them later in the survey.

50) Since you most recently discharged from residential care at (facility name), have you taken prescribed medication for anxiety, depression, a bipolar disorder, or some other mental health condition?

- Yes
- No (skip to question #52)
- I was prescribed but did not actually take such medication (skip to question #52)

51) Please give us your best estimate of the approximate total number of days you have taken mental health medication(s) since your most recent discharge from (facility name). If you took several medications, add up all days of all meds as best you can. For example, if you took Medication A daily for 30 days then later took medication B daily for 45 days while taking medication C daily for 15 of those days, you would say that you took mental health medication for a total of 90 days (30 days MedA + 45 days MedB + 15 days MedC).

Remember, your best estimate is fine. Individuals who take a number of daily medications for 3 months or more typically report several hundred days of use.

51) Total days of medication use since leaving (facility name): _____

52) Since your most recent discharge from residential care at (facility name)_, have you been admitted to any additional courses of residential or "in-patient" addiction or mental health treatment?

- Yes
- No (skip to question #54)

- 53) Please give us your best estimate of the total number of all days you spent in an additional course(s) of residential or “in-patient” addiction or mental health treatment since your most recent discharge from (facility name).

Total days of additional “in-patient” treatment since leaving (facility name): _____ days.

- 54) Since your most recent discharge from residential care at (facility name), have you received any “out-patient” or community-based addiction or mental health treatment (not including AA, NA, SAA, etc.)?

Yes

No (skip to question #56)

- 55) Please give us your best estimate of the total number of all days you received “out-patient” or community-based addiction or mental health treatment (not including AA, NA, SAA, etc.) since your most recent discharge from (facility name). For example, if you attended an out-patient program 3 days per week for 8 weeks, you'd say you received 24 days of out-patient treatment.

Total days of out-patient treatment since leaving (facility name): _____ days.

- 56) Since your most recent discharge from residential care at (facility name), have you spent any time at a Transitional Living Facility or “Halfway-House”?

Yes

No (skip to question #58)

- 57) Please give us your best estimate of the total number of all days you spent in a Transitional Living Facility or a “Halfway-House” since your most recent discharge from (facility name):

Total days of Transitional Living since leaving (facility name): _____ days.

Some recovering professionals get counseling or psychotherapy after leaving residential treatment and others do not. Such counseling could include personal-growth counseling, addiction/recovery counseling (not including AA, NA, SAA, etc.), marriage or couple counseling, family therapy, or some other kind of counseling or psychotherapy.

As you consider the following items, please do not include any counseling you may have received during some other course of residential or out-patient treatment.

-
- 58) Since your most recent discharge from residential care at (facility name), have you participated in any kind of individual or group counseling or psychotherapy (not including sessions attended while in residential or outpatient treatment)?

Yes

No (skip to question #60)

- 59) Please give us your best estimate of the total number of all sessions of counseling or psychotherapy you received (not including any you got while in residential or out-patient treatment) since your most recent discharge from (facility name): _____ sessions.
- 60) Since your most recent discharge from residential care at (facility name), have you attended any kind of recovery-oriented support group(s)? Some groups like these are based on The Twelve Steps of Alcoholics Anonymous and others are not.
- Yes
- No (skip to question #63)
- 61) Please tell us which recovery-oriented support group(s) you have attended since your most recent discharge from residential care at _____.

Please check as many as may apply:

- Alcoholics Anonymous (AA) Narcotics Anonymous (NA)
- Sexaholics Anonymous (SA) Sex Addicts Anonymous (SAA)
- Sexual Compulsives Anon. (SCA) Sex & Love Addicts Anon. (SLAA)
- Gambler's Anonymous (GA) Eating Disorders Anonymous (EDA)
- Anorexics & Bulimics Anon. (ABA) Some other 12-Step-based support group.
- A Support group not based on the "Twelve Steps" of AA.
- 62) Please give us your best estimate of the total number of recovery-oriented support group meetings (add up all meetings of all groups) you attended since your most recent discharge from(facility name).

Total meetings of support group meetings since leaving (facility name): _____ meetings.

- 63) Have you received any continuing education specifically addressing the nature and maintenance of professional boundaries? For this item, you may include any such training you received while you were most recently in residential care at (facility name) or at any time thereafter, regardless of location.
- Yes, I received boundary training either at or since leaving (facility name).
- No, I have not had boundary training at or since leaving (facility name) (skip to question #65)

- 64) Please give us your best estimate of the total number of hours of professional boundary training you received since your most recent discharge from (facility name).

Total hours of boundary training at or since leaving (facility name): _____ hours

Many professionals are referred to (facility name)by their licensing boards because they were accused of some form of professional misconduct or impropriety. In the following item, you will

be asked about any such complaints that may have been lodged against you since you most recently left residential care at (facility name).

As you respond, please consider only those complaints that refer to actions or behaviors alleged to have occurred after you most recently left residential care at (facility name), regardless of whether the complaints themselves were justified, have been investigated, adjudicated, or warranted disciplinary action.

Responding to this item does not constitute an admission of misconduct of any kind, and there is no way your personal identity can be linked to your response.

65) How many NEW licensing board complaints have been filed against you since you most recently discharged from residential care at (facility name)?

- 0 NEW misconduct complaints.
- 1 NEW misconduct complaints.
- 2 NEW misconduct complaints.
- 3 NEW misconduct complaints.
- 4 NEW misconduct complaints.
- 5 NEW misconduct complaints.
- 6 NEW misconduct complaints.
- 7 or more NEW misconduct complaints.

Congratulations--you are now more than 3/4 of the way through the survey! When you're done, you'll learn how to claim your \$100 American Express appreciation gift.

In the final portions of the survey, you will be asked some of the same questions as before. However, this time we would like you to respond in the context of how you were doing in the six months or so before other, significant people in your life became aware of your compulsive sexual behavior, to the best of your recollection.

Try as best you can to clear your mind of the responses you just gave and recall yourself as you were in the six months or so before other, significant people in your life became aware of your compulsive sexual behavior, as best you can.

- 66) What was the status of your employment during the six months or so before other, significant people in your life became aware of your compulsive sexual behavior? At that time, were you:
- Employed full time
 - Employed part-time
 - Employed on a contract/as-needed basis
 - On extended leave from work
 - Unemployed but hoping to work again
 - Retired / I did not work outside the home.
- 67) What was the status of your state-issued professional license at that time?
- Fully licensed to practice, no restrictions or conditions
 - Licensed, but with restrictions (e.g., no direct patient/client contact, limited clientele, chaperone, etc.)
 - Licensed, but under the mandatory supervision of another professional
 - Licensed, but with practice restrictions and under mandatory supervision
 - Suspended
 - Voluntarily surrendered
 - Revoked
 - My profession did not require a state-issued license at that time.
- 68) In the six months or so before other, significant people in your life became aware of your compulsive sexual behavior, did you have any interaction(s) of any kind with patients, clients, students, parishioners, or other such persons you may have served in the practice of your profession?
- Yes, I interacted with such persons during those six months
 - No, I did not interact with such persons during those six months. (skip to #94)
 - No, I was not a practicing professional during those six months. (skip to #94)

Now, we would like to know how you may have experienced the professional relationship in the six months or so before other, significant people in your life became aware of your compulsive sexual behavior, to the best of your recollection.

The following items include terms commonly used by health professionals; however, please feel free to replace words like patient or clinic with “client,” “office,” or other terms more appropriate to your professions.

As before, your responses do not constitute an admission of misconduct and your personal identity cannot be linked to any of your responses.

Some of the following items are written in the present tense, but remember, you’re responding as you recall yourself as you were in the six months or so before other, significant people in your life became aware of your compulsive sexual behavior.

We understand some questions may be difficult to answer precisely. Simply do the best you can. Please circle the response that best characterizes your behaviors in the six months or so before other, significant people in your life became aware of your compulsive sexual behavior:

	N = Never	R = Rarely	S = Sometimes	O = Often
69) I told patients personal things about myself to impress them.	N	R	S	O
70) I accepted social invitations from particular patients outside of scheduled clinic visits.	N	R	S	O
71) I used language other than clinical language to discuss my patient's physical appearance or behaviors I may consider seductive.	N	R	S	O
72) I found myself comparing the gratifying qualities I observe in a patient with the less gratifying qualities in my significant other.	N	R	S	O
73) I thought that my patient's problem would be helped if he/she had a romantic involvement with me.	N	R	S	O
74) I found myself trying to influence other employees in my workplace over whom I had supervisory influence, to support political causes or positions in which I had personal interest.	N	R	S	O
75) I felt a sense of excitement or longing when I thought of a patient or anticipated his/her visit.	N	R	S	O
76) I found myself talking about my personal life or problems with a patient and expected sympathy.	N	R	S	O
77) When a patient acted in a manner I considered seductive, I experienced this as a gratifying sign of my own sex appeal.	N	R	S	O

78) I engaged in a personal relationship with a patient, either while I was treating him/her, or after treatment was terminated.	N	R	S	O
79) I thought about what it would be like to be sexually involved with a patient.	N	R	S	O
80) I initiated or engaged in a personal relationship with an employee that I supervise.	N	R	S	O
81) I took great pride in the fact that such an attractive, wealthy, powerful, or important patient was seeking my help.	N	R	S	O
82) I found myself talking about my personal life or problems with patients.	N	R	S	O
83) I resisted or refused consultation with appropriate professionals when others told me I had problems that caused difficulty in my work or personal relationships.	N	R	S	O
84) I initiated or engaged in a personal relationship with a person over whom I had power, authority, or decision-making ability.	N	R	S	O
85) I asked one or more patients to do personal favors for me.	N	R	S	O
86) I found myself trying to influence my patients to support causes, business deals, or positions in which I had personal interest.	N	R	S	O
87) I initiated business deals with my patients.	N	R	S	O
88) I solicited gifts, bequests, or favors from patients for personal benefit or to benefit a business with which I was or planned to be involved.	N	R	S	O

- | | | | | |
|--|---|---|---|---|
| 89) I recommended treatment procedures or referrals that I did not believe to be necessarily in my patient's best interests. | N | R | S | O |
| 90) I found myself fantasizing or daydreaming about a patient. | N | R | S | O |
| 91) I made exceptions for patients, e.g., scheduling, benefits, and/or fees, because I found the patient attractive, appealing, or impressive. | N | R | S | O |
| 92) I made exceptions for patients because I was afraid he/she will otherwise become extremely angry or self-destructive. | N | R | S | O |
| 93) I sought social contact with patients outside of scheduled clinic visits. | N | R | S | O |

Now, we'd like you to rate any problematic sexual thoughts, feelings, or behaviors you may have experienced in the six months or so before other, significant people in your life became aware of your compulsive sexual behavior, to the best of your recollection.

As you think back, rate any such experiences that you now consider to have been problematic, addictive, or compulsive, regardless of how you may have thought about them at the time.

As before, your responses do not constitute an admission of misconduct and there is no way to link your personal identity to any of your responses.

Although the items refer to your experiences "during the past WEEK," remember, you are responding as you think about your experiences DURING A TYPICAL WEEK in the six months or so before other, significant people in your life became aware of your compulsive sexual behavior, as best as you can recall.

We understand some questions may be difficult to answer precisely. Simply do the best you can.

Please read the questions carefully before you answer.

94) If you had urges to engage in problematic sexual behaviors during the past WEEK, on average, how strong were your urges? Please circle the most appropriate number:

None	Mild	Moderate	Severe	Extreme
0	1	2	3	4

95) During the past WEEK, how many times did you experience urges to engage in problematic sexual behaviors? Please circle the most appropriate number.

None	Once	Two-to-three times	Several-to-many times	Constant or near constant
0	1	2	3	4

96) During the past WEEK, how many hours (add up total hours) were you preoccupied with your urges to engage in problematic sexual behaviors? Please circle the most appropriate number.

None	1 hr or less	1 to 7 hrs	7 to 21 hrs	Over 21 hrs
0	1	2	3	4

97) During the past WEEK, how much were you able to control your urges? Please circle the most appropriate number.

Complete	Much	Moderate	Minimal	No Control
0	1	2	3	4

98) During the past WEEK, how often did thoughts about engaging in problematic sexual behaviors come up? Please circle the most appropriate number.

None	Once	Two-to-three times	Several-to-many times	Constant or near constant
0	1	2	3	4

99) During the past WEEK, approximately how many hours (add up hours) did you spend thinking about engaging in problematic sexual behaviors? Please circle the most appropriate number.

None	1 hr or less	1 to 7 hrs	7 to 21 hrs	Over 21 hrs
0	1	2	3	4

100) During the past WEEK, how much were you able to control your thoughts of problematic sexual behaviors? Please circle the most appropriate number.

Complete	Much	Moderate	Minimal	No Control
0	1	2	3	4

101) During the past WEEK, approximately how much total time did you spend engaging in problematic sexual behaviors? Please circle the most appropriate number.

None	1 hr or less	1 to 7 hrs	7 to 21 hrs	Over 21 hrs
0	1	2	3	4

102) During the past WEEK, on average, how much anticipatory tension and/or excitement did you have shortly before you engaged in problematic sexual behaviors? If you did not actually engage in such behaviors, please estimate how much tension and/or excitement you believe you would have experienced if you had engaged in problematic sexual behaviors. Please circle the most appropriate number.

None	Mild	Moderate	Severe	Extreme
0	1	2	3	4

103) During the past WEEK, on average, how much excitement and pleasure did you feel when you engaged in problematic sexual behaviors? If you did not actually engage in such behaviors, please estimate how much excitement and pleasure you would have experienced if you had. Please circle the most appropriate number.

None	Mild	Moderate	Severe	Extreme
0	1	2	3	4

104) During the past WEEK, how much emotional distress (mental pain or anguish, shame, guilt, or embarrassment) has your problematic sexual behavior caused you? Please circle the most appropriate number.

None	Mild	Moderate	Severe	Extreme
0	1	2	3	4

105) During the past WEEK, how much personal trouble (relationship, financial, legal, job, medical, or health) has your problematic sexual behavior caused you? Please circle the most appropriate number.

None	Mild	Moderate	Severe	Extreme
0	1	2	3	4

These are the last two questions!

Many factors contribute to how an individual defines the status of an occupation. Some of these varying factors include: (a) the type of work performed, (b) amount of pay, (c) opportunities for promotion, (d) quality of bosses and coworkers, (e) overall working conditions, and (f) amount of workplace autonomy and personal freedom.

106) All of these factors considered, how similar is the status of your current job compared to the job you may have had in the six months or so before other, significant people in your life became aware of your compulsive sexual behavior?

-5	-4	-3	-2	-1	0	1	2	3	4	5
My job status is much lower now than it was then.			My job status is the same now as it was then.				My job status is much higher now than it was then.			

CANNOT SAY. I either did not work then or I do not work now.

107) Again, all factors considered—type of work, level of pay, opportunity for promotion, quality of bosses and coworkers, working conditions, and personal freedom—how similar is the amount of satisfaction you get from your current job compared to the job you may have had in the six months or so before other, significant people in your life became aware of your compulsive sexual behavior?

-5 -4 -3 -2 -1 0 1 2 3 4 5

My job satisfaction is much lower now than it was then.

My job satisfaction is the same now as it was then.

My job satisfaction is much higher now than it was then.

CANNOT SAY. I either did not work then or I do not work now.

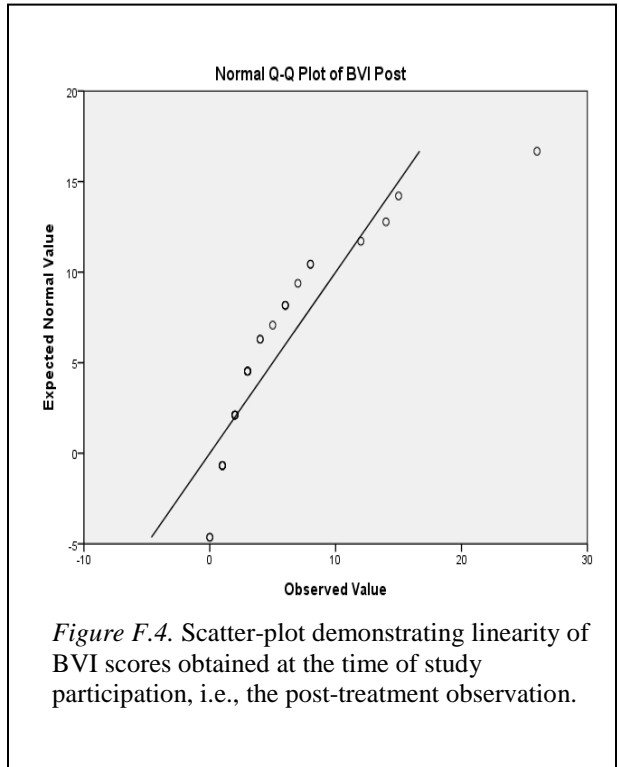
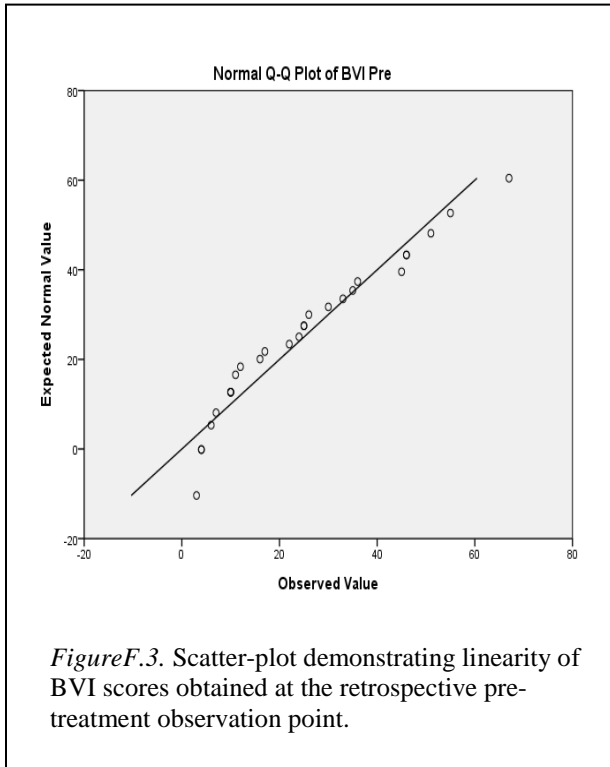
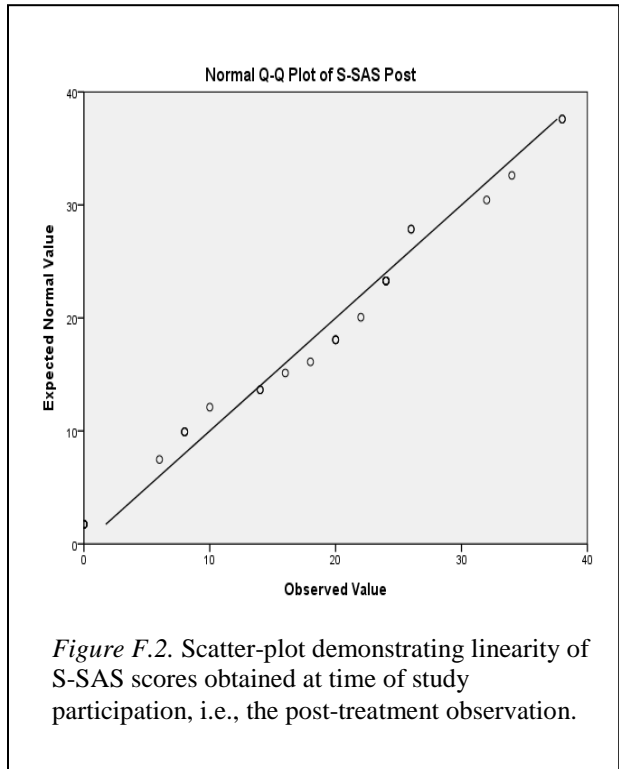
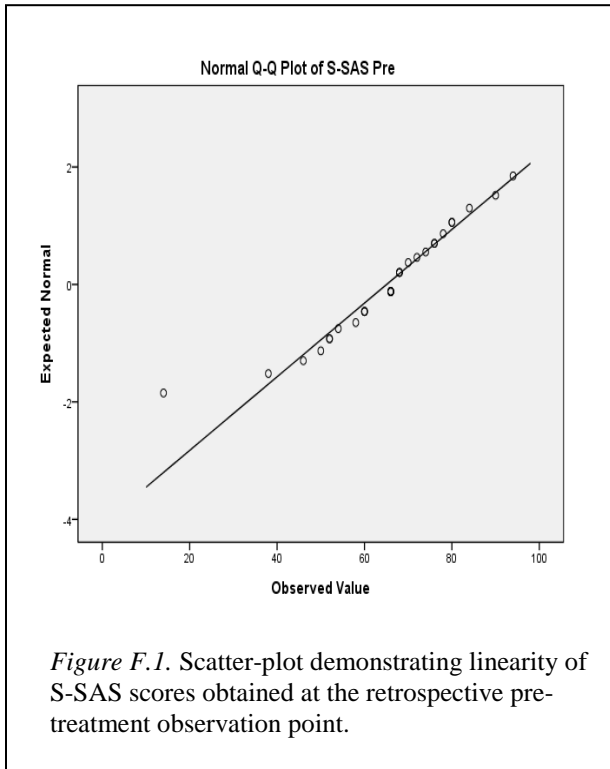
That completes the survey! Thank you for your time and your candor.

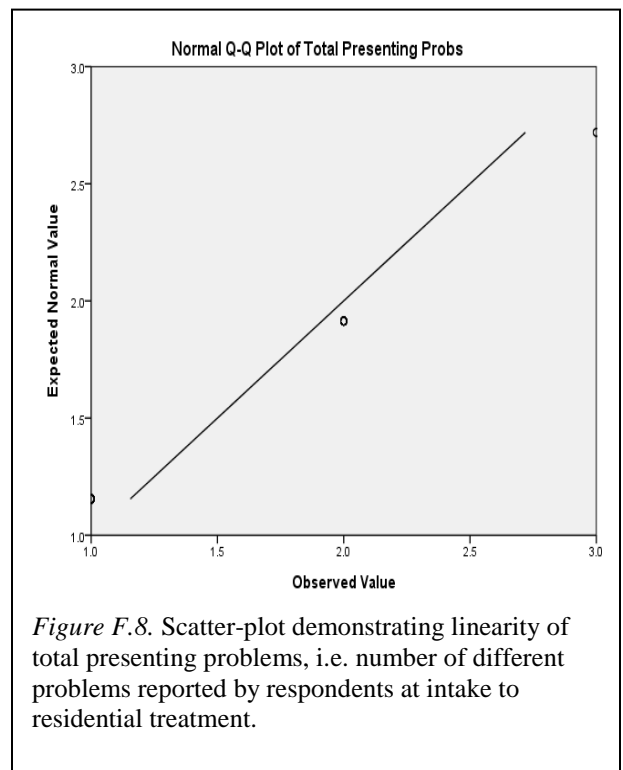
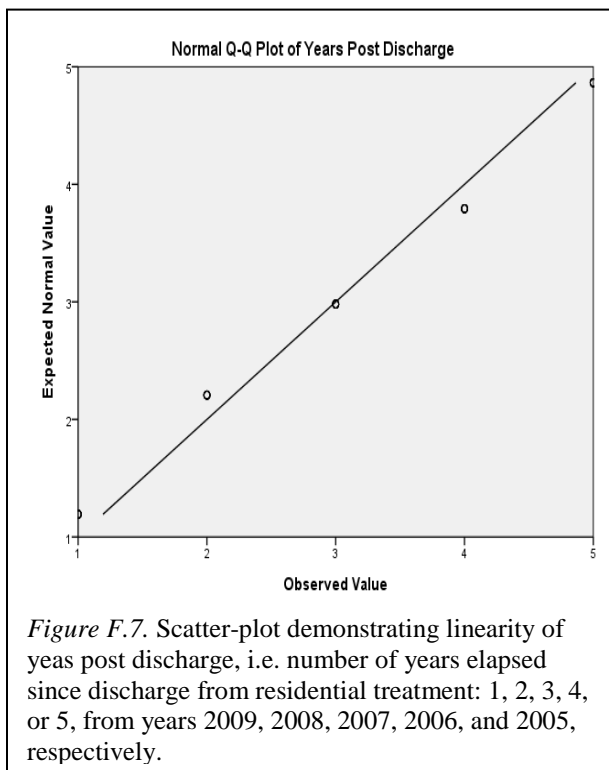
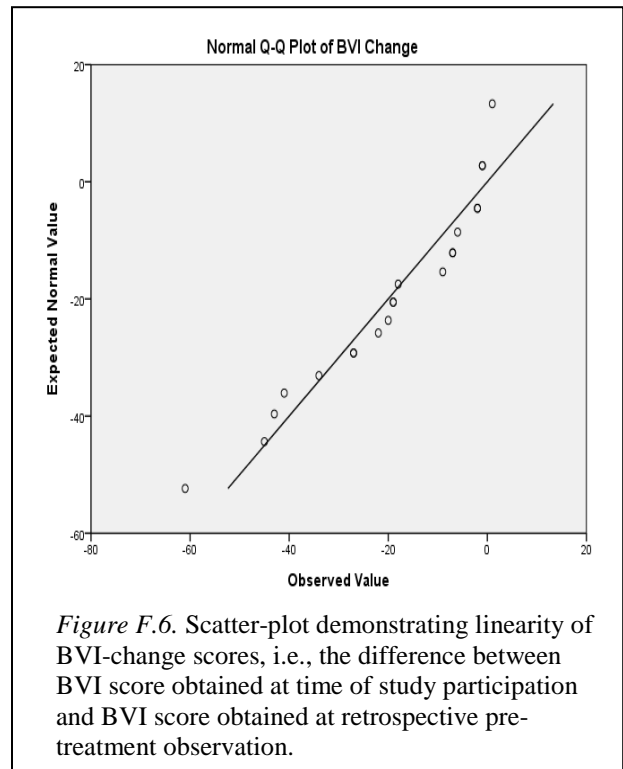
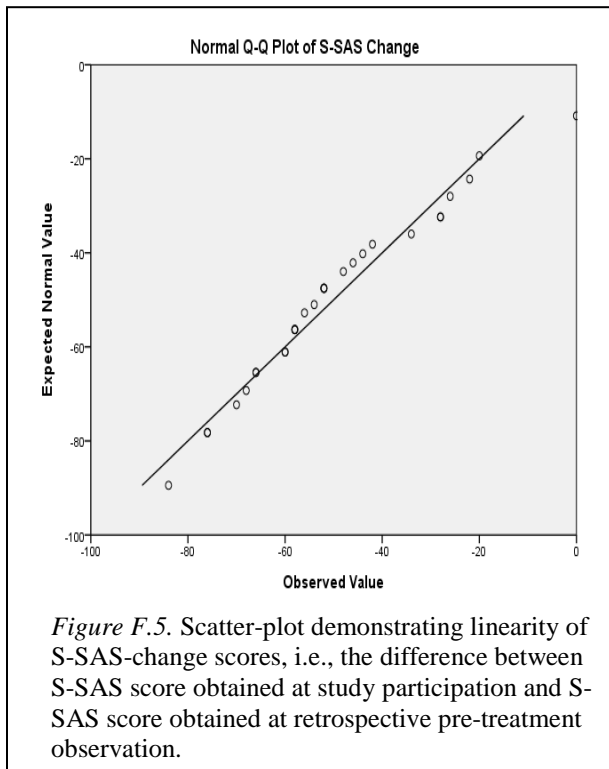
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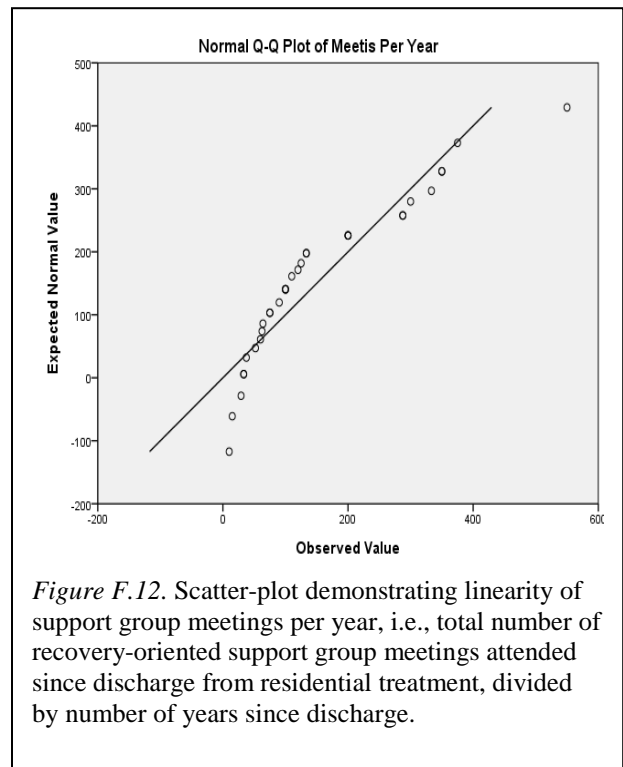
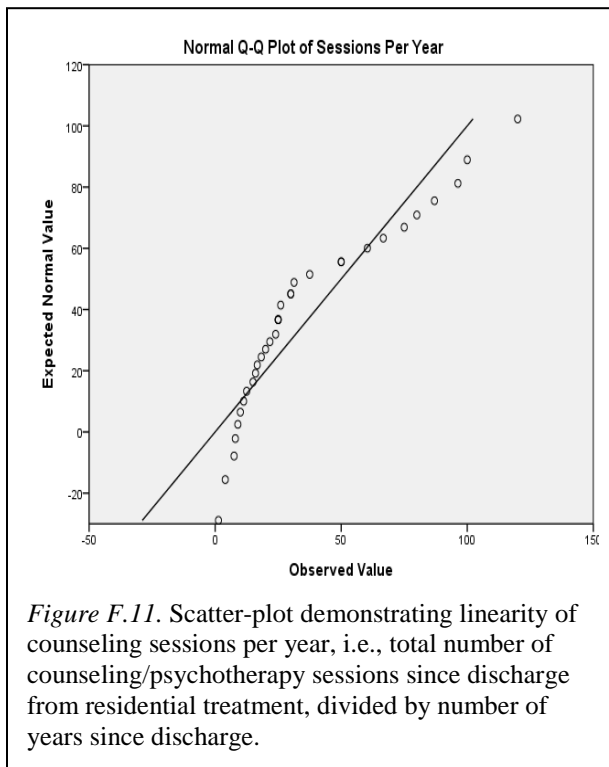
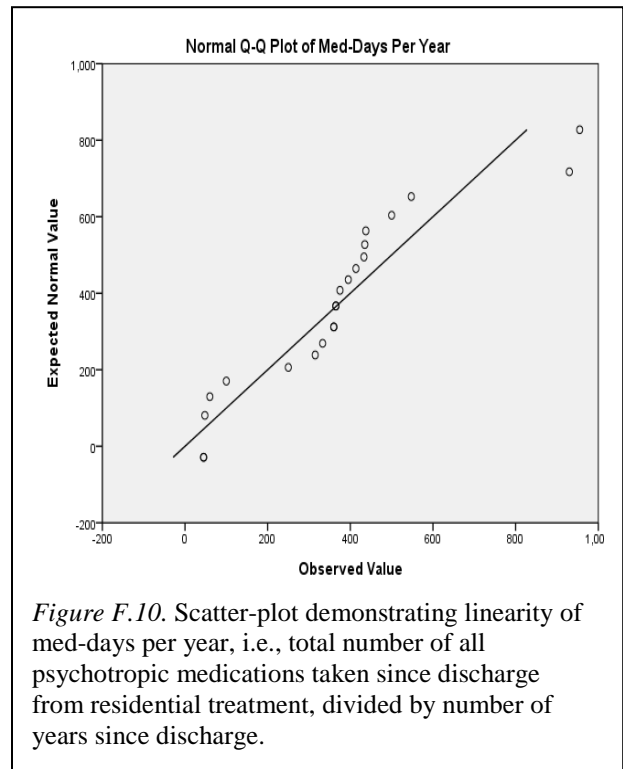
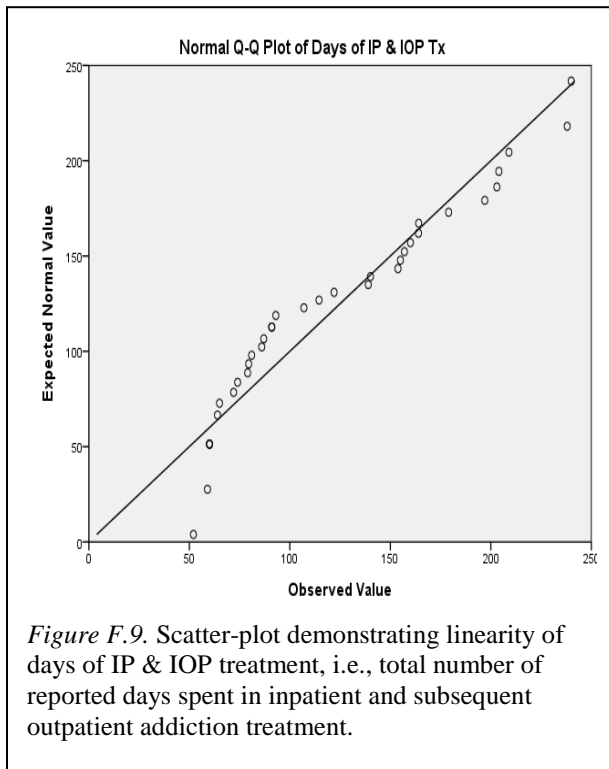
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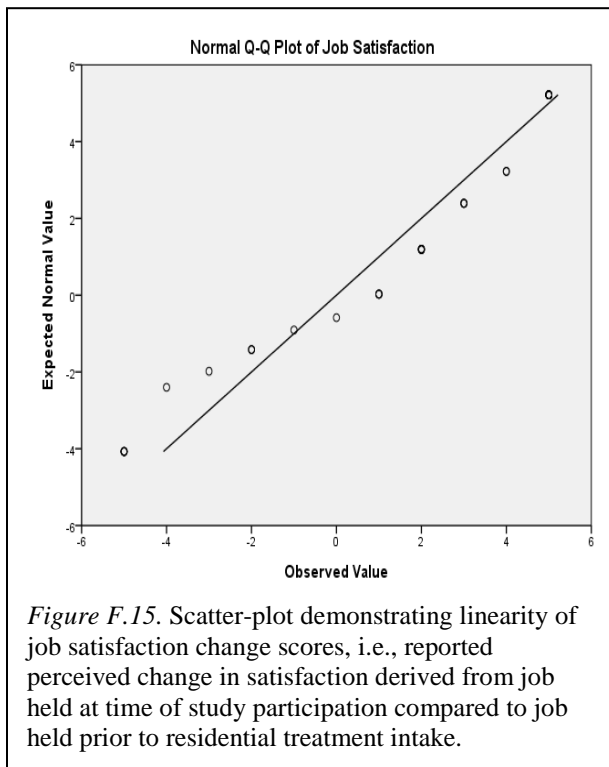
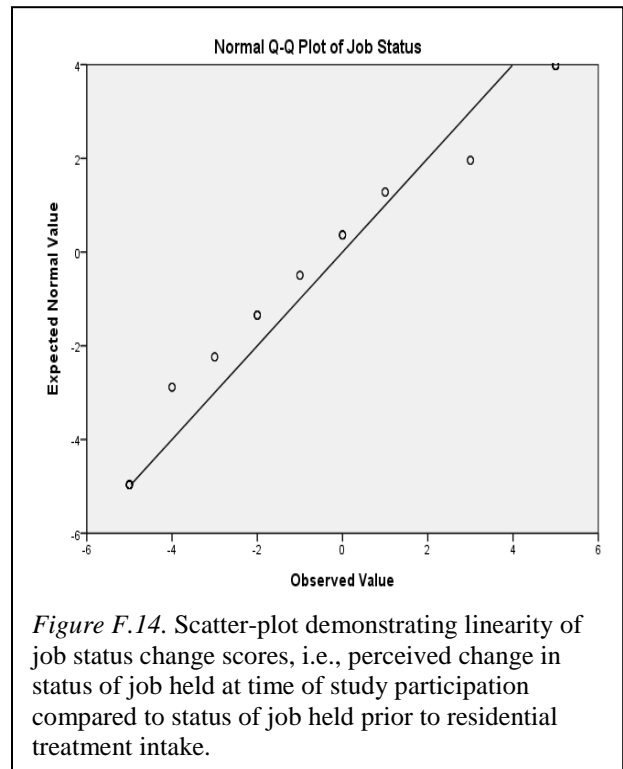
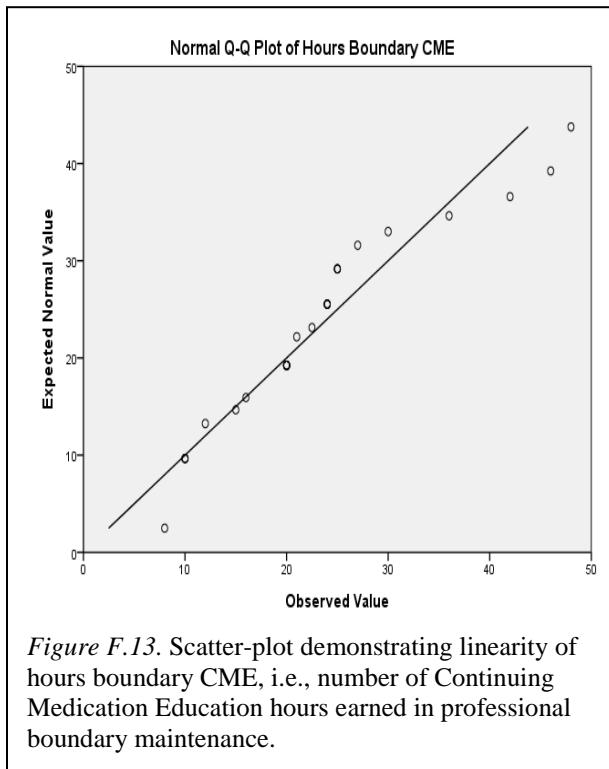
Thank you again, and we wish you serenity in your continued recovery!

APPENDIX F
GRAPHS DEMONSTRATING DATA LINEARITY









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