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Managing Romantic and Sexual Feelings Towards Clients in the Psychotherapy Room in Flanders (Belgium)

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Abstract

It is important that therapists manage adequately their romantic and sexual feelings toward clients as it can negatively affect the psychotherapeutic relationship and may even pose a risk of sexual abuse. This study explores how psychotherapists in Flanders (Belgium) manage such feelings, by conducting both a survey (using 105 of 786 respondents for analyses, as they reported romantic feelings) and focus groups (with a total of 36 participants). Results show that most therapists never consider starting a romantic relationship with a client. They reflect profoundly on their feelings, dwell on possible consequences, while maintaining strict boundaries. Although therapists themselves highly recommend referring the client to a colleague if feelings become too intense, this rarely happens in practice. Most therapists consider talking about their romantic and sexual feelings towards clients as something very important, but only a third have disclosed their feelings in supervision, peer-supervision, or in personal therapy. Therapists indicate there is still hesitance about this due to fear of condemnation.

Keywords

psychotherapy, managing feelings, romance, mixed method

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Introduction

Romantic and sexual feelings towards a client cannot be kept out of the psychotherapy room. At one point or another in their career, most therapists (60–90%) will experience such feelings towards a client (Garrett & Davis, 1998; Pope et al., 1986; Rodolfa et al., 1994). Nevertheless, it is not always easy for therapists to find an appropriate way to manage such feelings, to prevent them from negatively affecting the psychotherapeutic relationship. In some cases, mismanagement can even lead to sexual abuse of clients. Empirical studies, based on self-reports, showed that sexual relationships between therapists and clients ranged from 1 to 7%, with male therapists generally reporting this more often than female therapists (Borys & Pope, 1989; Garrett & Davis, 1998; Pope et al., 1986; Rodolfa et al., 1994; Stake & Oliver, 1991). Although emotional distress and being professionally isolated might be contributing factors for therapists to engage in sexual relationships, they cannot be interpreted as predictive (Barnett, 2014; Celenza, 1998, 2007; Smith & Fitzpatrick, 1995).

Ethical guidelines of all large professional psychotherapy associations indicate that sexual relationships with clients are not allowed. These guidelines apply to current clients of therapists, although relationships with former clients are also strongly discouraged, or at least a two-year waiting period after termination is recommended (American Psychiatric Association, 2013; American Psychological Association, 2016; European Association of Psychotherapy, 2018; European Federation of Psychologists' Association, 2015). These sexual relationships might be considered professional misconduct and can result in professional discipline and civil litigation, and in some jurisdictions even criminal charges when questions about consent are raised. These measures have been developed due to the consensus that such sexual relationship often has harmful implications for the client. It might lead to symptoms, such as guilt, feelings of emptiness and isolation, impaired ability to trust, emotional lability, sexual confusion, increased suicidal risk, etc. (Pope, 1988). Based on therapists' reports who treated clients that engaged in a sexual relationship with their previous therapist, about 75–90% of clients suffered harm, 1.8–11% of clients were hospitalized afterwards, 1–14% tried to commit suicide, and 0.3–1% committed suicide. This also applies to clients who only began a sexual relationship after the therapeutic relationship had ended (Aviv et al., 2006; Bouhoutsos et al., 1983; Pope & Vetter, 1991).

Due to these highly negative implications for the client, it is important for therapists to appropriately manage their feelings for clients. Understandably, clear guidelines for how to actually manage these romantic and sexual feelings appropriately do not exist. Each situation is unique and might require a different approach. Contextual factors, such as therapists' own experiences both in personal life and as a professional, specific characteristics of the client, etc. can differ substantially (Barnett, 2014, 2017). Often managing therapists' sexual feelings to clients are described in terms of managing countertransference (Arcuri & McIlwain, 2014). From this countertransference-perspective, it is stated that there are certain qualities of therapists that seems to facilitate this management, such as self-insight, empathy, self-integration (i.e., healthy

character structure), anxiety management (i.e., ability to understand and control anxiety) and the conceptualizing ability (i.e., ability to draw on theory and understand client's role in the therapeutic relationship) (Hayes, 2014; Hayes et al., 2018). Besides the characteristics of therapists, also certain strategies and behaviors help to manage (countertransference) reactions on romantic and sexual feelings, such as acknowledging these feelings, reflecting thoroughly on such feelings, seek guidance from senior colleagues or supervisors to assist the reflective process, being vigilant during sessions, and setting explicit boundaries with clients (Barnett, 2017; Fisher, 2004; Gelso et al., 2014; Hayes et al., 2015). However, it might also occur that therapists react with greater distance and coolness in the therapeutic relationship than is needed by the client (Gelso et al., 2014). They might apply strict boundaries (e.g., not touching the shoulder of a grieving client) which are not aligned to the clients' needs, while a certain amount of flexibility would be more beneficial (Barnett, 2014).

Literature on this topic often remains within theoretical paradigms and are rarely studied from a more pragmatist paradigm (Creswell & Plano-Clarck, 2006). Some of these latter studies also looked at managing sexual feelings (e.g., therapists' reflection on their feelings and seeking guidance from others), but these are often outdated (Blanchard & Lichtenberg, 1998; Ladany et al., 1997; Nickell et al., 1995; Paxton et al., 2001; Rodolfa et al., 1994). More recent studies on the management of sexual feelings only investigated how therapists would hypothetically manage these feelings (Arcuri & McIlwain, 2014; Sonne & Jochai, 2014; Williams et al., 2016). Consequently, the extent to which therapists nowadays actually manage such romantic and sexual feelings in their own practice (e.g., follow recommendations) and their perceptions about them are largely unknown. Our study therefore explores therapists' perceptions and use of management strategies for their romantic and sexual feelings towards clients, in Flanders (Dutch-speaking Northern part of Belgium). Research into the topic might be helpful and give direction to some guidance and educational programs for therapists, ultimately to prevent professional misconduct. This is useful, not only for Flanders but worldwide as romantic and sexual feelings are universal feelings in therapy, seldomly studied from a more real-world practice-oriented stance.

Method

From November 2016 to May 2019, a cross-sectional survey and a focus group study were conducted among psychotherapists, in practice or in their last year of training, in Flanders. In this convergent mixed method study, we collected different but complementary data on the same topic (Creswell & Plano-Clarck, 2006). The survey-study is limited in providing nuances in, for example differences between more momentary or more ongoing romantic or sexual feelings of the therapist, and their developmental process. However, in the focus groups there is more room for the complexity of this topic and these nuances. Likewise, the focus group study is limited to determine the magnitude in which management strategies occur, but this is overcome by the survey-study.

Survey Study

Population. In total 786 therapists completed and returned the questionnaire (response rate 39.8%), of whom 69% were female ($n = 541$) and 43.6% were in the age group of 20–39 years ($n = 342$). Of these 786 therapists, 105 reported having fantasized in the past about having a romantic relationship with (one of their) clients and these were used for further analyses.

Therapists were members of large, accredited psychotherapy associations in Flanders: Flemish Association for Person-Centered Psychotherapy ($N = 288$); Flemish Association for Behavioral Therapy ($N = 568$); Flemish Association for Psychoanalytic Psychotherapy ($N = 205$); and Flemish psychiatrists registered with the National Institute for Health and Disability Insurance (NIHDI) ($N = 910$).

Data Collection. The questionnaire was distributed through the participating accredited associations. Therapists received the questionnaire in an email or using a link in a digital newsletter, and twice by regular post with a return freepost addressed envelope to the researchers. An accompanying letter from the researchers provided detailed information about the study (see ethics) and emphasized that the questionnaire should only be filled in once, even if it was received multiple times. To increase the response rate, a letter of recommendation to participate in the study was also added by key figures in the psychotherapeutic field in our country. Due to the anonymity procedure, it was not possible to investigate non-response.

Questionnaire and Analysis. In the questionnaire, if therapists indicated that they had fantasized about a romantic relationship with a client, they were asked to think about the last adult client about whom they fantasized (or were fantasizing). Fantasizing about a romantic relationship was defined as regularly daydreaming about a client where feelings of excitement, attraction, connection, and closeness are strongly present (Sternberg, 1988).

Therapists were asked to answer the following 11 statements about how they managed this situation (with yes or no), which is based on literature on managing sexual feelings (Arcuri & McIlwain, 2014; Gelso et al., 2014):

1. Did you consider (are you considering) starting a romantic relationship with this client during the period of therapy?
2. Did you consider (are you considering) starting a romantic relationship with this client after the end of therapy?
3. Have you thought about the possible consequences of this romantic relationship for yourself and your surroundings?
4. Have you thought about the possible consequences of this romantic relationship for this client and his/her surroundings?
5. Did you (do you) apply very strict boundaries with this client because of these fantasies (i.e., not approach boundaries, such as gifts, touch, self-disclosure, with a certain flexibility aligned to the clients' needs)?

6. Have you referred this client to another therapist?
7. Have you told this client that you fantasize about a romantic relationship with him/her?
8. Have you told your family and/or friends that you fantasize about a romantic relationship with this client?
9. Have you told your fellow therapists that you fantasize about a romantic relationship with this client?
10. Did you say in supervision or peer-supervision that you fantasize about a romantic relationship with this client?
11. Did you say in personal therapy that you fantasize about a romantic relationship with this client?

Furthermore, the questionnaire investigated therapists' sociodemographic characteristics, such as gender and age, education-related characteristics, such as basic education, specific type of psychotherapy training, and personal experiences in life during the period they fantasized about a romantic relationship with a client. More specifically, it was asked if they had experienced important problems or changes regarding children, relationships, closest friends or family, health situation, financial or material issues, and in their professional life.

Associations between the management strategies and socio-demographic, education-related characteristics and personal experiences are investigated. For these analyses Chi-square Test and Fishers' Exact Test, using IBM SPSS Statistics, version 27.0, were used. Furthermore, age was recoded in two categories, namely 20–39 years, and 40 years or older.

Focus Group Study

Participants and Data Collection. In total 36 therapists participated in this qualitative study, distributed over eight focus groups, with predominantly female therapists (n = 28). 14 therapists were aged 20–39 years, 17 were aged 40–59 years, and five were aged 60 or older (Table 1). Participants were recruited by an invitation letter from key figures in the psychotherapeutic field within their own network. They emphasized that participation was voluntary and (negative) consequences were highly unlikely. It resulted in two homogenous groups with solely psychiatrists (mixed gender and age), three groups with solely female systemic therapists, of which one contained only relatively young therapists (aged 20–39), two groups with only interactional or integrative psychotherapists, of which one containing female therapists only, and one rather mixed group. Before the start of each focus group, the research moderator, being the first author of this paper, informed the participants extensively about the aim, procedure, and confidentiality of the study, which was then followed by signing the informed consent form by both the participant and the moderator. Then, therapists were asked to fill in a short form on demographic and educational information and finally asked for their consent to audiotape the conversation.

Table 1. Characteristics of Focus Group Participants.

ID	Gender	Age	Focusgroup
1	Female	40–59	4
2	Female	20–39	5
3	Female	60+	3
4	Male	40–59	2
5	Female	40–59	1
6	Female	40–59	1
7	Female	20–39	6
8	Male	20–39	8
9	Female	20–39	5
10	Female	40–59	1
11	Female	40–59	1
12	Female	40–59	7
13	Female	60+	1
14	Female	40–59	2
15	Female	20–39	6
16	Female	20–39	6
17	Female	40–59	3
18	Male	40–59	4
19	Female	20–39	6
20	Female	20–39	6
21	Female	40–59	8
22	Female	20–39	3
23	Male	60+	7
24	Female	40–59	3
25	Male	20–39	7
26	Female	40–59	8
27	Male	60+	8
28	Female	40–59	5
29	Male	60+	4
30	Male	20–39	7
31	Female	40–59	5
32	Female	20–39	3
33	Female	20–39	3
34	Female	40–59	2
35	Female	20–39	1
36	Female	40–59	2

Semi-Structured Discussion Guide. At the beginning of the focus group discussion, therapists were asked to think back to a situation where they encountered romantic or sexual feelings towards a client. They were given 5–10 minutes to reflect on their feelings individually. Then, each personal story was discussed, including how they

dealt with this situation. It was ensured that particular management strategies, also asked about in the survey, such as referral of clients to colleagues, disclosure of feelings to clients, and discussing these feelings with peers or in supervision, were also addressed in the focus groups. Therapists with no or little experience on this matter were also asked to give their opinion during the discussion. At the end of each focus group, the research moderator asked all participants which were the main issues identified, along with confirmation or clarification from the other participants.

Data Analysis. To gain insight in the data gathered, a thematic analysis was used (Braun & Clarke, 2008), with the support of the software package QSR International's NVivo 12 (QSR International Pty Ltd., 2018). After transcription of the audiotapes, the data were read and reread to form initial coding ideas (open coding). Then, a line-by-line analysis of each focus group was done, where the initial ideas were transformed into more specific themes and subthemes, by e.g., comparing codes across the data (axial coding). Finally, the core themes emerging from the open and axial coding were defined (selective coding). Data were analyzed until no novel information about this topic became apparent (until saturation).

Reliability was strengthened by using several strategies, as recommended by Morrow (2005). Firstly, after each focus group, the moderator wrote down her personal feelings and insights in a reflexivity journal and debriefed the supervisor profoundly. Secondly, reliability was enhanced by two authors, LV and HVP, doing the coding, regularly discussing together their findings (codes) to reach congruence. Furthermore, JB reviewed closely the whole process of data analysis. Finally, the interpretation and refinement of the emerging core themes were discussed with all co-authors, giving input from their different professional backgrounds (public health, sexology, psychiatry, and psychotherapy). A more detailed overview of our analysis process can be found in Table 2 (Olson et al., 2016).

Ethics

This study was approved by the Medical Ethics Committee UZ Brussels – VUB (B.U.N. 143201524243). The participants in both the survey and focus group study were well informed about the study. Participants in the survey received an extensive information letter that clearly informed the therapists of the aim and method of the study and about how anonymity was guaranteed by asking no questions that, in combination, could lead to identification of respondents, by printing no identification code on the hard copy and by assuring that no email addresses or IP addresses could be captured. By filling in the questionnaire, they agreed to their information being used for this research purposes. Focus group participants signed an informed consent before the start of the data collection, guaranteeing their privacy and confidentiality during analysis and reporting.

Table 2. Overview of Analytic Process of Focus Group Discussion.

1. Meeting between two researchers, LV and HVP, to clearly define the aim of this coding.
2. Both researchers/coders independently immersed themselves to the data by reading the transcripts several times, writing down initial ideas and making notes of anything that appeared significant and of interest. These initial ideas and notes were exchanged before the next meeting (step 3).
3. Meeting between the two researchers to unify codes.
   a. Initial ideas and notes (from step 2) were discussed.
   b. It was agreed to use both codes (issues) that were also addressed in the survey data (deductive coding) and codes that emerged from the qualitative data (inductive coding).
   c. Based on this discussion, one researcher created a new unified codebook that reflected the decisions that were made. This new codebook was sent to the other researcher, who approved this codebook (or made some final remarks).
   d. It was agreed to make analytic memos during coding.
4. Both researchers independently coded the first four transcripts, based on the codebook (from step 3c). When a researcher believed a significant code had been previously missed, a new code was defined and tentatively added to the unified codebook.
5. Meeting between the two researchers to further unify codes and reach consensus about coding.
   a. The first four transcripts were run over together to see where there were coding discrepancies or confusion.
   b. New emerging codes (from step 4) were discussed.
   c. Analytic memos were discussed.
   d. When consensus was reached about the codes, one researcher developed a new unified codebook, with further detailed information about the codes (definitions, representative quotes, exclusion criteria, …). The other researcher approved this codebook (or made final remarks).
6. Steps 5 and 6 were repeated for each two subsequent transcripts.
7. Based on the final codebook, one researcher coded all transcripts again line-by-line.
8. Meeting between the two researchers to identify themes and subthemes.
   a. Before the meeting, the researchers reviewed their initial ideas and analytic memos. Then, they independently explored several dimensions of the data (i.e., comparing responses of participants, identifying the most important themes).
   b. During the meeting consensus was reached about the themes, subthemes, and linkages between the codes/themes.
9. Based on the defined themes, subthemes, and linkages, both researchers independently explored the data and made a first outline to describe results (i.e., development of a structure).
10. Meetings between the two researchers (LV and HVP) and co-authors (DDW, FM, JB) to identify core themes and finalize findings of the study.
    a. The researchers and co-authors discussed the first outline of results (from step 9).
    b. One researcher elaborated on the description of results (i.e., development of a narrative), after which the others gave feedback.
    c. Step 10b was repeated several times.

Results Survey

Managing Romantic and Sexual Feelings

Only a small minority of the 105 therapists that fantasized about a romantic relationship also considered starting a romantic relationship, during (4.8%) or after the end of therapy (6.7%) (Table 3). The majority thought about the possible consequences for themselves (65.4%) and their client (68%), and their respective surroundings. Almost three quarters of therapists (71.6%) 'maintain strict boundaries' due to their fantasy about a romantic relationship with this client. Referring a client to a colleague (6.7%) and disclosing feelings to the client (1%) were rather unusual. Furthermore, disclosing their feelings to others was not common. Just over a third discussed their feelings in supervision or peer-supervision (35.4%) and/or in personal therapy (31.6%).

Differences based on therapists' characteristics (Table 3) show that male therapists maintain strict boundaries (81.1%) and discuss their feelings in personal therapy (52.9%) significantly more often than female therapists (61.2% and 15.8% respectively). Middle aged and older therapists (aged 40 or above) more often reflected on the possible consequences for themselves (74.6%) and their client (78%), and more often maintain strict boundaries (82.8%) than their younger colleagues (53.3%, 54.5%, and 56.8% respectively). Psychiatrists indicated more often (12.1%) than psychologists (1.6%) that they considered starting a romantic relationship with a client during the period of therapy. Behavioral and psychoanalytic psychotherapists discussed their fantasy with family (2.9% and 4.8%) and colleagues (11.8% and 9.5%) less often than person-centered therapists (respectively 20.8% and 50%). No difference was found in disclosing this in supervision or peer-supervision. None of the behavioral therapists disclosed their feelings in personal therapy, in contrast to (almost) half of the person-centered (40%) and psychoanalytic therapists (54.5%).

Based on therapists' personal experiences (Table 4), no differences were found in managing strategies between therapists who had the perception that the client also fantasized about a romantic relationship with them and therapists who had not that perception. Furthermore, no differences were found based on important problems or changes in their personal love life or professional life, except for the latter, regarding the strategy of maintaining strict boundaries. Therapists indicating that they had problems or changes in their professional life more often reported maintaining strict boundaries (84.8%) than those who did not indicate this (64.7%).

Results of the Focus Groups

Both the actual management strategies of the psychotherapists when experiencing romantic and sexual feelings for a client and their opinions about how they should ideally react were discussed in the focus groups. Data analysis showed that most participants would never consider engaging in a relationship with a client. Instead, they try to maintain strict boundaries and control their own personal feelings. Some

Table 3. Therapists' Managing Strategies, Related to Therapists' Characteristics (N = 105)[a].

	1	2	3	4	5	6	7	8	9	10[b]	11[b]
	Rel dur	Rel after	Conseq th	Conseq ct	Boundaries	Referral	Told ct	Told fam	Told coll	Told sup	Told p th
	%	%	%	%	%	%	%	%	%	%	%
Total											
N (yes)	(*n* = 5)	(*n* = 7)	(*n* = 68)	(*n* = 70)	(*n* = 73)	(*n* = 7)	(*n* = 1)	(*n* = 10)	(*n* = 24)	(*n* = 28)	(*n* = 12)
% (yes)	4.8	6.7	65.4	68	71.6	6.7	1	9.6	23.1	35.4	31.6
Characteristics											
Gender											
Male therapists (*n = 54*)	7.4	11.1	74.1	75.9	81.1	5.6	1.9	13	29.6	44.4	52.9
Female therapists (*n = 51*)	2	2	56	59.2	61.2	8	0	6	16	27.9	15.8
p-value	*.365*	*.114*	*.065*	*.091*	*.030*	*0.708*	*1*	*.323*	*.110*	*.159*	*.033*
Age											
20–39 years (*n = 45*)	0	2.2	53.3	54.5	56.8	6.7	0	11.1	24.4	28.9	22.2
40 years or above (*n = 60*)	8.5	10.2	74.6	78	82.8	6.8	1.7	8.5	22	41.5	44.4
p-value	*.068*	*.136*	*.037*	*.018*	*.007*	*1*	*1*	*.743*	*.817*	*.347*	*.289*
Basic education[c]											
Psychologists (*n = 64*)	1.6	6.3	60.9	65.6	62.9	4.7	0	9.4	23.4	29.4	21.7
Psychiatrists (*n = 33*)	12.1	9.1	66.7	65.6	81.8	6.1	3	9.1	18.2	40.9	45.5
p-value	*.044*	*.687*	*.660*	*1*	*.065*	*1*	*.340*	*1*	*.613*	*.418*	*.232*
Psychotherapy training[d]											
Person-centered therapy (*n = 24*)	0	8.3	58.3	62.5	69.6	8.3	*1*	20.8	50	40	40

(continued)

Table 3. (continued)

	1	2	3	4	5	6	7	8	9	10[b]	11[b]
	Rel dur	Rel after	Conseq th	Conseq ct	Boundaries	Referral	Told ct	Told fam	Told coll	Told sup	Told p th
	%	%	%	%	%	%	%	%	%	%	%
Behavioral therapy (*n = 34*)	2.9	5.9	70.6	70.6	69.7	8.8	/	2.9	11.8	18.5	0
Psychoanalytic therapy (*n = 21*)	4.8	0	57.1	66.7	66.7	0	/	4.8	9.5	35.7	54.5
p-value	*.586*	*.427*	*.503*	*.811*	*.969*	*.379*	/	*.046*	*.001*	*.236*	*.043*

1: Did you consider (are you considering) starting a romantic relationship with this client during the period of therapy? 2: Did you consider (are you considering) starting a romantic relationship with this client after the end of therapy? 3: Have you thought about the possible consequences of this romantic relationship for yourself and your surroundings? 4: Have you thought about the possible consequences of this romantic relationship for this client and his/her surroundings? 5: Did you (do you) apply very strict boundaries with this client because of these fantasies? 6: Have you referred this client to another therapist? 7: Have you told this client that you fantasize about a romantic relationship with him/her? 8: Have you told your family and/or friends that you fantasize about a romantic relationship with this client? 9: Have you told your fellow therapists that you fantasize about a romantic relationship with this client? 10: Did you say in supervision or peer-supervision that you fantasize about a romantic relationship with this client? 11: Did you say in personal therapy that you fantasize about a romantic relationship with this client?

[a]Due to missing data N varies from 102 to 105.

[b]Question was only answered when applicable; question 10 (*n* = 79) and question 11 (*n* = 38).

[c]Due to the low N (*n* = 6) the category 'other basic education' has been omitted.

[d]Only therapists solely educated in person-centered, or behavioral or psychoanalytic psychotherapy training are included (*n* = 79). Combinations of these were excluded.

Table 4. Therapists' Managing Strategies, Related to Therapists' Personal Experiences (N = 105)[a].

	1	2	3	4	5	6	7	8	9	10[b]	11[b]
	Rel dur	Rel after	Conseq th	Conseq ct	Boundaries	Referral	Told ct	Told fam	Told coll	Told sup	Told p th
	(n = 5)	(n = 7)	(n = 68)	(n = 70)	(n = 73)	(n = 7)	(n = 1)	(n = 10)	(n = 24)	(n = 28)	(n = 12)
	%	%	%	%	%	%	%	%	%	%	%
Perception feelings were mutual											
Yes	6.1	6.1	75.5	73.5	77.6	10.2	2	8.2	28.6	36.6	31.6
No	3.8	7.5	56.6	63.5	66.7	3.8	0	11.3	18.9	33.3	37.5
p-value	*.669*	*1*	*.060*	*.295*	*.269*	*.256*	*.480*	*.743*	*.350*	*.814*	*.736*
Personal problems or changes regarding											
Children											
Yes *(n = 18)*	5.6	11.1	66.7	70.6	72.2	5.6	0	11.1	11.1	21.4	50
No *(n = 86)*	4.7	5.8	65.1	67.4	71.4	7	1.2	9.3	25.6	38.5	30
p-value	*1*	*.349*	*1*	*1*	*1*	*1*	*1*	*.683*	*.233*	*.357*	*.378*
Relationships											
Yes *(n = 23)*	8.7	8.7	60.9	69.6	72.7	0	0	17.4	13	38.9	33.3
No *(n = 80)*	3.8	6.3	66.3	68.4	70.9	8.8	1	7.5	26.3	35	33.3
p-value	*.310*	*.651*	*.629*	*1*	*1*	*.344*	*1*	*.225*	*.265*	*.785*	*1*
Closest friends or family											
Yes *(n = 28)*	7.1	10.7	67.9	71.4	71.4	3.6	0	10.7	17.9	25	18.2
No *(n = 76)*	3.9	5.3	64.5	66.7	71.6	7.9	1.3	9.2	25	40	40
p-value	*.609*	*.383*	*.819*	*.813*	*1*	*.671*	*1*	*1*	*.601*	*.306*	*.268*
Health situation											
Yes *(n = 14)*	7.1	14.3	78.6	85.7	71.4	7.1	0	14.3	35.7	62.5	50
No *(n = 90)*	4.4	5.6	63.3	65.2	71.6	6.7	1.1	8.9	21.1	32.4	30
p-value	*.522*	*.238*	*.370*	*.216*	*1*	*1*	*1*	*.621*	*.304*	*.124*	*.378*

(continued)

Table 4. (continued)

	1	2	3	4	5	6	7	8	9	10[b]	11[b]
	Rel dur	Rel after	Conseq th	Conseq ct	Boundaries	Referral	Told ct	Told fam	Told coll	Told sup	Told p th
	(*n* = 5)	(*n* = 7)	(*n* = 68)	(*n* = 70)	(*n* = 73)	(*n* = 7)	(*n* = 1)	(*n* = 10)	(*n* = 24)	(*n* = 28)	(*n* = 12)
	%	%	%	%	%	%	%	%	%	%	%
Financial and material											
Yes *(n = 18)*	11.1	16.7	44.4	52.9	70.6	0	0	5.6	16.7	25	60
No *(n = 86)*	3.5	4.7	69.8	70.9	71.8	8.1	1.2	10.5	24.4	38.1	29
p-value	*.206*	*.098*	*.056*	*.163*	*1*	*.602*	*1*	*1*	*.759*	*.393*	*.307*
Professional life											
Yes *(n = 34)*	5.9	8.8	67.6	67.6	84.8	0	0	8.8	20.6	35.7	36.4
No *(n = 69)*	4.3	5.8	65.2	68.1	64.7	10.1	1.4	10.1	24.6	36	32
p-value	*1*	*.682*	*1*	*1*	*.038*	*.092*	*1*	*1*	*.805*	*1*	*1*

1: Did you consider (are you considering) starting a romantic relationship with this client during the period of therapy? 2: Did you consider (are you considering) starting a romantic relationship with this client after the end of therapy? 3: Have you thought about the possible consequences of this romantic relationship for yourself and your surroundings? 4: Have you thought about the possible consequences of this romantic relationship for this client and his/her surroundings? 5: Did you (do you) apply very strict boundaries with this client because of these fantasies? 6: Have you referred this client to another therapist? 7: Have you told this client that you fantasize about a romantic relationship with him/her? 8: Have you told your family and/or friends that you fantasize about a romantic relationship with this client? 9: Have you told your fellow therapists that you fantasize about a romantic relationship with this client? 10: Did you say in supervision or peer-supervision that you fantasize about a romantic relationship with this client? 11: Did you say in personal therapy that you fantasize about a romantic relationship with this client?

[a]Due to missing data N varies from 102 to 105.

[b]Question was only answered when applicable; question 10 (*n* = 79) and question 11 (*n* = 38).

therapists would end therapy and refer the client to a colleague, if necessary. Overall, therapists indicated reluctance to disclose their romantic or sexual feelings to the client, because it would burden the client too much. Talking to peers or supervisors when experiencing romantic and sexual feelings is generally considered to be important, although there is still much hesitancy about doing so, mostly because of their fear of being condemned for it.

(Not Considering) Starting a Relationship

Consideration. Most therapists expressed the opinion that therapists should restrain from engaging in a relationship with a client. However, a few therapists indicated it was possible to follow their feelings and engage in a romantic or sexual relationship with a client, but only after the therapeutic relationship had ended. They also emphasized that it depends on the type of mental problems the client has. Only clients with minor problems are perceived as eligible for being a potential partner, whereas clients with a more serious psychiatric pathology are not. *"They're ill or someone who – to put it bluntly – has problems. That's a big distinction. Someone who's ill... is what I'm saying... it would be inappropriate. You really might learn to encounter different sides of someone. Yes, that can happen. Obviously, any form of professional contact stops then",* said one participant (P27).

Consequences. An important reason given for refraining from engaging in a relationship with a client was the negative consequences for clients. Most therapists were of the opinion that there is a power imbalance between therapist and client. It was thought that such relationship could not develop to one where there is equality between partners, as one participant (P6) said: *"But then there's a difference in power, though. If they come to you for however many weeks and expose their soul and don't know anything about you. That's always going to... No, I don't think it's healthy".* This can have very negative consequences for clients because clients could feel abused afterwards, as is illustrated in the following quote (P35): *"I've had various patients like that, who've actually had something going on with a therapist, and afterwards – not at the time – they felt like they were the seducers and that's how... they managed to hook them... but afterwards they really did feel like victims. They really have been abused. They even felt raped, although they were the ones who made the first move".* Besides negative consequences for the client, negative consequences for therapists themselves were also taken into account in their decision to refrain from engaging in a relationship with a client, such as getting into personal difficulties and losing their job. *"You do have to be professional, otherwise it even threatens your livelihood, to put it very bluntly",* said one participant (P11).

Being Aware and Reflecting On It. Regardless of whether a relationship with a client is considered acceptable or not and aside from the reasons to refrain from it, therapists almost unanimously perceive it as extremely important to be aware of, recognize, and reflect thoroughly on these romantic and sexual feelings. One participant (P14) explains it

as follows: *"But then I feel like... it's important to recognize this in myself and know that it's there. That it may get in the way of certain processes".* Another participant (P27) mentioned: *"There is also a lot of therapy that is really intense. But then...you know... suddenly it crops up and you say... huh... what's happening? Yes, you start to analyze it then, and you might see a form of transference in it, but... The point is... what is it doing to me at that moment?"* In another focus group it is illustrated by the following excerpt:

P19: I really liked that client. I did... I was aware of it... that I really liked them. But you can't... just stop feeling that way... because you're aware of it.

P16: But isn't that the important part?! Just... being aware of it.

Maintaining (Strict) Boundaries

A lot of therapists in the focus groups reported that it is important to maintain strict boundaries when experiencing romantic and sexual feelings towards clients. It was formulated as 'being professional', 'keeping a distance', 'maintaining boundaries', 'maintaining the therapeutic framework', etc. Based on their explanations, it seems that they want to be in control of the therapeutic situation with the client as well as their own romantic or sexual feelings to avoid escalation. Furthermore, it is indicated that their emotional wellbeing and confidence affect being able to keep control.

Controlling the Situation. Overall, 'maintaining (strict) boundaries' seems mainly to express a great willingness to behave with appropriate professionalism and not cross boundaries or harm clients, as illustrated in the following excerpt:

P18: If you have feelings for a client yourself… then... that (knowing what appropriate behavior is) is a lot harder.

M: And what do you do then?

P18: Be sure to maintain those boundaries as well, of course.

However, how these boundaries are actually guarded is never really clear. Nevertheless, one participant (P34) describes her effort to remain professional and in control: *"I was like... I have to stay professional myself. I also want to be here for this person. But I felt... I noticed that I was very... even if the person came up in conversation, that I really prepared myself well for that. Making sure you're properly grounded, that you've got your feet on the ground. So, I call that working on 'still being there' and staying within my therapeutic role".*

Controlling One's Own Feelings. Also, several therapists indicated they want to keep control over the development of their own romantic and sexual feelings. As the following quote (P6) illustrates, it is also formulated as 'being professional': *"Of course, it*

always happens that some clients appeal to you more. But you're a professional, aren't you? You keep your distance. You close that door". In this context of controlling feelings, some therapists also find sexually fantasizing about clients has to be avoided, because they believe this could give rise to deeper feelings. *"Say I have a pleasant feeling, then I can... Maybe my thoughts can feed that feeling in such a way that I end up falling in love. Or I can also say... this is my professional relationship... I think he's a good-looking man, but that's all. I shut it off",* said one participant (P13). Another participant (P9) mentioned the following: *"If you let yourself fantasize about someone for too long, that in itself creates all kinds of feelings that you also have to deal with. In all kinds of directions, you know"?*

Emotional Wellbeing. In order to keep control over the situation and one's own feelings, it is perceived that being emotionally stable might be important. Compared to therapists with a strong relationship in their private lives, therapists who are not in a relationship, going through difficult times within their relationship or having a hard time in general are perceived as having more difficulties maintaining these boundaries. One participant (P21) said: *"Because I think... if you... if you yourself are going through a difficult period and you feel really lonely, that it's risky then to maintain your boundary, I think".* Another therapist (P27) mentioned in this regard how important his wife was: *"I don't think I'd be able to do my job as a therapist if it weren't for my wife. So, if I were a single man... fft... no... I don't think I'd be able to deal with the intimacy of conversation therapy".* One therapist even mentioned avoiding older male clients in her practice, because she knew that she would have difficulty controlling these kinds of feelings due to the situation she was in that specific period.

P10: I am single, actually... I've been single for 3 years. And yes, I do avoid it a bit taking on older men as clients. I really do avoid it, yes.

M: And why is that?

P10: The feeling of missing warmth... missing input... yes, attention...

Confidence. Besides the emotional wellbeing of therapists, feeling professionally experienced and confident also seems to matter in maintaining boundaries. More specifically, a few rather young and inexperienced therapists indicated a preference for keeping strict control of these feelings and the situation immediately, to avoid ending up in a situation they could no longer manage. *"Up to now I think... But maybe that's also due to my lack of experience... that I don't want to get near that grey area. That I really want to stay where things are clearly ok. And otherwise not yet start experimenting with what actually would still be all right. I really don't want to at all",* said one participant (P8).

(Stop Therapy and) Refer Client to Another Therapist

Although no one had ever actually done so, several therapists indicated they would stop therapy and refer the client to another therapist if romantic or sexual feelings became

too intense. One participant (P28) mentioned she had considered referring her client, but as her feelings diminished, it was less opportune: *"Then I really did think very hard about. Should I... shouldn't I refer that person to someone else... come on... is this really okay? You know... What are we doing here? Now that has faded away again. I mean my feelings about it..."*. The following excerpt from a focus group illustrates their opinion about referrals:

P6: Say I really did have feelings for them... and in my situation... say I really had feelings for that person... then I'd say... go somewhere else...

P11: Yes.

P6: I'd refer them to someone else. Oh, no... I can't do that.

Based on the firm recommendations of therapists to refer clients to another therapist, the question was raised of how to actually go about it. Then a lack of clarity about how to manage that situation emerged, as the following excerpt illustrates:

P3: (...) Sometimes having to say... I have to refer you to someone else.

M: So how do you deal with it? Do you say... 'I'm falling in love with you... I'm referring you to someone else...' How should I see that then?

P22: It isn't very protective if you say it like that, is it?

P3: I'd certainly never say that... 'I'm in love with you'... I'm referring you to someone else.

M: What do you say then?

P3: How do you do it?

P22: I haven't been in that situation yet.

P3: Me neither. So I really have to fantasize now... (...)

P17: I've been thinking about that as well.

P3: It's never happened to me!

In another focus group it became apparent as follows:

M: Don't you have to give a reason why you're referring someone?

P2: You can just say 'due to circumstances'...

P28: ... for reasons of my own that I can't go into...

P2: I don't think... That raises questions... or 'due to circumstances'. The situation in my private life has changed for the moment and I have to refer several clients to other therapists...?

(Not) Disclosing to a Client

Overall, therapists indicated that romantic or sexual feelings should not be disclosed to a client. Besides being considered unprofessional to disclose this to the client, the reason mentioned for not disclosing these feelings to the client are the negative consequences for the client and his/her surroundings. It was thought that such information would burden the client and would not be helpful in the therapeutic process. It could be threatening for the client, or the client could feel abused. Furthermore, it was mentioned that this knowledge might affect the client's social circle, such as the relationship with their partner, or have implications for further therapeutic relationships. One participant (P23) mentioned the following: *"I don't know. I think I'd be putting a huge burden on her. If I were to say... do you know that I dream about you sometimes. That I sometimes end up in bed with you then. Come on... I think she'd feel abused. And she'd have a point, so..."*. Another participant (P27) said: *"Erm... in the sense that I had the impression that there were many occasions where that sexual attraction was clearly present... that it was mutual... like... I find you attractive. But knowing that if I were to give it a name, then that's so threatening for her"*. Another participant (P2) explicitly mentioned the consequences for the client's surroundings and further implications on his/her life: *"But what meaning does that gain for the one hearing that. Not just that person, but their partner too... But then... and... thinking about subsequent... more serious consequences in therapeutic relationships...I'm here because my previous therapist had sexual feelings for me. Maybe I should watch what I say, because before I know it this one will start having feelings for me too"*.

Talking About Romantic or Sexual Feelings With Other Relevant Professionals

Important. Most participating therapists find it necessary that sexual feelings towards clients can be freely explored and discussed with other relevant professionals, although it was not that clear who these professionals would be: peers, for example, or a supervisor. The participants thought it might be helpful to explore boundaries and how to manage these feelings well. *"If that were to happen... I don't think it would matter if it happened... but it would be... How do you deal with it? How far do you allow it? How far don't you allow it? And at that point you would have to be able to talk about it, certainly if you felt that... oh no... I might not have this entirely under control"*, said one participant (P26). Another participant (P2) mentioned: *"But when it comes to feelings, whether they're sexual or in another area... just... do something about them. Come out with... talk to people... Phone after a conversation if you need to. Don't keep them to yourself. And there is growth in that too. It doesn't have to be negative or bad... not at all... it's something human.* It is perceived as highly undesirable to carry this burden of feeling sexually attracted towards a client all alone, as following quote illustrates (P3): *"Or... whatever you do, talk to your supervisor or talk enough about it with a colleague. For me that, I think, that's the most important thing. Not to keep it to yourself"*. In this regard, one participant (P14) described the need for extra reassurance from important

others that having romantic or sexual feelings is just normal and can be experienced by any therapist. In the following quote, she describes the moment she told colleagues who were her friends that she had some sexual fantasies about a client: *"Because of what you said about fantasy... you know... we were talking about it recently... oh... you know... with that person... I did have a fantasy and the other person said: yes, exactly the same thing happened to me. Then you think: Wow, okay, I'm normal. So there. And then you can laugh about it and whatever"*.

Hesitance to Discuss. Although the majority of therapists are clearly in favor of talking about sexual and romantic feelings they encounter, therapists are hesitant to talk about these feelings in practice. They find it especially difficult to share these experiences with colleagues where such feelings are still not widely accepted. They fear being condemned for it. In one focus group, young therapists explain that even during the focus group they feel this hesitance, as the following excerpt illustrates:

P19: I don't know. I can honestly say that I have not yet had feelings like these, but I don't know if I would ever have dared to admit to them.

P16: Yes, I was thinking the same thing the whole time... right... isn't everyone else hiding something?

P19: Yes, exactly!

P16: Right, that's what you're thinking the whole time...

In another focus group, the following was said:

M: Is that something you find easy to tell colleagues or is it more something you would keep to yourself?

P1: No! I don't think I've ever... talked to colleagues... like that (...)

P18: But sometimes I do think... there are... things you feel and think... during a session... that you never tell anyone. Or hardly ever.

P1: That's true. That's how it is. Yes.

No Need to Discuss. In contrast to the majority of therapists who expressed the need to talk about these experiences, there were also a few therapists who said they did not feel this need to discuss their feelings with other relevant professionals. These therapists do not experience these romantic feelings as something wrong or something that might jeopardize their therapeutic work. They feel confident enough to handle such situation alone, as long as it does not get too intense, as following excerpt illustrates:

M: Is it that you don't feel the need because you're afraid of being judged, or because you feel confident about your own capacities in that area?

P27: It's more a question of self-confidence. I know... it sounds arrogant to say it like that... I can hear what I sound like... but I have the feeling... I know what I can do about it. If I really did something wrong, then I would feel the need to ask a colleague for advice. But not on the level of something happening without me feeling that I was doing anything deontologically wrong.

Another participant (P30) emphasized that the limited intensity of his feelings was the reason not to disclose this in supervision: *"I didn't talk to my supervisor about it because it was just a fleeting thing... that person was there for 2 weeks. I only saw them three times, I think"*.

Discussion

Romantic and sexual feelings towards clients are present in the psychotherapy room. This study, in which both a survey and focus groups among psychotherapists were conducted, investigated how they manage such feelings. The results show that most therapists never consider starting a relationship with a client when such feelings occur. They do consider possible (negative) consequences for themselves and the client, and they try to maintain strict boundaries due to their feelings. Keeping (strict) boundaries was more difficult when the therapist was less emotionally stable, according to the focus groups. Referring the client to a colleague was rather unusual, according to the results of the survey, although the participants in the focus groups emphasized that if feelings became too intense, a client should be referred to another therapist. Disclosing romantic and sexual feelings to other persons, such as supervisors or in peer-supervision and/or in personal therapy, was not that common either. Although it is perceived by most therapists as very important to talk about these feelings with relevant others (e.g., peers), discussion in the focus groups made very clear there is still much hesitance to do so, mainly for fear of condemnation by the same peers.

The strength of this study is that it contributes to more insight into how therapists nowadays manage romantic and sexual feelings towards clients, resulting in possible improvements to guidance for therapists on this issue. Furthermore, this study combines quantitative data with qualitative data from therapists with different professional backgrounds, therefore enriching the interpretation of the results. A limitation of the survey study is that the total N is rather small, which entails limitations for statistical analyses. Also, non-response could not be investigated due to the anonymity procedure. Moreover, response bias cannot be excluded, where possibly both therapists who are more conservative and therapists who violated boundaries were less willing to participate. Furthermore, we did not investigate to what extent therapists experience sexual feelings for a client. A limitation of the focus groups is that not all therapists had experienced romantic or sexual feelings. Finally, it cannot be excluded that socially desirable answers have been given or that particular information remained undisclosed, due to e.g., feelings of shame and discomfort.

A first important finding of the survey study is that most therapists with romantic fantasies towards clients do not consider engaging in a relationship with a client. They do think over the possible consequences of a romantic relationship for themselves, their client, and their respective social surroundings. This also became apparent in the focus groups. They find it important to recognize and reflect thoroughly on these romantic feelings, and they realize that due to the power imbalance, the client might feel abused afterwards. Furthermore, as was clearly indicated in the focus groups and in other studies, they also refrain from engaging in a relationship, being afraid it would cause personal troubles or job loss (Garrett, 1999).

Furthermore, the data from the survey study showed that about three quarters of therapists with romantic fantasies towards clients applied strict boundaries with these clients, which was also confirmed in the focus groups as an important thing to do. Male therapists more often reported maintaining strict boundaries than female therapists. A possible explanation may be that male therapists are afraid their romantic behavior might be interpreted more easily as inappropriate than the same behavior by their female colleagues. Furthermore, middle aged and older therapists more often reported maintaining strict boundaries than their younger colleagues. Focus group participants indicated that due to less experience, young therapists are less secure in handling romantic and sexual feelings towards clients. The development of general confidence and competence over the years, and possible earlier experiences in handling romantic or sexual feelings within the therapeutic context, probably result in feeling more relaxed and competent when it comes to managing such situations (Arcuri & McIlwain, 2014; Gareffa & Neff, 1974). Another finding from our focus groups is that being less emotionally stable, e.g., having personal relationship problems or lacking a relationship and intimacy, makes it more difficult to keep control over the situation and their own feelings. Other studies, based mainly on qualitative results and clinical evaluations of offenders of sexual boundary violators, also inform us that stressors in personal and professional life are contributing factors for boundaries to start crumbling, leading to mismanagement of romantic and sexual feelings (Arcuri & McIlwain, 2014; Barnett, 2014; Celenza, 1998; Celenza & Hilsenroth, 1997; Smith & Fitzpatrick, 1995). Because the results of this survey do not conclusively confirm this finding and other largescale quantitative studies are scant, more empirical research on this topic is recommended.

Concerning the referral of the client to a colleague when feelings become too intense, it was observed that this referral was a suggestion from therapists to each other rather than something they actually do (7%), when comparing the survey and focus group results. Although they are not in favor of continuing therapy when in love with the client (Vesentini, Van Overmeire, et al., 2021), they seem unprepared for referring clients when encountering strong romantic or sexual feelings (Marshall & Milton, 2014). Participants in the focus groups were unclear how to exactly manage the referral of the client. Most therapists indicated they would not disclose their feelings in this matter to the client, to not burden the client with this knowledge, as is also confirmed in earlier studies (Fisher, 2004; Gelso et al., 2014).

In line with earlier studies (Fisher, 2004; Nickell et al., 1995; Pope et al., 1993, p. 41), our focus group participants very explicitly and repeatedly emphasized the

importance of recognizing and openly discussing romantic and sexual feeling towards clients with colleagues. However, our survey study showed that only just over a third of therapists with romantic fantasies towards clients discussed them with a supervisor or in peer-supervision, and/or in personal therapy. These results are rather low, also compared to earlier survey studies with percentages roughly around 50% (Giovazolias & Davis, 2001; Pope et al., 1986; Stake & Oliver, 1991). The most probable explanation, also emerging from our discussions in the focus groups, is the work environment which is still perceived as too unsafe to talk openly about such feelings.

In conclusion, when it comes to managing romantic and sexual feelings towards clients in the psychotherapy room, it is recommended to invest in good support and guidance for therapists. Especially, rather young, and inexperienced therapists, and therapists who are single or going through difficult times in life seem to be vulnerable and deserve the required attention and follow-up. Furthermore, referring a client to another colleague when feelings get too intense needs to be further reflected on, in terms of both views about this and how it is dealt with. Finally, more effort is needed to let therapists talk about their romantic or sexual feelings with supervisors, in peer-supervision, or in personal therapy. To accomplish this, educational programs should create time to fully introspect and explore on this topic, in a safe environment, with trustworthy persons where confidentiality and discretion is assured. Supervisors should be better prepared to be able to adequately guide therapists during introspection, exploration, and decisions how to adequately deal with such situations. Ideally, the supervisor itself brings up this subject of intimacy and sexuality on a regular base, making it less difficult for therapists to talk about it when needed (Vesentini, Van Puyenbroeck, et al., 2021). These recommendations are not only useful for all educational programs in psychotherapy, but also to other stakeholders in the field.

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