The "Vicissitudes of Love" Between Therapist and Patient: A Review of the Research on Romantic and Sexual Feelings, Thoughts, and Behaviors in Psychotherapy

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Beginning with Freud's observations in the early 1900s, therapists' and patients' experiences of romantic and sexual reactions to each other during the course of therapy has been a topic that has generated alternating waves of avoidance and intense discussion in the professional literature. Research in the area flourished in the 1980s and 1990s but then nearly disappeared with very little integration. We offer a review of the research to date. Although we focus primarily on quantitative studies, we also reference some qualitative studies when the data help illuminate other findings. Our review is structured to answer 10 key questions in an effort to integrate the findings in a meaningful way for clinicians and researchers. In our conclusion, we note implications raised by the review for clinicians to consider in their practice and we highlight some directions for future research. © 2013 Wiley Periodicals, Inc. J. Clin. Psychol. 70:182–195, 2014.

In his earliest writings, Freud observed that patients and their therapists experience romantic and sexual thoughts and feelings about each other during the course of their therapeutic work together (Freud, 1915/1958; Schafer, 1993). As Gabbard and Lester (1995) noted, "the vicissitudes of love or substitutes thereof continued to haunt Freud" throughout his career (p. 70); he struggled with the complexities of these phenomena conceptually and clinically. Since the turn of the 20th century, the topic has generated periods of intense clinical interest and discussion, as well as of apparent resistance and avoidance among mental health professionals (Barrett, 2013; Stirzacker, 2000; Tansey, 1994). Research in the area flourished in the 1980s and 1990s but then nearly disappeared with very little integration. In this article we first review the research literature published to date and attempt to integrate the findings in a meaningful way for clinicians and researchers. Although we focus on quantitative studies, we do reference some qualitative studies when the data help illuminate other findings. Second, we note implications raised by the review for clinicians. And third, we highlight some directions for future research to further our understanding of these complicated transactions between therapist and patient.

Our literature review is structured to answer 10 questions. First, do patients experience and express romantic and/or sexualized thoughts and feelings regarding their therapists? Second, if so, how do therapists react to their patients' disclosures and enactments? Third, do therapists experience romantic and/or sexualized thoughts and feelings regarding their patients? Fourth, if so, do patients perceive their therapists' attractions? Fifth, what are the characteristics of the therapists who report romantic and/or sexualized thoughts and feelings? Sixth, what are the attributes of the patients about whom therapists have romantic and/or sexualized thoughts and feelings? Seventh, how do therapists react emotionally to their attractions to patients? Eighth, how do therapists react behaviorally to their attractions? Ninth, what are therapists' perceptions of the effect of their attractions on the therapeutic process? And, 10th, what training on the topic of romantic and/or sexual feelings, thoughts, and behaviors do therapists receive and what are their evaluations of that training?

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Do Patients Experience and Express Romantic and/or Sexual Thoughts and Feelings About Their Therapists?

Research to date suggests that patients do indeed experience romantic and/or sexual responses to their therapists. A study by Geller, Cooley, and Hartley (1981–1982) provided some of the earliest data. Their respondents (who were psychotherapists also in treatment) acknowledged that they had fantasies of sexual involvement with their therapists–being held by, kissing, and having sex–in the physical absence of the therapist. However, compared to other fantasy themes (e.g., a wish for nonsexual reciprocity, like sharing a meal or talking outside of the therapy session), those of sexual involvement were the most rare. Using a similar methodology, Pope and Tabachnick (1994) found that over one third (36%) of psychologists who had experienced personal therapy reported that they felt sexually attracted to their own therapist at least rarely; 6.5% acknowledged that attraction happened often.A similar percentage (33%) indicated that they had sexual fantasies about a therapist at least once; 5.2% had fantasies often.

Some patients do disclose their attractions to their therapists. DeMayo (1997) surveyed female therapists regarding their experience of patients' sexualized behaviors during therapy. A little less than half of his sample (48.2%) indicated that at least one patient had described a sexual fantasy involving the therapist in session. Pope and Tabachnick (1993) found that 73.3% of their sample of male and female therapists indicated that patients had disclosed their sexual attraction to them. A closer look at their data, however, revealed that if any disclosures were made to the therapist, then they were most often made by only a very small number of patients (1% to 2%), a frequency far lower than might be expected given patients' reports of attraction.

When patients are queried, their reticence to disclose such feelings to their therapists is underscored. Pope and Tabachnick (1994) found that less than one half of their patient respondents who experienced sexual fantasies and feelings regarding their therapists reported that they disclosed their attractions in therapy. Similarly, Hall and Farber (2001) reported that their patient participants discussed their sexual reactions to the therapist *least* of all 80 moderately to highly intimate topics presented to them by the researchers. Not surprisingly, the authors indicated that overall patient disclosure of difficult topics in therapy increased the longer patients were in therapy and the stronger they perceived their alliance with the therapist.

Some patients also do enact romantic and/or sexualized behaviors toward their therapists. The frequencies of therapist reports of specific patient behaviors tend to parallel the continuum of more benign to more explicitly sexually aggressive behaviors. For example, a majority of therapists reported that they had some patients who flirted with them (Pope & Tabachnick, 1993), gave them suggestive looks (DeMayo, 1997), or engaged in sexual teasing, jokes, remarks, or gestures (Morgan & Porter, 1999). A much smaller percentage (about one quarter) felt pressure for dates from a patient, experienced deliberate touching, leaning over, or cornering by a patient, or were kissed by a patient (Morgan & Porter, 1999; Pope & Tabachnick, 1993). Fewer still reported that they had received letters or phone calls from a patient containing sexual material (Morgan & Porter, 1999). And extreme behaviors, such as sexual assault by a patient, were very rare (0.2%; DeMayo, 1997). Morgan and Porter reported that male and female psychiatrists reported similar frequencies of sexualized behavior by patients. However, the incidents occurred almost exclusively in therapist/patient dyads of different genders (e.g., male therapist, female patient; female therapist, male patient). Unfortunately, the methodologies used by these researchers do not provide any mechanism for the determination of the actual base rates of each specific patient behavior.

How Do Therapists React to Patients' Disclosures and Enactments of Romantic and/or Sexualized Attraction?

In general, research findings suggest that therapists often react to patients' revelations of their attraction with marked discomfort. Further, that discomfort appears to negatively affect both the therapist's perceptions of the patient and the therapy process, as well as the therapist's actual interventions with the patient. Using an ingenious analogue methodology, Schover (1981) presented postgraduate psychologists, social workers, and psychiatrists with a mean of 14 years

of experience with two tapes–one of a patient's discussion of his or her sexual dysfunction (woman's inability to reach orgasm during intercourse or man's premature ejaculation) and the other of a patient's disclosure of sexual attraction to the therapist (including sexual dreams about the therapist, the desire to be touched and to engage in sexual intimacy once the therapy was terminated, and thoughts about whether the therapist was attracted to the client). The therapist participants were asked to read a brief description of the patient and then listen to each tape, which contained seven pauses, and record a response to the patient's disclosure after each pause. The therapist responses were coded according to the categories of the responses (e.g., reflection, interpretation, advisement) and whether they were discouraging or encouraging the patient's discussion of the topic. After their review of the tape, the therapists were asked to respond to several questions regarding their reactions to the interactions with the patient.

Schover (1981) found that, overall, therapists reported more anxiety with the patient sexual attraction tapes than the patient sexual dysfunction tapes. Further, they used more discouraging responses, more disapproval and process statements, and fewer information-seeking questions and reflections in response to the patient sexual attraction tapes. They also indicated that establishing a good therapeutic alliance with such patients would be more difficult and the treatment process less enjoyable. Interestingly, therapist characteristics appeared to mediate some of these findings. Male therapists responded with a high frequency of self-disclosures to a female patient who expressed sexual attraction; female therapists did not self-disclose to a male patient revealing sexual feelings and thoughts. Further, those male therapists with liberal views on abortion and heterosexual relations rated themselves as only mildly anxious and more sexually aroused by the patient disclosures. These respondents also made relatively more approach responses to the tape. Although noteworthy, this study was conducted over 30 years ago; thus, the gender differences reported may have been influenced by the gender culture/politics of that time.

Harris' (2001) survey of marriage and family therapy graduate students with minimal clinical experience revealed that the participants anticipated that they would feel cautious (85%), uncomfortable (48%), self-conscious (46%), anxious (44%), embarrassed (22%), vulnerable (18%), and scared (15%) if a patient expressed an attraction to them. Also of note is that 44% indicated that they would feel respectful of the patient. Not surprisingly, when asked to describe how they would respond to a patient's disclosure of sexual attraction, only 15% indicated that they would feel comfortable working with the client; in contrast, 51% endorsed that they would not feel comfortable and 34% were undecided.

DeMayo (1997) and Morgan and Porter (1999) found that therapists perceive some patient sexualized disclosures and behaviors as sexual harassment (defined according to the Equal Employment Opportunity Commission criteria as "unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature"; EEOC, 1980, p. 25024). DeMayo found that there was a great deal of variance in these respondents' ratings of what constituted sexual harassment. For example, nearly half of the respondents rated the patient's disclosure of a sexual fantasy about the therapist as at least mildly harassing, while 4.6% found the behavior extremely harassing. Further, while 74.1% of the sample rated a patient's request for a hug as not at all harassing, a quarter of the sample found the behavior at least mildly harassing. Morgan and Porter found that 100% of their psychiatry trainee participants regarded deliberate sexualized touching, leaning over, or cornering as sexually harassing. There was more variance among the respondents regarding whether the other behaviors listed (i.e., sexual teasing, jokes, remarks, questions, looks, or gestures; pressure for dates; or sharing of letters, phone calls, or material of a sexual nature) were perceived as sexual harassment.

Do Therapists Experience Romantic and/or Sexualized Thoughts and Feelings Regarding Their Patients?

Therapists do report that they experience romantic and/or sexualized feelings toward their patients, though the percentages of those reporting these feelings differ between therapists who are in their own practice versus those still in graduate training. Pope, Keith-Spiegel, and Tabachnick (1986, 2006) reported that the vast majority of their psychologist respondents (87%)

indicated that they had experienced feelings of sexual attraction to at least one client, a frequency similar to that found by Bernsen, Tabachnick, and Pope (1994) in their survey of social work therapists (81%) and by Rodolfa, Hall, Holms, Davena, Komatz, Antunez, and Hall (1994) in their sample of counseling and clinical psychologists (88%). Several other researchers have replicated the finding that practicing therapists commonly report experiences of sexual attraction to patients (Blanchard & Lichtenberg, 1998; Brock & Coufal, 1994; Giovazolias & Davis, 2001; Nickell, Hecker, Ray, & Bercik, 1995; Paxton, Lovett, & Riggs, 2001; Pope & Tabachnick, 1993; Pope, Tabachnick & Keith-Spiegel, 1987; Stake & Oliver, 1991).

In contrast, when Harris (2001) surveyed marriage and family therapy (MFT) graduate students with at least some clinical experience, he found that only 34% acknowledged that they had been sexually attracted to at least one of their patients, while 58% denied any attraction, and 8% indicated that they were unsure. Interestingly, in another study, when practicing psychologist participants were asked to retrospectively report any feelings of sexual attraction to a patient while the psychologist was in training, they acknowledged a much higher frequency (78%; Paxton et al., 2001).

We found only one study that reported details about the nature of therapists' romantic or sexualized attraction to patients. Ladany, O'Brien, Hill, Melincoff, Knox, and Petersen (1997) used an interview methodology to explore specific attributes of graduate student therapists' reported experiences of sexual attraction. Their respondents indicated that their sexual attraction typically developed over the first third of the therapy relationship. The authors also found that attraction "at first sight" (p. 416) occurred occasionally. In addition, several of the therapists noted that they experienced a physical response during sessions with the patient to whom they were attracted. The majority of intern therapists in their sample indicated that their feelings of attraction to their clients were not completely resolved during the course of the therapy; a minority reported that some feelings persisted beyond termination.

A minority of practicing therapists report more intimate sexual fantasies about patients. Pope and his colleagues (1986, 2006) found that 29% of their participants indicated that at least rarely they had sexual fantasies about a current or former patient while engaging in sexual activity with someone other than a patient. Bernsen et al. (1994) and Rodolfa et al. (1994) reported consistent findings when they queried their respondents about sexual fantasies about patients in general (22%, and 21.2% [former patient] and 25% [current patient], respectively). Of note too, 18% of Pope et al.'s therapists indicated that they had had serious thoughts of engaging in actual sexual involvement with a patient, a figure somewhat higher than Bernsen et al.'s and Rodolfa et al's reported frequencies (13% and 8.1%, respectively).

Are Patients Aware of Their Therapists' Romantic and/or Sexualized Thoughts and Feelings?

One study suggests that some patients, albeit a minority, are aware of their therapists' attraction to them; notably, though, this was a study of patients who themselves were therapists. Pope and Tabachnick (1994) reported that 14.2% of their respondent psychologists who had engaged in personal therapy thought that their therapist seemed sexually attracted to him or her at least on one occasion, while 8% indicated that at least once their therapist seemed sexually aroused in their presence.

What Are the Characteristics of the Therapists Who Report Romantic and/or Sexualized Thoughts and Feelings?

Gender is the most common therapist characteristic associated with the therapist's experience of romantic and/or sexualized attraction to patients. Male therapists more often reported attraction to their patients than female therapists (Bernsen et al., 1994; Harris, 2001; McMinn & Meek, 1996; Nickell et al., 1995; Paxton et al., 2001; Pope et al., 1986, 2006; Rodolfa et al., 1994; Stake & Oliver, 1991). Similarly, male therapists reported significantly more sexual fantasies about patients than female therapists (Bernsen et al., 1994; McMinn & Meek, 1996; Nickell et al., 1995; Pope et al., 1986, 2006; Rodolfa et al., 1994). And male therapists reported more often

that they considered sexual involvement with a patient (Nickell et al., 1995; Pope et al., 1986, 2006; Rodolfa et al., 1994).

A repeated, though not as consistent finding, is that therapist age appears to be a factor in therapist attraction. Younger therapists significantly more often acknowledged sexual attraction than older therapists in some studies (Pope et al., 1986, 2006; Rodolfa et al., 1994), but not others (Bernsen et al., 1994). And while Pope et al. (1986, 2006) found that younger therapists indicated significantly more fantasies than older therapists, Rodolfa et al. (1994) reported that older psychologists in their sample were significantly more inclined to seriously consider sexual involvement with a client than were the younger psychologists.

Limited research findings suggest that therapists' religious affiliation is also associated with reports of sexual attraction to patients, but that that association appears to be moderated by education level and licensure status. McMinn, Meek, and Rhoads (1997) surveyed licensed Christian psychologists, licensed Christian counselors (licensed in social work, marriage and family counseling, or professional counseling), nonlicensed Christian counselors (graduate degrees but no license), and lay Christian counselors (no graduate degree), using an adaptation of Pope et al.'s (1987) questionnaire. They compared the responses they received to those of Pope and his colleagues. Among all of the Christian therapists queried, approximately 44% reported that they were never sexually attracted to any client; Pope et al. (1987) found that only 9% of psychologists surveyed from APA Division 29 denied any attraction and Rodolfa et al. (1994) reported only 12%. Of note is that the subsample of licensed Christian psychologists did *not* differ from Pope et al.'s comparison psychologists in their reports of sexual attraction; only 17% reported never experiencing attraction. In a later study, Meek and McMinn (1999) limited their sample to Christian psychologists trained either in secular or Christian graduate training programs. They found that only 11% of their respondents reported that they had never felt sexual attraction toward a client.

Although often suggested in the clinical literature as factors associated with therapists' experience of sexual attraction to patients, limited empirical findings to date do not appear to support the significant association of personal relationship issues or other situational stressors in the therapist's life with such feelings. Ladany et al. (1997) found that a minority of their therapist respondents reported relationship problems or other life stressors at the time of their sexual attraction. It is important to note, however, that their sample of therapists was both quite small ($N = 13$) and consisted entirely of predoctoral psychology interns.

What Are the Attributes of the Patients About Whom Therapists Have Romantic and/or Sexualized Thoughts and Feelings?

Pope et al. (1986, 2006), Bernsen et al. (1994), and Rodolfa et al. (1994) asked their respondents to describe the characteristics of the patients to whom they were attracted. By far the most common characteristic noted across respondents in all three studies was "physical attractiveness," defined by the authors as "beautiful, healthy looking, athletic, nicely dressed, etc." Interestingly, again in all of the studies, the patient characteristic "sexual" (defined as "sexy, sexual ideal, sexually active, sexual material discussed in therapy, etc.") was endorsed far less frequently. Also of note is that in both the Pope et al. and the Bernsen et al. studies therapists seldom reported that their attraction was related to their clients' resemblance to someone in their life (e.g., the therapist's mother, father, spouse, lover, someone from the past). Ladany et al. (1997) reported similar findings.

Some researchers have noted significant interactions of therapist and patient characteristics associated with therapists' feelings of sexual attraction. The role of gender again is most consistent. The majority of male social work and psychologist therapists who acknowledged feelings of sexual attraction reported that they were attracted only to female patients; a much smaller percentage reported attraction only to male patients. The trend was the same for female therapists (more reported attraction only to the opposite gender and fewer to the same gender), but the differential between the patient genders was less (Bernsen et al., 1994; Pope et al., 1986, 2006).

Therapist gender also interacts with other patient characteristics. Both Pope et al. (1986, 2006) and Bernsen et al. (1994) noted that of the 19 types of attractive client characteristics derived from their respondents, male and female therapists gave relatively balanced endorsements with two exceptions. "Physical attractiveness" was mentioned far more often by men than by women, and "successful" (defined as "accomplished, wealthy, from a good background") was mentioned more often by women than by men.

Pope et al. (1986, 2006), Bernsen et al. (1994), and Rodolfa et al. (1994) all reported another interesting interaction of therapist and patient factors. They asked respondents whether, in the instances when they were attracted to a patient, the patient was also attracted to them. Most therapists (83%, 72%, and 64%, respectively) indicated that they perceived that the attraction was mutual. Bernsen et al. and Rodolfa et al. also found that male therapists were more likely to report mutual attraction than female therapists. Ladany et al.'s (1997) psychology intern respondents were less likely to perceive mutual attraction.

Findings by Pope and Tabachnick (1993; 1994), however, tend to raise a question about the mutuality or co-occurrence of the patient's sexual feelings or expressions and those on the part of the therapist. In both studies factor analyses revealed that items relating to patient sexual material and those relating to therapist sexual material loaded on separate factors. One explanation of this discrepancy is that therapists who experience sexual attraction to a patient likely struggle with negative reactions (see below) to those feelings; their perception of the patient's shared attraction may then offer a rational explanation.

How Do Therapists React Emotionally to Their Attractions to Patients?

Therapists (professionals and trainees) commonly acknowledge negative emotional reactions to their sexual attraction to a patient, including surprise, shock, discomfort, anxiety, fear, guilt, confusion, and anger (Bernsen et al., 1994; Giovazolias & Davis, 2001; Ladany et al., 1997; Nickell et al., 1995; Pope et al., 1986, 2006; Rodolfa et al., 1994; Rodolfa, Kraft, & Reilly, 1987; Rogers, 2011). However, many therapists also report positive reactions such as enjoyment, curiosity, and a desire to better understand their attraction and use it as a catalyst for more productive therapy (Ladany et al., 1997; Rogers, 2011). Indeed, using a content analysis of therapists' responses to an open-ended question regarding their reactions to their attraction, Giovazolias and Davis (2001) found that nearly half of their sample (45%) "normalized" their feelings and reacted in a "more positive way (i.e., acknowledgement of feelings/acceptance, consideration of attraction as a normal feeling)" (p. 283).

Clearly there is some variability in therapists' emotional responses to their sexual feelings and thoughts about patients. Results of studies to date reveal only inconsistent findings regarding therapist gender and age as factors associated with their reactions. Bernsen et al. (1994) found that men were more likely to report at least some discomfort than women. Conversely, Blanchard and Lichtenberg (1998) reported that their male therapists indicated less negativity, and more feelings of self-assurance, regarding their experience of sexual feelings toward patients than female therapists. Pope et al. (1986, 2006) found no gender differences but did note that younger therapists reported more negative reactions than older therapists. Rodolfa and colleagues (1994) found no gender or age differences.

Although not explicitly examined in any research we reviewed, some findings do offer insight into one possible therapist factor associated with the discomfort noted by so many therapists—their perception of the ethicality of feelings of sexual attraction and fantasies. In one study a sizable minority of therapist respondents (over 22%) rated the experience of sexual attraction to a patient as either "unquestionably not ethical" or ethical only under rare circumstances. In addition, an even larger percentage (33%) indicated that engaging in a sexual fantasy about a patient was never ethical or ethical only under rare circumstances (Pope et al., 1987). Along the same lines, Nickell et al. (1995) found a significant degree of variance in respondents' judgments of the ethicality of feeling sexually attracted to a client and engaging in a sexual fantasy about a client.

Some studies suggest that religious affiliation may account for some of the variability in therapist perceptions of the ethicality of sexual attraction and sexual fantasies. For example,

McMinn and colleagues (1997) found that Christian therapists tended to rate sexual attraction and engaging in sexual fantasies as "unquestionably not ethical" significantly more frequently than Pope et al.'s (1987) respondents. However, when Meek and McMinn (1999) limited their sample of Christian therapists to psychologists, only 19% of their participants reported that sexual attraction toward a client was always unethical. Their results paralleled those reported by Case, McMinn, and Meek (1997) and McMinn and Meek (1996), suggesting that education level moderated the effect of the therapists' religious values on the perceived ethicality of such therapist experiences.

Therapists' experience of training on the topic of sexual attraction, and their perception of the adequacy of that training, appear to be associated with the overall reactions they have to their sexual feelings about a patient in a rather complex way. Although neither the experience of training nor the perceived adequacy of training if received accounted for any differences in therapists' general negative reactions, those who received training in graduate school reported feeling significantly more self-assured when they experienced attraction than those who had no training. In addition, those who perceived their training as adequate felt significantly more self-assured than those who rated their training as inadequate.

Research findings also suggest that the context of therapists' training is a factor. Case, McMinn, and Meek (1997) reported that when their respondents rated the conditions of their graduate training on the topic of sexual feelings more favorably (i.e., more accepting, safe, encouraging, and respectful, according to Pope, Sonne, and Holroyd's, 1993, proposed conditions of effective training), they were less likely to judge sexual attraction to a patient as always unethical.

How Do Therapists React Behaviorally to Their Attractions to Patients?

While a few therapists acknowledge that they deny, refocus, or repress their experience of sexual attraction to a patient (Bridges, 1994; Ladany et al., 1997), research findings indicate that a majority engage in personal processing of their feelings and thoughts. For example, Blanchard and Lichtenberg (1997) found that 75.4% of the counseling psychologists they surveyed indicated that they responded to their sexual attraction by "introspecting about their feelings" (p. 633). Likewise, Ladany et al. (1997) reported that their therapists-in-training often reflect on and work through their feelings on their own. Some therapists engage only in that personal exploration without discussing their experience with anyone (Giovazolias & Davis, 2001).

On the other hand, several investigations have revealed that many professional therapists who experienced sexual attraction to a patient sought supervision and/or consultation (Bernsen et al., 1994; Blanchard & Lichtenberg, 1998; Giovazolias & Davis, 2001; Nickell et al., 1995; Pope et al., 1986, 2006; Rodolfa et al., 1994; Stake & Oliver, 1991). However, therapists-in-training appeared less likely to pursue such contacts. Less than one third of the student therapists in Paxton et al.'s (2001) sample sought assistance from a supervisor or other faculty. Moreover, Ladany et al.'s (1997) student respondents only occasionally discussed the attraction with their supervisors. Ladany, Hill, Corbett, and Nutt (1996) found that feelings of sexual attraction were among the topics that therapists-in-training often did not disclose to their supervisors.

Although levels of education and experience as a practitioner appear to be related to whether or not therapists seek supervision or consultation, other studies reveal additional factors. For example, Rodolfa et al. (1994) reported the following factors were positively associated with seeking consultation or supervision: concern for client welfare, fear of having lost objectivity, desire to gain an understanding of their attraction, absence of fear of acting out the sexual attraction, and a positive supervisory or collegial relationship. Post hoc analyses by Pope and colleagues (1986, 2006) showed that those who reported feeling uncomfortable, anxious, or guilty about their attraction were more likely to seek guidance from others than those who felt no negative emotional reaction. Rodolfa et al.'s participants who did not seek supervision or consultation indicated that they did not do so because they perceived that their attraction did not interfere with the course of therapy. In contrast to Pope et al.'s findings, these researchers also found that anxiety or shame actually inhibited a small number of their respondents from speaking with a supervisor or colleague. Last, Nickell et al. (1995) found that their therapist

participants varied widely in their assessments of the ethicality of seeking supervision regarding sexual attraction to a patient.

Ladany et al.'s (1997) intern therapists reported that if there was a discussion with a supervisor regarding any feelings of sexual attraction, it was they (the trainees) who typically initiated it, and that the discussion typically yielded helpful input from the supervisors and strengthened the supervisory relationship. Paxton et al. (2001) found that student therapists who pursued supervision assistance significantly more often felt prepared to manage their sexual feelings professionally, and that association was stronger when the perceived quality of the supervision was higher. Adding further complexity to this picture, Rodgers' (2011) trainee respondents indicated that while overall supervision was beneficial, the discussion of their attraction was complicated when therapists and supervisors worked from different theoretical perspectives.

Ladany and colleagues (Ladany et al., 1996, 1997) reported that interns who did not disclose their sexual attraction chose this course primarily because they thought their feelings of attraction were not important enough or relevant to supervision. Further, the nondisclosing trainees reported negative feelings about their supervisor (including the perception that the supervisor was not competent enough or was sexually harassing or otherwise disrespectful), or fears that their supervisor would not be supportive, a rationale also noted by Rodgers (2011). Not surprisingly, those therapists who did not discuss their sexual attraction reported that the issue ultimately had a negative effect on their supervision (Ladany et al., 1997).

A smaller percentage of practicing therapists and trainees reported that they talked with their own therapists about their experience of sexual attraction to a patient (Giovazolias & Davis, 2001; Ladany et al., 1997; Stake & Oliver, 1991). In addition, while there is evidence that some trainees spoke with peers or colleagues (Ladany et al., 1997), there is also evidence that some were reluctant for fear that the colleague would judge the attraction as unethical or that the colleague could report the trainee for an ethical violation (Harris, 2001).

Some practicing therapists disclose their attraction to their patients (Blanchard & Lichtenberg, 1998; Brock & Coufal, 1994; Giovazolias & Davis, 2001; McMinn & Meek, 1996; Nickell, et al., 1995; Pope et al., 1987; Pope & Tabachnick, 1994; Stake & Oliver, 1991). In contrast, none of Ladany et al.'s (1997) intern therapists disclosed their attraction to their patient.

In addition to education level and experience, several other factors appear to affect whether therapists disclose their attraction to their patients. Stake and Oliver (1991) found that male therapists were significantly more likely to disclose than female therapists; Schover (1981) reported similar findings. Further, the majority of practicing therapists in several research samples commonly reported that it would be unethical to tell patients of their sexual attraction (Brock & Coufal, 1994; McMinn & Meek, 1996; Pope et al., 1987). Harris' (2001) MFT trainees tended to believe that disclosure would result in more damage than good.

Research by Goodyear and Shumate (1996) lends further insight. They asked their therapist participants to view a videotape of a simulated therapy session in which the patient disclosed sexual attraction to the therapist and the therapist either was noncommittal about his or her feelings or disclosed mutual attraction but stated that he or she would not act on such sexual feelings. The respondents then were asked to rate the attractiveness, expertness, trustworthiness, and helpfulness of the therapist. Participants rated the disclosing therapist as significantly more attractive and significantly less expert; interestingly, they did not rate the disclosing therapist as also less trustworthy. In addition, the participants' evaluation of the overall therapeutic value of the clinical interaction between the simulated patient and therapist was significantly lower when the therapist disclosed attraction. The results of this study failed to demonstrate any effects of the interaction of gender (of the client, therapist, or observer) and disclosure condition on the ratings.

Though therapists rather commonly acknowledge sexualized feelings and thoughts about at least one patient, studies suggest that a fairly small (though still quite alarming) percentage actually engage in overt sexual contact (i.e., touching in a sexually arousing manner or having genital contact) or other erotic activity (e.g., genital exposure; Bernsen et al., 1994; Pope, et al., 1986, 2006; Rodolfa et al., 1994; Stake & Oliver, 1991). Pope (2001) pooled data from eight national therapist self-report studies; he found that overall about 4.4% of the therapists reported having engaged in sexual activity with at least one client. He also noted that although the genders of the therapist and of the client were not consistent significant predictors of such behavior across

the studies, in no study did the percentage of female therapists reporting sexual involvement equal or exceed the percentage of male therapists, or the number of female patients equal or exceed the number of male patients. And by far the most common therapist-patient dyad in the sexualized relationships was male therapist/female client (see Sonne, 2012, for a full review).

Rodolfa et al. (1994) reported three factors that contributed to therapists' sexual acting out with patients: "the break-up or absence of a primary relationship, poor self-concept, and environmental stress (job problems)" (p.170). Bernsen et al. (1994) found that when their data and the data from Pope et al. (1986, 2006) were combined, sexual acting out associated with the therapist's sexual attraction to the client decreased with the increase of relevant graduate training.

Perhaps reflecting concerns that their sexual attraction to a patient would result in a negative outcome (e.g., that it was unethical, interfere with the therapy process, or result in actual sexual contact), 22.1% of therapists who experienced such feelings and thoughts reacted by referring the patient to another therapist (Stake & Oliver, 1991). Blanchard and Lichtenberg (1998) reported that 7.8% of their respondents indicated that they would do so.

Nickell et al. (1995) assessed what sources their MFT therapists reported as influential in their decision making about how to respond to their feelings of attraction to a patient. Ratings of good-to-excellent influence were designated by the respondents as follows: American Association for Marriage and Family Therapy code of ethics (74%), an informal network with colleagues (65%), independent reading on the topic (63%), knowledge that state and federal laws make sexual contact a felony (51%), continuing education programs on the topic (41%), and internship experience (28%). In a related finding, Meek and McMinn (1999) reported a significantly positive relationship between Christian psychotherapists' favorable perceptions of their training regarding sexual feelings and their enactment of "healthy" responses to their attraction (as judged by experts—discussing sexual attraction with a personal therapist, a supervisor, or a peer consultant).

What Are Therapists' Perceptions of the Effect of Their Attractions on the Therapeutic Process?

Therapists in professional practice report both positive and negative effects of their sexual attraction to a patient on the psychotherapy process. A substantial percentage of practicing therapists (48% to 69%) reported that their sexual attraction had been beneficial in at least some instances (Bernsen et al., 1994; Giovazolias & Davis, 2001; Pope et al., 1986, 2006; Rodolfa et al., 1994). The beneficial factors included enhanced empathy for the patient, greater interest in the patient's problems, increased awareness of the patient's nonverbal behaviors, and increased awareness of transference-countertransference dynamics (Giovazolias & Davis, 2001; Rodolfa et al., 1994). Many of Ladany et al.'s (1997) interns believed that they were more "invested, caring, and attentive than usual because of the sexual attraction" (p. 418). In two studies, male therapists were more likely than female therapists to consider the attraction to be beneficial (Bernsen et al., 1994; Pope et al., 1986, 2006).

However, a substantial minority (37% to 49.3%) of the practicing therapists surveyed in three studies reported that their attraction had a negative impact on therapy in at least some instances (Bernsen et al., 1994; Pope et al., 1986, 2006; Rodolfa et al., 1994). Interestingly, Giovazolias and Davis (2001) found that only 6.3% of their therapists reported a negative effect on therapy. Rodolfa et al. listed the following harmful effects: "therapists feeling distracted from client issues, difficulty confronting clients, early referral or termination, and feeling overly involved with the client" (p. 170), effects mirrored by Giovazolias' and Davis' participants. Male therapists were more likely than female therapists to report that their attraction had been harmful (Bernsen et al., 1994; Pope et al., 1986, 2006). And while Bernsen et al., Pope et al., and Rodolfa et al. found that therapists' sexual attraction was more likely to be perceived as harmful if the patient was aware (rather than unaware) of the therapist's feelings, Giovazolias and Davis reported that the patient's awareness was associated with positive effects. The discrepant findings by Giovazolias and Davis are noteworthy. Given that this study was conducted several years after the other three cited, it is possible that these findings reflect therapists' growing acceptance of their sexual attraction and ability to effectively process and understand their feelings and thoughts as they relate to the

therapy dynamics. It is also possible, however, that the methodology used by Giovazolias and Davis influenced their findings. The researchers content-coded therapists' responses to open-ended questions for these data. Therapists may have been more self-conscious in writing out narratives, leading to a self-serving bias in their reporting.

The graduate student therapists in Ladany et al.'s (1997) study indicated that their feelings of attraction "created tension or distance (e.g., the therapist was cautious and distanced herself from client to compensate for sexual attraction)" (p. 418). These therapists also reported that the attraction contributed to therapists' loss of boundaries or objectivity, distraction from what the client was saying, and/or complicated the termination process.

Finally, Harris' (2001) study of MFT graduate students revealed a remarkable finding. When asked prospectively what they thought the potential effects of their sexual attraction to a patient would be on the therapeutic process, a striking 65% reported that if they did experience feelings of attraction, they could make sure that those feelings would not affect the treatment.

What Training on the Topic of Romantic and/or Sexual Feelings, Thoughts, and Behaviors Do Therapists Receive and What Are Their Evaluations of that Training?

Research findings indicate that training on the topic of sexual feelings toward clients is offered in various contexts of graduate clinical and counseling programs, but is generally regarded by therapists as not adequate. Blanchard and Lichtenberg (1998) surveyed training directors of APA-accredited counseling psychology programs. Nearly all (97.4%) of the directors thought that the topic of sexual feelings toward clients was important to include in training programs and 95% indicated that the topic was formally addressed in their training programs in practicum (89%), class (55.6%), informal discussion (52.8%), and seminar (44.4%). The most commonly cited reason for including such training was the likelihood that therapists would experience sexual attraction to patients.

Notably, research studies conducted in the 1980s and 1990s revealed that a substantial percentage (40% to 55%) of the practicing therapist participants from various disciplines reported that they received little or no formal education in their graduate training programs or in their internships regarding therapist sexual attraction to patients (Bernsen et al., 1994; Blanchard & Lichtenberg, 1998; Nickell et al., 1995; Pope et al., 1986, 2006; Rodolfa et al., 1994). Participants in the Rodolfa et al. study indicated that what training there was occurred primarily during supervision, rather than during a structured seminar or class. Nickell et al.'s finding also suggested that clinical supervision provided better, though still infrequent, coverage of the topic. In his more recent summary of the topic, Pope (2000) concluded that training in the area of sexual attraction in therapy remains woefully underdeveloped.

Not surprisingly, Pope et al. (1986, 2006) and Bernsen et al. (1994) found that only a small percentage of therapists in their samples thought that they had received adequate training on the subject (9% and 10%, respectively); their results were mirrored more recently in the narratives of Ladany et al.'s (1997) and Rodgers' (2011) participants. Blanchard and Lichtenberg (1998) reported a somewhat higher percentage (about 33%). Those who reported their training as adequate reported that the training occurred in a significantly greater number of contexts (e.g., practicum, class, informal discussion, seminar). Shedding a bit more light on the issue of what constitutes adequate training, Paxton, Lovett, and Riggs (2001) reported that having an ethics course that specifically addressed issues of sexual feelings in therapy and more comprehensive graduate training (training dealing with sexual feelings in therapy and/or personal attitudes and beliefs about their own sexuality vs. no training other than ethics courses) were each associated with therapist perceptions of being prepared to respond appropriately to their feelings of attraction.

When queried regarding their recommendations to programs and internships regarding training on the topic of therapist sexual attraction to clients, most of Ladany et al.'s (1997) intern therapists noted the importance of including didactic instruction in the graduate curriculum, including the discussion of case examples and the use of videotape training. The majority of respondents also noted the importance of normalizing such feelings and thoughts. Several

underscored the necessity of creating a safe environment for discussions of sexual attraction and discussing what actually the therapist would do in such circumstances.

Conclusion: Reflections and Recommendations

This review of the empirical research on patients' and therapists' romantic and sexual feelings, thoughts, and behaviors in psychotherapy provide a solid foundation for understanding these phenomena. What have we learned? First, it is clear that patients do experience and occasionally express romantic and/or sexual feelings and thoughts in interaction with their therapists. Patients are typically reluctant to disclose their attraction to their therapists. They do enact romantic and/or sexualized behaviors toward their therapists; some behaviors are more common (e.g., flirting, giving the therapist suggestive looks, and sexual teasing), some less common (e.g., initiating phone calls or giving the therapist letters containing sexual material), and some exceedingly rare (e.g., sexually assaulting a therapist). Second, in general, therapists tend to respond to patients' disclosure or enactment of sexualized feelings, thoughts, and behaviors with discomfort, and that discomfort, not surprisingly, tends to negatively affect the therapy. There is some evidence that therapists' emotional responses vary as a function of therapist and client gender, therapist experience, and therapist personality characteristics and appraisal of the disclosure or enactment (e.g., whether it was considered as sexual harassment).

Third, therapists across disciplines commonly experience romantic and/or sexual feelings (sexual attraction) and thoughts (sexual fantasies) about their patients. However, the reported frequencies vary according to the type of experience (i.e., sexual attraction is far more often reported than sexual fantasies) and level of clinical experience (i.e., markedly higher percentages of practicing therapists report such feelings and thoughts than therapists-in-training). Fourth, relatively few patients report awareness of their therapists' attraction to them. Fifth, several therapist factors appear to be associated with their reports of sexual attraction to a patient. Therapist gender is the most common factor; male therapists significantly report sexual attraction and sexual fantasies more often than female therapists. Also noted in the research are therapist age and religious affiliation (moderated by education level and licensure status). Sixth, specific attributes of the patient are commonly associated with therapist sexual attraction, as well as interactions of therapist/patient characteristics (e.g., therapist/patient gender dyads; therapist gender/patient personal attributes). Seventh, therapists acknowledge both negative and positive emotional reactions to their sexual attraction to patients. Although there is considerable variability in therapist reports of their emotional reactions to their attraction, research to date has not identified specific sources of variance with consistency or clarity.

Eighth, therapists react behaviorally to their romantic and sexual feelings and thoughts in a variety of ways. The responses are most often benign or constructive (e.g., introspection, supervision or consultation, discussions with their own therapist). Some are questionable (e.g., disclosing their attraction to their patient; reflexively referring the patient to another therapist). And, alarmingly, in some cases the responses are likely or clearly malignant and destructive (e.g., denying, repressing, or acting out their sexual attraction). Factors affecting therapist behavioral responses are as follows: the therapist's gender, level of education and experience, feelings regarding their attraction, appraisal of whether the attraction would interfere with the course of therapy, the quality of the relationship between the therapist and the person to whom the attraction would be disclosed, perception of the ethicality of the attraction and/or of the disclosure (both in the therapist's opinion and in the opinion of others), and degree of training on the topic of therapist sexual attraction. Ninth, therapists report both positive and negative effects of their attraction to their patients on the therapy process. The valence and degrees of the effects appear to vary by therapist gender and experience level, and, in the case of perceived negative effects, by the therapist's perception of the patient's awareness of the attraction.

And, finally, the data we reviewed suggest that only a minority of therapists rate their training on the topic of sexual feelings, thoughts, and behaviors in the therapy context as adequate. Notably, therapists report the greatest benefit from the experience of a breadth of training contexts (e.g., in seminars, in supervision.), topics (e.g., specific information regarding the phenomena as

well as exploration of the therapist's personal sexual attitudes and beliefs), and methods (e.g., didactic lecture, experiential sessions using videotape).

Implications for Clinicians

The research we reviewed offers clinicians several take-home messages. We want to highlight three. In our opinion, the most fundamental message is that in general clinicians need an "attitude adjustment" regarding the romantic and/or sexualized feelings and thoughts that emerge in their interchanges with patients. They must shift from the all-too-common perception that such experiences are unusual ones that inherently signal the therapist's clinical mistake or ethical/legal misstep, or the patient's malevolent motivation or unmanageability in treatment—a perception sure to generate anxiety, fear, confusion, guilt, and/or anger. Instead, therapists need to perceive the feelings and thoughts as fairly common clinical material that carries meaning regarding the therapist's and the patient's intrapersonal dynamics, as well as their interpersonal exchange. And clinicians must accept the responsibility to explore and understand what that meaning is to advance the treatment and ensure the welfare of the patient. The exploration can take place through careful self-reflection, but should not be limited to such an isolated experience. Clinicians may gain valuable insight through open dialogue with trusted supervisors, colleagues, their own therapists, and peers.

We are not suggesting that it is easy or simple for clinicians to "just get over" the negative perceptions and related emotional reactions they experience when romantic and/or sexualized reactions occur in therapy. This shift takes time and requires clinicians' interest and perseverance. Herein lies our second take-home message. We urge all therapists to actively seek out and engage in training on the topic, not once but several times over the course of their careers to inform their self-awareness and decision making around romantic and/or sexualized reactions. The training should comprise both didactic and experiential components and include an exploration of cultural sex roles and socialization, as well as the therapist's personal attitudes and beliefs about his or her own sexuality. Continuing education workshops, conference presentations, and online education programs offer valuable resources. Clinicians may also form small peer training groups within their professional or graduate communities. Pope and colleagues published two books that include didactic material and a variety of scenarios for self-exploration and group discussion (Pope, Sonne, & Greene, 2006; Pope, Sonne, & Holroyd, 1993). In addition, the group may view and discuss videotapes depicting vignettes of patients' expressions of sexual attraction (e.g., American Psychological Association, 2007).

And third, clinicians who mentor and/or supervise therapists-in-training need to mindfully foster relationships with trainees that encourage discussion of romantic and/or sexualized attractions between the therapist and patient. Then they need to initiate that discussion. The research we reviewed consistently revealed that graduate students experience greater difficulty recognizing and therapeutically managing these reactions *and* are more reticent to bring up the topic with mentors or supervisors. Clinicians should help their trainees normalize their own and their patients' attractions, and emphasize that those feelings, thoughts, and behaviors are certainly relevant and important topics for discussion in supervision and consultation.

Implications for Clinical Researchers

It is now time for a new wave of research—one that advances our knowledge of these complex processes in therapist-patient interactions by expanding existing areas of inquiry and opening new ones. The expansion most obvious to us is to propose and test multifactor models of both therapist and patient experiences of and responses to their romantic and/or sexual feelings, thoughts, and behaviors.

As a case in point, we have repeatedly noted the variance in therapists' emotional and behavioral reactions to their sexual attraction to patients, and some factors associated with that variance identified in different studies. Investigators may now develop and empirically validate models that account for several of those factors at once. For example, more modern research methodologies (e.g., meta-analyses) and statistical modeling techniques may offer a more

comprehensive exploration of the variables involved in whether a therapist seeks supervision and/or discloses his or her sexual attraction to the patient, findings that would be of critical importance given the apparent confusion and ambiguity regarding the ethicality and the effects of each on therapy (e.g., see Fisher, 2004). The same methods may be applied to confirm, or inform changes to, existing guidelines for therapist training on the issues of sexual attraction in therapy (e.g., Brodsky, 1989; Edelwich & Brodsky, 1991; Ford & Hendrick, 2003; Gorton, Samuel, & Zebrowski, 1996; Hamilton & Spruill, 1999; Pope et al., 1993; Pope et al., 2006; Rodolfa, Kitzrow, Vohra, & Wilson, 1990; Vasquez, 1988).

In addition, though undoubtedly more difficult, the time has come to develop methodologies other than surveys that depend on therapist or patient retrospective and prospective self-report. As we noted above, it is likely that respondents' naiveté, poor memories, or self-serving biases confuse the data. Psychotherapy analogue methodologies offer exciting potential. In addition, the examination of case studies (e.g., with task analysis) and use of qualitative methods (e.g., from grounded theory or consensual qualitative research paradigms) could facilitate more in-depth examination of the dynamics inherent in the therapist–patient interchanges and open new areas for further research.

Our review of existing research also highlights some areas for expanded investigation of sexual attractions within diverse therapist-patient dyads. For example, examination of the phenomena in same-gender dyads and dyads that include LGBTQ therapists and/or patients is needed (see Elise, 2002; Hayden, 1996; Spilly, 2008). And, the effects of therapist and patient personal characteristics on experiences of, and responses to, sexual attraction deserve further attention. Notably, the effects of therapists' and patients' sexual values and attitudes, and their religious values and affiliation on the nature of and responses to sexual attractions are topics just barely touched on in the literature (e.g., McMinn & Meek, 1996; Schover, 1981). Also, there is a call for further understanding of these experiences in therapists and/or patients who have survived sexual abuse (e.g., Lijtmaer, 2004).

To develop new areas of inquiry, researchers undoubtedly would benefit from studying the existing clinical literature on the topic, much of which is written from the psychoanalytic or psychodynamic perspective. For example, one potential new area for research concerns the complicated nature of "sexual attraction," whether on the part of the patient or the therapist. Gabbard (1994) and De Masi (2012) draw a distinction between loving feelings, thoughts, and behaviors, and those that are lustful/sexualized. Each type of attraction may serve a different psychological function (e.g., a desire for parental attachment, nurturance, or approval vs. a drive for power and control). Gabbard suggests that for some the experience of being loved intensely may be far more uncomfortable than being lusted after. It may be that some of the gender differences so often highlighted in the research reflect differential experiences of two different types of attraction (Celenza, 2006; De Masi, 2012; Hobday, Mellman, & Gabbard, 2008; Rouholamin, 2007).

Our review also reveals the dearth of research about sexual attractions in contexts other than individual adult psychotherapy. Some have noted the importance of exploring such issues in couples or family therapy (e.g., Harris, 2001; Harris & Harriger, 2009) and in group therapy (e.g., Moeller, 2002). Others have written about the intricacies of sexual feelings, thoughts, and behaviors in the treatment of adolescents and children (e.g., Alvarez, 2010).

In conclusion, Person (1985) referred to the romanticized and sexualized transactions between therapist and patient as "both goldmine and minefield" for the psychotherapeutic process and participants (p. 163). Certainly it is true that these phenomena represent a goldmine for researchers. And with more extensive and refined research, training may be sufficiently enhanced to help therapists think less like they are forced into a dangerous minefield (with the accompanying negative emotional reactions) and more like they can competently explore and understand these potentially rich veins of clinical material for the benefit of their patients.

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