How Therapists Experience and Manage Patients' Romantic and Sexual Feelings for Them

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Abstract

Objective: Many therapists will one day be confronted with a patient develops romantic or sexual feelings toward them. Studies on this topic often remain theoretical in nature and less often focus on how therapists manage such situations. Therefore, this study aimed to investigate how therapists experience this occurrence and manage their feelings.

Methods: In total, eight focus groups were conducted with 36 participants, in Flanders (Belgium). Both therapists-in-training and therapists-in-practice participated, having different educational backgrounds. The data were explored using the principles of thematic analysis.

Results: Therapists indicated that they try to dissuade any further-development of their patients' romantic or sexual feelings by using strategies such as: emphasizing their personal relational status, adjusting their appearance, and by avoiding any physical contact with their patients. Some therapists question their own professional behavior, feeling guilty, confused, or insecure, wondering if they may have, in some way, provoked these feelings. Therapists who are at an earlier stage in their careers experience more difficulties managing their patients' romantic or sexual feelings toward them and worry they will not be considered a good professional therapist if such a situation occurs.

Conclusions: Educational programs in psychotherapy should be more cognizant of the incidence of patients' developing romantic or sexual feelings toward therapists and provide more comprehensive and practical instruction on how to cope with such feelings.

Keywords: psychotherapy, romantic and sexual feelings, managing feelings

Most therapists will be confronted with a patient's romantic or sexual feelings toward them at some point in their career [1]. Studies show that about three quarters of therapists' report that a patient disclosed that they were sexually attracted to them (73.3%), and (72%) of therapists reported that they had patients who made sexual jokes, remarks, looks or gestures at them. Nearly 90% of therapists indicated that a patient has flirted with them and almost half (48.4%) reported that a patient seemed to be sexually aroused in their presence [2, 3].

The patients' feelings, from a more psychoanalytic and psychodynamic perspective, are likely to be indicative of erotic transference, implying that the patients' erotic feelings involve a carryover from the past and a displacement of these feelings onto the therapist [4-7]. Although newly emerging, other therapeutic orientations have been trying to understand and explain these romantic and sexual feelings from their own theoretical framework. From a cognitive-behavioral therapy perspective, it is suggested that patients can develop such feelings because they feel socially isolated and their romantic schema is activated (e.g., when it includes listening attentively, as often enacted by therapists), and/or due to their cognitive distortions, they might easily conclude that the therapist is a 'wonderful' person, based only by being treated with respect by the therapist [8].

Despite the high prevalence and the insights of the occurrence, therapists-in-training seem to be ill-prepared to deal with romantic or sexual feelings directed toward them by a patient, effectively. This topic is neglected in training programs and reluctantly discussed in supervision [9-12]. Furthermore, about half of family-therapist trainees (51%) reported that they would not feel comfortable dealing with a patient if that patient was sexually attracted to them [13]. The qualitative study of Luca [14] showed that trainees who actually encountered such situations felt guilty, believing they themselves caused the sexual attraction of their patient, and they anticipated the moral judgements of their colleagues and supervisors. A similar result was found in a qualitative study of female therapists, where they reported fear of

rejecting their patient and the retaliation this could bring (e.g., fear of being at fault), when feelings were not mutual. In case of mutual feelings, they described a conflict of roles (between themselves as sexual women and as therapists) [15].

This discomfort with a patient's sexual feelings toward them, may harmfully influence the therapist's perception of the patient [1]. Studies show that a considerable number of therapists perceive a patient's sexualized behavior towards them, such as sexual verbal remarks (34%), receiving letters or telephone calls of a sexual nature (44%), as sexual harassment [3, 16]. A therapist's discomfort with the perception of being sexually harassed has the potential to negatively affect the therapeutic process [1].

For therapists to appropriately manage the incidence of patients' having romantic or sexual feelings toward them, therapists are encouraged to acknowledge what is happening or has happened and being fully aware of the own feelings, reflect mindfully on them, preferably with colleagues or supervisors [17, 18, 4, 8]. Additionally, skill training in being assertive (i.e., expressing personal thoughts, feelings, and appropriate boundaries, while continuing to maintain respect for the patient) can be helpful, as well as the improvement of distress tolerance skills (e.g., paced breathing) [8].

However, scientific literature is currently focused on using a theoretical viewpoint on how to manage romantic and sexual feelings in a therapeutic relationship (i.e., guidelines). It is essential and would be highly valuable to have more practical oriented studies; those that investigate how therapists deal with these situations in their daily practice. These latter studies remain scarce and are often limited to (hypothetical) experiences of trainees or case-studies. Therefore, this study aims to gain further, in-depth knowledge about how therapists (those in training and in practice) experience and manage patients' romantic and sexual feelings in psychotherapy. The results of this study, conducted in Flanders (Belgium), might give input

for educational programs to more adequately address and guide therapists when encountering romantic or sexual feelings of their patients.

Method

To explore more in-depth therapists' experiences and the management of their patients' romantic and sexual feelings from within the therapeutic relationship, we conducted focus groups in Flanders, the Dutch speaking Northern Region of Belgium. A pragmatic (i.e., more practice-oriented) approach was used, aiming to provide input for educational programs [19, 20].

Participants and recruitment

All Flemish speaking accredited therapists could participate in the focus groups. Key figures in the field (mainly training coordinators) made a non-committal and general appeal for our study within their own networks. The number of focus groups was not pre-determined, but rather guided by saturation of data, constraints of time and resources, and finding participants [21, 22]. This resulted in eight focus groups with 36 participants, with varying group sizes, ranging from 3 persons (1 group), 4 persons (4 groups), 5 persons (1 group), up to 6 persons (2 groups). Of the participants, 28 were female and 8 were male therapists. Most therapists were in the age group of 20 to 39 years (n=14) or in the age group 40 to 59 years (n=17). Only 5 therapists were 60 years of age or above. Participants consisted of psychiatrists (n=8), psychologists (n=10), and therapists with other backgrounds, unknown to the researchers (n=18). The participants predominantly followed/were following integrative/interactional psychotherapy (n=11) and systemic psychotherapy (n=19). Almost half of the participants

(n=17) had between 0-5 years of professional experience. Of the participants, 14 were trainees in their first specialized psychotherapy training.

Data collection and research instrument

The focus groups were held from February 2018 to May 2019, were consistently moderated by the same person, using a questioning route (Table 1). The questioning route is based on literature [1, 3, 2, 23, 13] and was discussed with all co-authors, who have experience with both (qualitative) research methodology and psychotherapy practice.

At the start of each focus group, a short questionnaire was given to participants to collect data about age-category, gender, and type of education. These were closed questions with response categories (e.g., for type of basic education, response categories were: 'psychiatry', 'psychology', and 'other'). Furthermore, the moderator (first author LV) verbally explained the aim, rights, and procedures of the study, as described in the informed consent. After all participants had given their written consent, the permitted audio recording was started.

First, therapists introduced themselves. They were asked to bring to mind a situation with a patient who experienced romantic or sexual feelings for them. All participants were invited to talk freely about their particular situation. The moderator ensured that topics, such as perceptions and management of the situations, were also discussed. At the end, based on the aims of the study, each group reflected on the topics discussed, identifying the most important topics as well as which of these important topics were, perhaps, not (thoroughly) discussed, thereby enhancing the validity of the focus group findings [21, 24].

After each focus group the moderator took notes with regard to her impressions about the course of the focus groups, as well as personal feelings and experiences. These notes were

discussed with the supervisor of the study. The duration of the focus groups was between 90 and 140 minutes.

Data analysis

The audio recordings of the focus groups were transcribed and then analyzed using the software package NVivo [25]. Thematic analysis was done to explore the data [26]. Due to the pragmatic approach no theoretical framework was used.

The iterative process of data analysis consisted of subsequent steps. First, the researchers immersed themselves in the data, by reading and re-reading the transcripts three times each. Initial coding ideas were discussed among the researchers (open coding) and adapted based on these discussions. These codes were listed in a codebook, clearly describing the meaning of each code, along with a detailed description. Codes determined during this phase were, e.g., 'blocking patients', 'appearance', 'avoiding', 'feeding feelings'. Then, a line-by-line coding was done. Researchers then reviewed and refined the codes further, based on their search for similarities and differences across responses (axial coding), and adapted the codebook accordingly (see supplemental file). For example, under the denominator of the initial code 'blocking patients' (i.e., referring to dissuade the development of patients' romantic and sexual feelings) the codes 'appearance' and 'family' were added. Lastly, the researchers examined the core themes along with the larger structure in which these core themes are embedded (selective coding). This iterative analysis process stopped once saturation was reached (i.e., when the ability to obtain additional new information was saturated so that no new information could be obtained) [27, 28].

To ensure trustworthiness, from the start until the end, co-authors were closely involved in this iterative process, including the determination of reaching data saturation, while continuously reflecting and discussing with each other [29, 30]. More specifically, LV

took the leading role in organizing meetings between researchers, coding transcripts, creating and adapting the codebook, creating a first outline to describe results, and a narrative to further elaborate the description of results. HVP and JB also independently coded transcripts, were involved in discussions to unify codes, and reviewed all of LV's work. RVO, FM, and DDW were involved in the meetings to discuss core themes and description of results.

Ethics

Study approval was received from the Medical Ethics Committee of the Vrije Universiteit Brussel (B.U.N. 143201524243). Participation in the focus groups was voluntary, and no incentives were given. Prior to the start of the focus group, the moderator thoroughly informed participants about the aims of the study and all points mentioned in the informed consent. Once all concerns were satisfied, the informed consent form was signed by both the moderator and participant. Throughout the study, the privacy of all participants and the confidentiality of their input were protected by deleting all references to the identity of participants in the transcripts, deleting the audio recordings, and through storage of the study transcripts on a secure platform of the university, which is only accessible to the researchers involved. The data collected will be used only for scientific analysis.

Results

Analysis of the data established that when patients indicate, either through behavior or disclosure, that they have romantic or sexual feelings toward their therapist, it elicits disparate thoughts and emotions within the therapist. The most prominent of these were self-doubt; questioning their own self-competence, accompanied with the feeling of discomfort. The self-doubt and discomfort being experienced by therapists was most significant in young, early career therapists; those between 20-39 years of age and with 5 years or less experience. Also

identified in the data analysis, were therapists' specific strategies to dissuade any (further) development of romantic or sexual feelings from their patients. Once aware that a patient had developed romantic or sexual feelings toward them, therapists set firm boundaries or, when appropriate, therapy was terminated. Young, early career therapists, at times, did not know how to handle these situations and tried to ignore certain behaviors or statements from the patient. Researchers also noted that therapists found it difficult to seek help and support within their work environments (Figure 1).

Therapists' perceptions regarding patients' romantic or sexual feelings and accompanying emotions

Most participating therapists indicated that the development of patients' romantic or sexual feelings towards their therapist would be considered a human and natural phenomenon within the course of the psychotherapeutic process. One participant described it as follows: "I think it's human that patients fall in love with their therapist. I get that because you open yourself for that therapist". Another participant described that perceiving these romantic feelings of the patient as something human, helped her in dealing with this situation. She said: "It's human of him. I don't want to blow this out of proportion. I shouldn't view this as transgressive behavior. Things like that happen".

Despite perceiving these romantic and sexual feelings of the patient as a natural human response, it continued to elicit a number of negative emotions and thoughts within the therapists. Some therapists did indicate that they had concerns as to whether they had behaved professionally. More specifically, they wondered if they had in some way provoked or encouraged the emergence of these feelings. This self-doubt was accompanied with feelings of guilt, confusion, and insecurity. These perceptions and feelings were predominantly expressed by young, early career therapists. One participant described her feelings as follows:

"I thought, 'Am I being professional?', 'Am I keeping enough distance?' That makes me very insecure". Another participant mentioned: "I especially questioned if… 'I did anything to encourage that?' I don't think so, but you wonder about it".

Aside from their doubts, young, early career therapists also indicated that they feel extremely uncomfortable and sometimes overwhelmed by a patient's sexual feelings toward them. This was certainly the case when the patient behaved in an overtly erotic way. This was well illustrated by the following quote: "He sat there with his legs open and his crotch thrust all the way forward. It threw me off; took me off guard. I sat there all cramped up". Not only female participants mentioned to be uncomfortable or overwhelmed. One male participant described the following situation. "I had a female patient that entered the consultation room in a very seductive way. She was being very flirtatious and I felt very intimated. I sat back further and further in my chair".

It was often indicated, by the more experienced therapists, that they sometimes experienced positive feelings in this context, such as feeling flattered. Nevertheless, even among the more experienced therapists, a kind of self-doubt never completely vanished. One participant described it as a pleasant, but inappropriate way to be affirmed. Another participant said: "It's flattering for you. But at the same time, you wonder if it's professional." Along with the therapists' self-doubt, there was also the concern that romantic or sexual feelings of a patient toward the therapist might interfere or disrupt the therapeutic relationship. This is illustrated by the following quote: "It's of course nice to hear when someone thinks you're amazing or attractive. That's nice. But it sometimes blocks you in your work, and that shouldn't happen".

Managing patients' romantic and sexual feelings for the therapist

Not provoking or further encouraging patients' romantic or sexual feelings

Overall, it was well established that therapists of the focus groups made conscious efforts to avoid any behavior that might provoke or further the development of romantic or sexual feelings of a patient when this type of situation occurred. The therapists conducted themselves in ways that would not give hope to patients that something romantic could happen between them and that discouraged any erotic fantasies. They quite intentionally employed several strategies in an effort to prevent such feelings from developing One of these strategies was to let the patient know that they are already in a steady relationship, and therefore 'not available' for them. This was mentioned rather directly, as one of the participants said, "I sometimes hear myself say, 'I'm married'. That's preventive". Sometimes this message is conveyed more implicitly. One of the participants deliberately had a picture of her children on her screensaver. She said: "This picture of my children implies there is also a husband or partner."

Another strategy used by the therapists to prevent romantic or sexual feelings from emerging or further encouraging these already present feelings, was the adjustment of their appearance. Therapists were mindful of how they dressed and groomed themselves in their roles as therapists, thus presenting themselves in an appropriately professional manner with the intention of eliminating a patient from interpreting their appearance as sexually appealing. Only female therapists mentioned using this strategy. One female participant said, "I like to wear bright red lipstick, but when I know that I have male patients that day, then I will certainly not wear that!". This is further illustrated in the following excerpts:

P1: "But sometimes you're very conscious about what you wear".

P2: "I really do think about that in the morning".

P3: "Me too. And I think, 'I certainly shouldn't be wearing an open blouse today'".

Not touching patients of the opposite gender, was also mentioned as strategy. Though there were situations where touching the patient was perceived as beneficial to the patient,

some therapists refrained from doing so. Both female and male therapists mentioned this, but male therapists seemed to be even more careful than their female counterparts. One male participant stated: “As a man, I’m very aware of it. I very rarely touch my patients, though I know that it can be healing at times to do that. I’m careful in what I stir in someone else. Especially in a heterosexual male-female relationship, you might conjure up sexual or erotic feelings”.

Setting firm boundaries

The ways in which patients expressed their romantic and sexual feelings were diverse. Some seem to develop genuine feelings of love, while others act provocatively enticing or erotic, often due to their pathology. In addition, the intensity of these feelings differed between patients. In all cases, but most certainly in a case where extreme feelings or behaviors are present, therapists most often tried to handle the situations by ‘setting firm boundaries’. This seems to refer to indicating what is and what is not acceptable within the therapeutic relationship. One participant mentioned: “There are men and when they say that they think I’m attractive and then make propositions… I block those off immediately”. Another participant said: “I try not to stir up that fantasy. For me, it’s searching for the right boundaries and distance. I’m going to make clear that there are boundaries”. However, it was not always clear if setting boundaries referred to boundaries for the patient or for the therapists themselves. One participant mentioned: “I think that following that boundary very strictly has made sure that I have been able to work professionally with this patient”.

Referring to another colleague

Despite setting firm boundaries, in some cases therapists indicated that they terminated therapy because it was impossible to work therapeutically with the patient. The patient was

then referred to another colleague. This is made clear with the following quote: “I had to stop therapy one time. That man fantasized tremendously. I said ‘Sir, this can’t go on like this’”. Another female therapist described the situation with a patient having erotomaniac delusions. She said: “It was a difficult decision, but eventually I very consciously asked a male colleague to take over this patient”.

Ignore and saying nothing about it

Young, early career therapists indicated that they found it difficult to appropriately manage these romantic or sexual feelings of their patients. As mentioned earlier, some of the young, early career therapists were overwhelmed by a patient’s feelings toward them, certainly in the moment itself, in the therapy room. Sometimes, they did not know how to manage this type of situation, and therefore just tried to ignore what happened. One participant said: “I didn’t know how to react, so I avoided it at the moment”. Another participant commented: “I didn’t know what to do, so I just ignored it”.

In addition, some of these young, early career therapists indicated that they found it difficult to discuss and search for help and support within their own work environment when they encountered a romantic or sexual situation with a patient. This was largely due to their own doubts of having behaved in an ethically correct way and questioning if they may have unintentionally provoked the development of the patients’ romantic or sexual feelings toward them (as mentioned earlier). The young, early career therapists also shared that they were somewhat reluctant to bring these situations up because they were concerned about the opinions of their colleagues. They affirmed that, especially when young and just starting out somewhere new, there is anxiety about not being perceived as a good and professional therapist. Discussing a situation like this could be a huge risk for their reputation if in some way they are viewed as responsible or having contributed to the situation, even if it was done

so unwittingly. This is made clear by the following quote: “I thought, maybe I gave a wrong signal to this patient? That stopped me from saying something about it (to my colleagues). I had not worked there long at the time either. Now, it would be much easier to mention, I think”. Another participant added: “When you’re just starting out, you look at yourself more to see if you are the one who caused the problems. If you have more experience and certainty about your job and function, and you know your colleagues better, then it will be easier to say something about it”.

Discussion

This study showed that when romantic or sexual feelings toward a therapist are experienced by a patient, therapists question their own professional behavior. They wondered if they, in any way, may have provoked the patients’ feelings. Their doubt was accompanied by other feelings such as guilt, confusion, and insecurity. Predominantly young, early career therapists expressed feelings of doubt and questioned their own behavior as a potential cause for their patients’ feelings. Also, they felt uncomfortable, especially in situations where the patient’s behavior was overtly erotic. However, despite these negative emotions, older, later career therapists conveyed that at times they felt flattered, even when some doubt about their individual professionalism still remained. In contrast to the therapists’ self-doubt, it was considered to be quite normal and a natural human response for patients to develop such feelings for the therapist. The study further highlighted that, above all else, therapists actively tried to prohibit patients from initially developing these intimate feelings toward them or from encouraging any further development. The therapists used specific strategies in their efforts to limit these kinds of feelings in patients, such as emphasizing their personal relational status, adjusting their appearance (female therapists only) and refraining from physical contact with patients. For this latter strategy, even if touch could have provided added therapeutic value,

patients of the opposite gender were not touched. It was reported that therapists felt it was of import “to set firm boundaries” to manage patients’ romantic or sexual feelings. However, “to set firm boundaries” is an ambiguous term, leaving this strategy’s application somewhat vague. Sometimes therapy was terminated if the situation had become unmanageable for the therapist. Especially young, early career therapists experienced more difficulties in managing these types of feelings experienced by the patient. Some of them reported that they had ignored certain inappropriate statements or actions by the patient, because they were unsure as how to react. These young, early career therapists, proposed that the presence of self-doubt and the fear of being perceived as an unprofessional or underqualified therapist by their colleagues, created a barrier for them in seeking help and support within their work environment.

An important result of this study was that anxiety was a common response by therapists when considering their own possible influence in the emergence or further development of a patient’s romantic or sexual feelings toward them. Therapists often question themselves to assess whether they may have contributed in some way to furthering these feelings. The therapists’ sense of personal responsibility and reflexivity has also been found in other studies [14, 15] and as such this is perhaps not so surprising. Good therapists are expected to question themselves, reflect on what they feel and do during therapy. Maintaining some physical distance or adapting their appearance to minimize the possibility of generating certain romantic or sexual feelings can be framed in this context.

Being overwhelmed in certain (overtly erotic) situations with patients, ignoring such situations (i.e., not knowing what to do), and being fearful to disclose this in their work environment, proves consistent with results of earlier studies on therapists-in-training [14, 13]. Interestingly, interpreting transference, i.e., the meaning of patients emerging sexual feelings (e.g., what needs in the patients were being evoked) was not mentioned by any of the

study participants. These are concerning findings that provide a clear indication that more and timely guidance is needed. Although there currently is a better understanding of erotic transference in orientations other than psychodynamic [31, 32] and these other orientations, such as cognitive behavioral therapy, have recently developed explanations and guidelines for managing patients' attraction from their own framework [8], some psychodynamic education and training is also recommended for therapists working in that orientation. It will likely take significant time and effort before these perceptions and guidelines, as described in scientific literature, are adequately addressed in educational programs, and become part of the daily practice of all therapists, regardless of their main orientation.

Conceivably, a first hopeful result, indicating positive change, is recognizing that none of our participants reported having been sexually harassed by their patients. This would stand in direct contrast to earlier studies [3, 16]. Although they sometimes felt overwhelmed or intimidated by some (overtly erotic) situations, they also believed that such feelings experienced by the patient are both human and a naturally occurring phenomenon in psychotherapy. However, it cannot be ruled out that therapists who have experienced sexual harassment, by a patient, might have been unwilling to participate in the study or were unable to participate, by chance, given the rather small sample.

One remarkable finding in this research, which was also confirmed in another study [14], was the understanding that some therapists used their personal relational status (e.g., being married) to manipulate or control the romantic or sexual feelings of the patient. Although it might be a helpful strategy to adjust a patient's romantic or sexual expectations, it cannot – by definition - be considered an appropriate strategy. It is not a technique, or an intervention, but rather a statement of fact used as a buffer to lessen or moderate a potential uncomfortable conversation or situation. Not all therapists can rely on this statement as a buffer, as not all therapists are married or in committed relationships. It may be that this type

of statement about personal relational status feels like a comfortable or safe option for the therapist to keep the patient at a distance. It looks like they prefer to hide behind their personal situation rather than engage in a more difficult conversation with a patient (when necessary) about their emerging feelings. It seems to confirm the anxious response and fear such situations can generate, as was mentioned earlier. This result would suggest that therapists are not (or do not feel) sufficiently equipped to handle the situation and therefore, out of necessity, use what they have available to avoid the situation all together.

A strength of this study is that it provides more comprehensive information about therapists' experiences and management of romantic and sexual feelings of patients toward them. Due to its pragmatic approach, it may highlight valuable and useable input to advance educational programs in the field. A limitation of the study is that therapists were predominantly integrative/interactional and systemic psychotherapists, therefore sufficient experiences of therapists with more diverse educational backgrounds were missing. Furthermore, due to practical reasons, only two focus groups with psychiatrist participants were conducted. This was unfortunate, as psychiatrists might have experienced other sorts of situations involving patients being sexually attracted to them, due to the pathology of these patients. The number of participating male therapists was somewhat limited, and the sexual orientation and gender identity of the therapists was not considered. Finally, it cannot be excluded that therapists feeling considerably free to talk about such sensitive issues in psychotherapy, were more likely to participate in the focus groups. Therefore, more research on this topic would be interesting, e.g., exploring differences in interactions between therapist and patient according to gender identity and sexual orientation. Consequently, it might also be useful to appraise therapists' romantic and sexual countertransference reactions.

Overall, romantic and sexual feelings in psychotherapy should be addressed more often in the course of psychotherapists' training to include the theoretical perspective (e.g., erotic transference), but also to provide a more practical and solution-oriented perspective, thereby providing therapists with clear guidelines for professional behavior and expectations in practice. Needless to say, more effort is necessary to reassure young, early career therapists that they can safely talk about their experiences with their supervisors or colleagues, when patients are romantically or sexually attracted to them or behave in a sexually explicit way. It is understandable that young, early career therapists are hesitant to initiate such a sensitive and personal topic, especially when they are fairly new in their position. It might be helpful if supervisors and colleagues themselves proactively bring up this topic on a more frequent basis. This might help communicate the message, that all therapists can encounter patients developing romantic or sexual feelings for them, regardless of their age, stage of career, or professionalism.

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Table 1

Questioning route focus groups

Opening	1. Introduce yourself (name, professional background, …)
Key Question	2. Bring to mind a situation with a patient who experienced romantic or sexual feelings for you. Topics: • Managing of situation • Differences based on gender • Personal relational status • Appearance • Ethics • Ability to discuss this in the work field • Perceptions and evoked emotions
Ending	3. What are the most important issues that have emerged during the discussion? 4. Did we forgot to discuss other important issues? Which one?

Figure 1:
Overview themes