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Sexual feelings towards clients in the psychotherapeutic relationship: the taboo revealed.

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Abstract

Talking about sexual feelings towards clients is still difficult for many mental health professionals. This is unfortunate, because exploring and talking about these feelings with peers (especially senior ones) or supervisors can help professionals to recognize, acknowledge, accept and handle these feelings well. This focus group study explores the various factors that contribute to psychotherapists' hesitancy to talk about these feelings. The analysis revealed two important impeding factors: the psychotherapists felt discomfortable and a safe environment was lacking. Young, less experienced psychotherapists and psychiatrists seemed to be most vulnerable. Furthermore, more profound sexual feelings were 'disguised' in some cases by using a more acceptable narrative, such as ' intimate feelings', which possibly also impeded acknowledgement and discussion of these feelings. These insights might help to open up the way for psychotherapists to explore and come forward with their sexual feelings and experiences.

Keywords: psychotherapy, sexual feelings, taboo, intimacy, focus group

Introduction

It is not uncommon for psychotherapists to have sexual feelings for a client. Previous studies have shown prevalence rates for sexual attraction towards clients ranging from 60 to 90% and around a quarter of therapists have had sexual fantasies about a client (Garrett & Davis, 1998; Ladany et al., 1997; Pope, Keith-Spiegel, & Tabachnick, 1986, p. 40; Pope & Tabachnick, 1993; Pope, Tabachnick, & Keith-Spiegel, 1987; Rodolfa et al., 1994; Sonne & Jochai, 2014). In this context such sexual or also romantic attraction of the therapist might be considered as erotic countertransference (Gabbard, 1994).

Countertransference is defined by Hayes et al. (2018), as "internal and external reactions to clients in which unresolved conflicts of the psychotherapist, usually but not always unconscious, are implicated". It is seen as reactions not only to a clients' transference, but to many other factors as well. Countertransference can be elicited, not only by erotic transference, but due to diverse reasons, e.g. from clients who are low-income (Thompson et al., 2015). This countertransference of the psychotherapist is not necessarily problematic. It might be used to benefit clients, if managed well. Supervision helps in self-insight and management of this countertransference (Hayes et al., 2018). Exploring and talking about sexual feelings can be helpful to recognize, acknowledge, accept and handle these feelings, and to enhance the general wellbeing of psychotherapists (Bridges, 1994; Bridges, 1998; Hayes et al., 2018; Pope, Sonne, & Holroyd, 1993, p. 79). Unfortunately, for many years, sexual feelings towards clients have been and still are largely taboo topics within the mental health professions (Barnett, 2014; Edelwich & Brodsky, 2014; Luca, 2014).

Sexual feelings often elicit negative emotions, such as shock, discomfort, shame, anxiety, confusion, anger, and guilt (Giovazolias & Davis, 2001; Ladany et al., 1997; Pope et al., 1986; Rodolfa et al., 1994; Sonne & Jochai, 2014). Also, there is fear of condemnation of

colleagues and supervisors, or being afraid they would not react supportive when these feelings are expressed (Harris, 2001; Ladany et al., 1997; Sonne & Jochai, 2014).

These emotions should be contextualized in an environment where a good therapist is perceived as someone that helps clients and provides care. The therapist having sexual feelings for a client contradicts with the image of a good therapist (Barnett, 2014; Pope, Sonne, & Greene, 2010, p. 37). One study found that experiencing sexual attraction (22%) and having sexual fantasies (33%) were perceived as unethical by a sizable minority of therapists (Pope et al., 1987). Another study found that the majority of therapists indicated that continuing therapy when being in love with a client (87.4%) and flirting with a client without ulterior motives (97.2%) is completely or rather unacceptable (Vesentini et al., 2020).

In the ethical guidelines of all major professional associations it is clearly mentioned not to act out on sexual feelings, i.e. starting a sexual relationship with a client (American Psychiatric Association, 2013; American Psychological Association, 2016; European Association of Psychotherapy, 2018; European Federation of Psychologists' Association, 2015). In some countries, such as the United States of America, Canada, Australia and New Zealand there is a criminal legislation regarding sexual relationships with clients (Tschan, 2014, p. 22). These guidelines and legislation help to maintain the negative emotions that sexual feelings can elicit and confirm the perception that a good therapist does not experience sexual feelings.

Unmistakable, all these factors, often interrelated to each other, impact the hesitance to explore and talk about sexual feelings for clients (Barnett, 2014). Only around 50% of therapists sought supervision or consultation to discuss their sexual feelings (Giovazolias & Davis, 2001; Pope et al., 1986; Stake & Oliver, 1991).

This study was conducted to gain further in-depth scientific knowledge about the psychological and sociological factors that contribute to this hesitance to explore and talk about sexual feelings towards clients, and the complexity of how the topic is silenced.
In this study, conducted in Belgium, where no penal codes for starting sexual relationships with clients exists, we aim to explore the various factors that contribute to the hesitance of psychotherapists to talk about these sexual feelings. Furthermore, we aim to gain more insight into how this hesitance is expressed narratively and in interaction with peers. The meaning of sexual feelings in this study is to be taken broadly. It is not just sexuality purely in the sense of lust perception of oneself or another person. When sexuality overlaps with the concepts of intimacy, referring to warmth and trust (e.g. romantic attraction), and eroticism, referring to seduction and the sexualization of an intimate situation (e.g. sexual fantasy) it is also included (Heemelaar, 2000). The results of this study might have positive implications for practice. It might help to open up the way for psychotherapists to explore and come forward with their sexual feelings and experiences towards clients when they need to do so, which is ultimately beneficial for the psychotherapeutic relationship, the psychotherapist and the client.

Method

Study Design

To explore psychotherapists' experiences of sexual feelings towards clients, we used focus groups. This is a very suitable method for obtaining rich information about subjective views and feelings on a specific theme. Although some responses may be the result of conformance, conflict avoiding, etc., focus groups provides, for this reason, valuable additional information about interactions between participants related to the topic under research and their discourse in this condition. It contributes to our insight into discussions that these topics might also

evoke on the work floor (Kidd & Parshall, 2000; Wellings, Branigan, & Mitchell, 2000). Furthermore, instead of silencing therapists, the group interaction might also encourage participants to share certain opinions and feelings when other participants also express them.

Participants

The focus groups were conducted in Belgium with Flemish-speaking psychotherapists, consisting of psychiatrists, psychologists and therapists with another basic education. Most of them followed or were following specific psychotherapy training. In total, 36 participants attended the focus groups, of whom 28 were female and 8 male therapists, of whom 14 were between 20-39 years, 17 were between 40-59 years, and 5 were 60 years or older (mean 44.3 years ± SD 11.8). Regarding basic education, 8 participants were psychiatrists, 10 were psychologists, and 18 had another basic education (See supplemental file 1).

Recruitment

An appeal to participate at the focus groups was made 1) at the end of a survey on the same topic that was sent to all psychotherapists in Flanders, and 2) through key figures in the field (mainly training coordinators) who made a non-committal and general appeal within their own network. There was no incentive to participate to the study, or a requirement as part of their employment. In total, 8 focus groups were held, varying from three to six persons (supplemental file 1). The small groups of three persons were mainly due to signed-up participants who cancelled their attendance at the last minute. Focus groups are ideally homogenous to enhance sharing perceptions and experiences within the group discussion, but with sufficient diversity among participants to allow for contrasting opinions (Krueger & Casey, 2015, p. 81). There was great diversity among the participating psychotherapists in terms of gender, age, basic education, type of psychotherapy training, type of practice and

years of experience (supplemental file 1). Of the 8 focus groups, two homogeneous groups were conducted with solely psychiatrists and one group with solely interactional/integrative psychotherapists. Four groups were homogeneous on several aspects: one was with solely female interactional/integrative psychotherapists, two with solely female systemic psychotherapists, and one with solely female systemic young psychotherapists.

Data Collection

The focus groups were held between February 2018 and May 2019 (supplemental file 1), and moderated by Lara Vesentini. Before the start of each focus group, she went through the informed consent document with the participants, which then was signed by both her and the participants. Furthermore, a short questionnaire was given to participants to collect their demographic and professional characteristics, such as age, type of education, type of practice, and years of clinical experience in psychotherapy.

The main task for participants was to think about an intimate or sexually explicit experience with a client and to describe the emotions and thoughts it evoked (Supplemental file 2). Intimacy and sexuality were not defined in advance by the researchers, but could be constituted by participants themselves. To help participants in their reflection process and start the conversation, each of them received a set of 26 cards in an envelope that they could explore in silence at their leisure. On each card a certain emotion or thought was printed, either positive or negative in nature, such as: happy, fear, appreciation, reputation, love, insecure. Participants were invited to describe other additional emotions or thoughts if they felt like it. Although this approach of working with cards is not common, it has some important benefits (Colucci, 2007). Firstly, it gives participants extra time to reflect and formulate their opinion. Their opinion can be initially formed without the influence of the opinion of peers, which will enrich the discussion afterwards. Secondly, this sensitive topic

might appear less threatening when it is discussed trough a practical task. Thirdly, by giving cards with emotions and thoughts to choose from that were negative and positive in nature, the implicit message was given that all opinions were welcome. The words were inspired by previous qualitative studies on this topic (Arcuri & McIlwain, 2014; Ladany et al., 1997; Markovic, 2014; Martin, Godfrey, Meekums, & Madill, 2011), and reflections on this topic with the co-authors and co-researchers (Hubert Van Puyenbroeck, Dirk De Wachter, Frieda Matthys, Charlotte Benoot and Johan Bilsen) qualified in qualitative research.

During the discussion about the emotions and thoughts, evoked by intimate or sexually explicit experiences with a client, there were additional questions about the importance of appearance, differences based on gender, being single or in a partner relationships, is their hesitance to talk about this topic, etc. We rounded off the focus groups by defining together the main issues.

In order to counter social desirable answers to obtain an accurate reflection of participants' feelings and thoughts, the confidentiality of the gathered data was thoroughly assured, safety was (attempted) to build up during the focus groups, and the issue of answering socially desirable was brought up to participants. Furthermore, the moderator was attentive to how participants told their story, observed interaction between participants, and sought clarification on areas of ambiguity.

Data Analysis

Focus groups were audiotaped and transcribed. We used the software package QSR International's NVivo 12 (QSR International Pty Ltd., 2018) to explore the data according to the principles of thematic analysis (Braun & Clarke, 2008). First, independently two researchers, Lara Vesentini and Hubert Van Puyenbroeck, immersed themselves in the data by reading the transcripts and fieldnotes several times and writing down initial coding-ideas.

They discussed their ideas on a daily base. Secondly, a combination of broad-brush coding was used (i.e. coding conversations about important issues for the group) and a line-by-line thematic analysis of each focus group, i.e. initial coding of the stories, feelings, thoughts, perceptions, etc. of participants (Kidd & Parshall, 2000). Then the researchers searched for themes, reviewed and refined these themes (looking for similarities and differences across participant responses), and finally defined and named the themes. The emerging themes were also regularly discussed with all researchers Dirk De Wachter, Frieda Matthys and Johan Bilsen, from varied points of view, because of their different professional backgrounds, to enhance the plausibility and coherence of the themes. Themes did not only emerged based on numeric content. Because in focus groups agreements and disagreements are fundamental processes, and opinions might change as the group progresses, it was also assessed to what extent responses may have arisen from conformity, conflict avoidance, etc. (Kidd & Parshall, 2000). As such, the way how participants spoke about this topic and how the group interacted were also taken into account. For example, we looked at the discomfort of participants, difficulties in communication (such as repetition, hesitation, lack of clarity), and humor (Barbour, 2014, p. 316; Duggleby, 2005; Wellings et al., 2000). The whole process of data analysis was closely reviewed by the supervisor Johan Bilsen.

Ethics

Approval for the study was received from the ethical committee of the Vrije Universiteit Brussel (B.U.N. 143201524243). Data collection was carried out after participants gave informed consent. The privacy and confidentiality of participants during analysis and reporting were guaranteed.

Results

The analysis showed which factors contribute to the hesitance of psychotherapists to talk about sexual feelings towards clients. The first factor is the attitude and opinions about sexual feelings in the psychotherapeutic relationship. How intimacy and sexuality are placed within this relationship and their opinions about what constitutes professionally and ethically appropriate or inappropriate behaviour, can determine a) whether or not to discuss particular experiences or feelings, and b) how – in which narrative – they would be discussed. A second factor revolves around the theme of 'feeling unsafe'. A distinction was made between internal safety, referring to psychotherapists who do not feel self-confident or 'safe' to be so vulnerable, and external safety, referring to an unsafe, condemning environment of psychotherapists. Finally, observations are described where the sensitivity of the topic came to light in the group interaction, in moments of laughter, silence, backing down and sensing each other.

Attitude and Opinions about Intimacy versus Sexuality in the Psychotherapeutic Relationship

Overall, psychotherapists in our focus groups find it important to behave professionally and ethically towards clients. Their opinion about what constitutes professional behaviour or ethical appropriateness, will therefore influence their behaviour and hesitance to discuss this topic. In general, finding a client attractive and experiencing intimate feelings are perceived as acceptable, whereas sexual feelings are less accepted by some psychotherapists. These opinions are shaped by their professional attitude about the place that intimacy and sexuality can have in this relationship.

Professional attitude.

We observed that some psychotherapists have the attitude that a clear distinction should be made between intimacy and sexuality. They are two different things that do not overlap. They feel comfortable with the subject of intimacy, but less comfortable with the subject of sexuality within the context of the psychotherapeutic relationship. One participant mentioned the following, at the end of the focus group discussion, giving advice to the moderator:

> *P: Disconnecting intimacy and sexuality. Because I believe they are two very different things, although they are thrown together here very insistently. And I do think they are two extremely different things.*

In another focus group, also at the end, the moderator asked the participants how they experienced this focus group discussion:

> *P1: In that sense I found your questions confrontational. […]. Your questions always returned to the theme of sexuality.*
>
> *P2: And we want to talk about intimacy.*
>
> *P1: Yes. […]. That was the case with my... inner struggle. […]. Does it always have to be about sex…*

Opinions.

Attractive.

Overall, psychotherapists in our focus groups have the opinion that finding a client attractive or good-looking is acceptable within the psychotherapeutic relationship, because it doesn't evoke emotions or influence the therapist. They seem to feel rather comfortable with this attraction. One participant described this as follows:

> *P: But being in love is such a heavy feeling, isn't it! For me it's more, come here, sexy thing, but that's something completely different.*

Another participant mentioned:

P: *With that client I've never had the feeling of... er.... that I haven't got things under control or this is getting too... this is taking on a life of its own or something.*

Another example:

P: *[…]. So the thing with me is that I... I block it out, or something. […]. So I... I... it really doesn't happen to me that… I might objectively think that … that that man isn't bad looking, but that's it. It doesn't really do much in terms of... you know. I notice that that part doesn't become involved (when giving therapy).*

Consequently, because psychotherapists do not perceive finding a client attractive as unacceptable, there is less hesitance to mention this to peers or to discuss it and joke about it.

P: *[…]. "So you've seen him again... he was cute, wasn't he…" There is absolutely no taboo on that at all with us. But really... being in love. I don't know if anyone would admit to that. I think that's a step further.*

It is also possible that some psychotherapists who do experience more profound sexual feelings just describe the sexual features of their client, concealing their own feelings. Some of the psychotherapists in our focus groups emphasised in the beginning of the focus group how sexually attractive a client was. Only later, more at the end of the focus group, it came apparent they were really affected by these clients and they had more profound feelings for them. One participant initially mentioned the following about a client:

P: *[…] and er... he just came into the room... really, really virile.*

Later, during the focus group she said about this client:

P: And his wife got angry with me afterwards. And she really said…"You believed my husband more than me" … And they didn't come as a couple anymore. So, there I thought…er … maybe she felt my feelings for him.

Another participant repeated several times how cute a client was.

P1: […]. I've had a really cute dad at the practice before now... and he was a really nice guy as well.

At one point she mentioned that '*more*' could possibly have happened, as the following excerpt illustrates.

P1: […] that at some point… I was like… "You are really cool"… and maybe even a bit more…[…]… I never worked with him for that long.. so it hasn't ..

P2: …this feelings could not grow …

P1: .. yes, and that is not bad I guess…er…but I can imagine that something could have happened between us.

Intimate and sexual feelings.

The opinions about the acceptability of experiencing sexual feelings towards a client are shaped by the attitudes of psychotherapists regarding intimacy and sexuality in the psychotherapeutic relationship. As attitudes differed about intimacy and sexuality among psychotherapists in our focus groups, opinions about the acceptability of it were also more divided. Some psychotherapists have the opinion that more profound sexual feelings are not allowed. Not allowing them to develop is constituted as being professional. For example, one participant said the following:

P: But that happens everywhere, doesn't it, that there are patients that appeal to you more and... well, you're a professional, aren't you? You keep your distance... You close that door...

Another participant had the following opinion:

P: Personally, as a therapist, I don't think I can allow that.

When psychotherapists perceive sexual feelings as unprofessional or unethical, there is more hesitance to discuss these feelings. Whereas intimacy between therapists and clients is still discussable, psychotherapists in our focus groups mentioned that there is clearly hesitance when it concerns sexuality. This is described in the following excerpt:

M: I'll call it an intimate relationship, then. […].

P1: Often that doesn't have sexual implications, I'd say.

P2: Right. Once it becomes sexually charged, I think we don't do it (discuss it).

One participant mentioned the following:

P: […] intimacy and it's easy to discuss and so on, and openness is very good. And that sexuality often goes too far... that's harder to discuss…

As it is more permissible to discuss intimate feelings, it is possible that feelings of a more sexual or romantic nature are described more in terms of intimacy. A few therapists described their intimate feelings for a client, never defining them as sexual or romantic, although the context of their story indicates that they might be. They conclude their story with a more open interpretation of what these feelings might be or what the future could bring, as the following excerpt illustrates:

P: […] it's like, yes,… they aren't sexual feelings, but I did feel something for him. Something more than purely between a patient and therapist. You know…but what exactly it is…

M: A kind of intimacy that went beyond normal professionalism?

P: *Yes, and I call it something like maternal feelings, but I don't know if that's really it. I just don't know what it is. It's strange. But it's certainly not a sexual thing. And it's certainly not friendship either. It's... I don't know. Difficult, isn't it? [Earlier in the conversation: Yes. Yes. And charmed. […] that was something that surprised me about myself. That I was charmed, in a way. […] and… that's so flattering. Yes, it flattered my ego. Yes. He wasn't a bad-looking guy either, so…]*

One participant described her experiences as follows:

P: *I've had a couple of male clients like that... who are... searching... from that kind of emotion... creating a bond and keep coming back and... they like you... but without a sexual... charge... but that is a difference with women. They do it too, towards me I mean. And sometimes that confuses me even more. […]. Then I think… if that was a man I'd keep on seeing somewhere, or bump into in a pub... then it would be... Where are you then, in that grey area?*

Feeling Unsafe

Besides the attitude and opinions about intimacy and sexuality, safety is also an essential aspect when talking about the hesitance to discuss these sensitive topics. The unsafe feeling can arise from being discomfortable with their own feelings, as well as the perception of an unsafe judgmental environment.

Discomfort.

We observed that some of the psychotherapists in our focus groups are sometimes hesitant to discuss these kinds of topics, because they feel discomfortable to be so vulnerable. They will not discuss their emotions and experiences, even if they know there is a person in their

environment who is able to listen in a non-judgmental manner. In one focus group, participants discussed if sexual feelings could be discussed with a supervisor. The feeling of safety was stressed out. One participant mentioned that not every supervisor feels equally safe to discuss this. Another participant responded that besides this, it also depends on your own willingness to discuss this.

> P: *That's not just … your supervisor can be a very safe person... but if you're not prepared for it yourself... then I think that you…The supervisor can bring it up as a theme, but if you are not ready yet to discuss this, it might have a different effect.*

Another participant reported in this respect:

> P: *[…]. What you just said, I think... coming clean with yourself or something... or maybe knowing yourself a bit better or... I think it has to do with that. […]. To an extent it has to do with self-acceptance too, doesn't it?*

Rather young and inexperienced psychotherapists, or psychotherapists with less life experience or less 'sexual self-development', are perceived to experience more discomfort. They are not ready yet to talk about their sexual feelings. Mainly experienced psychotherapists, who look back on their own progress as a therapist, conclude this, as the following quote illustrates:

> P: *When you're older…that you dare to do more... under supervision... When I'm being supervised and there's something sensitive or related to this topic that I want to discuss... I think I'd have found it more difficult to do this 10 years ago…*

In this regard, another participant mentioned the following:

P: With my mental health care team I wouldn't be so quick to discuss this... Now... after all these years I would... but I mean... in the early years... when you're still getting used to it... your job, I wouldn't do so.

In one focus group, participants claimed that therapists should always behave professionally. Sexual feelings should be managed well. However, because responses remained rather superficial, the moderator argued the responses of participants sounded very rational, as if it was just something easy to do so. It elicited a participants' description of the individual progress that precedes this.

M: That all sounds very good…rational…logical…but…you can say…ok…"I am a professional"…"I look at what is most important to the client"... But.. Is it just like that (that easy)?

P: Not just like that, no. I mean... You don't know how many hundreds of hours of therapy and training I've gone through (to manage my sexual feelings)... It doesn't happen just like that! I really think... […]. To really look at your own sexuality and seek patterns... and to work it out in a group and struggle with it and then […] to the extent that you feel free to work with sexuality.

Unsafe environment.

Even when they are not discomfortable to talk about these feelings, psychotherapists in our focus groups indicated to be hesitant to disclose their feelings due to an unsafe environment, where there is fear of being condemned by others. As such, psychotherapists perceive their field of work as an unsafe environment, as the following excerpt illustrates.

P1: We are concerned about saying anything about it (sexual feelings)... er... and about how we see each other then.

P2: I think so. Yes, and how they think of us. Yes, I do think so, yes.

In particular, we noticed that the concern that they would be perceived as unprofessional by peers contributes to the hesitance to discuss their more profound sexual feelings for clients. In one focus group, participants reflected on their own contributions to the discussion, and noticed their own hesitance.

P1: I think you are already hearing it here in the stories. The fact that you aren't likely to talk about it.

P2: Yes!

P1: … that does mean that there's something... something stopping you, doesn't it?

P3: I think so too.

P1: That you do think... uh-oh... what have I done... to...

P3: Yes, yes, yes.

P1: Or how will it look... is it still professional enough…

We observed that psychiatrists experience this unsafe judgemental environment more often. They perceive that they are more severely judged by their environment for their feelings and behaviour compared to non-psychiatrists, because higher demands are made on them. One participating psychiatrist stated the following:

P: […]. As a psychiatrist you'd say... 'I'm in love with one of my patients'... Then .. 'What kind of psychiatrist is that!' […]. Although... I think if... an experienced gestalt therapist said... 'I've fallen in love with one of my clients'... then you'd say... yeah, yeah... it happens. So it also has something to do with... being a doctor... being a psychiatrist.

Another participating psychiatrist described how the environment reacted when a colleague started a relationship with one of his patients.

P: *[…] they got to know each other... in a doctor-patient relationship. And then if you hear in the team how... well... almost condescendingly... that people talk about it... how... Then I think, oh... Imagine I was in that situation... then you directly feel like... No! As... as... a doctor, this is clearly... not done... that you start a relationship with a client.*

Factors contributing to feeling unsafe.

Values, norms and events in society.

We noticed that several elements contribute to feeling unsafe, resulting in hesitance to talk about sexual feelings. One of these elements, mentioned by the psychotherapists in our focus groups, is the values, norms and events in society. For instance, society can have strong condemning reactions when the media presents stories of sexual assaults by important persons in power-imbalanced relationships. These events affect psychotherapists. One participant described this effect as follows:

P: *[…] but if in society... people find out about... a psychotherapeutic relationship and sexuality, then the cases that come out are always the extreme, difficult cases, that make everyone... shrink back into their taboo... and say... oh... I'd better not say too much... about possible feelings.*

Another participant paraphrased it as follows.

P: *So we live in a culture where there isn't much touching, where taboo still counts... taboo on sexuality... there's a new prudishness... and #MeToo... and all those things and so on... so that social context... I'm really aware of it in the therapeutic space.*

According to the psychotherapists of our focus groups, the perspective of clients, in what they expect to be an appropriate distance, also has an influence. One participant describes the paradox of this appropriate proximity and distance.

> *P: That's how it is in public opinion too... it's like... er... If you look at a doctor or a specialist... (there is the blame) that the human aspect is not explicitly present enough. Or people don't feel or experience it. That it's all too distant... too categorical. So that's an invitation to bring in more humanity, but on the other hand... so... the paradox is... that if humanity is explicitly brought in... that doctors in particular will be directly singled out... That's my experience, anyway. Then it is said… 'You're supposed to be a doctor' (he laughs). Public opinion needs to grow as well...*

Atmosphere in work meetings.

Another observed element contributing to the feeling of unsafety, resulting in more hesitance to discuss sensitive topics, is the atmosphere in work meetings. Both overly 'solution-focused' meetings as well as overly 'informal' meetings have a negative effect on the feeling of safety. Solution-focused meetings refer to rather short and efficient meetings with colleagues, mainly focused on how to treat a client. There is no room to talk about these kinds of feelings in such situations, as is illustrated by the following quote.

> *P: There was certainly supervision but that supervision was more practical. Er... kind of targeted, it was more about... what medication should we initiate here. Come on... there are five of you sitting there... you've got 10 minutes. It was difficult to start a discussion of that sort of issue there.*

Also, another participant described that within such a solution-focused atmosphere it is not easy to talk about feelings.

M: *Is it something you'd find easy to talk about with colleagues, or do you think...*

P: *I don't think it would be very easy. It would be more suitable for... if you have a consultation session or something... on psychotherapeutic matters and so on...*

Informal meetings refer to a relaxed atmosphere, where topics like sexuality are often discussed while laughing, therefore implicitly making it more difficult to talk about it in a more serious professional way when necessary. One participant described the atmosphere of her intervisions and the effect of it on the extent to which such feelings are to be discussed.

P: *In my experience intervision is .. you know… you start something to tell … and then there's a glass of wine... or …depending on …when exactly it is... But then you immediately start talking about something else... That is my experience of intervisions.*

In another focus group, where participants know each other very well, they reflected on the extent and context in which they discussed sexual feelings.

P1: *But it's not that we avoid the issue. Because in our conversations... in the pub... we sometimes talk about it together a lot.*

P2: *It's always about sex... with us. […].*

P3: *Yes, right… but … not with clients… you know… Not professionally, I mean.*

Trustworthiness.

The age of peers is also perceived as an important element that creates (un)safety. Psychotherapists in our focus groups are more willing to talk to older peers than to younger peers. It is expected that young psychotherapists would be less understanding in their reaction than older therapists. One participant mentioned the following about it:

P: *[…]. I do find it... hard to... bring up the issue with people or colleagues my own age or a bit younger. Because I don't know how it would go down with them. […]. Which is why I… found it very important… for myself, I mean …to discuss it with someone I... well... think of as someone who has been through a lot.*

In another focus group, a participant described her need to discuss her feelings with someone older, which was confirmed by the other participants.

P1: *If I found myself in an intervision group and they were all school leavers or something... who really haven't got that experience... it wouldn't prevent me from saying it... but I'd... I would have a need to say it to someone who has been in the field for years as well. Because of a kind of acknowledgement, you know […].*

P2: *Yes, me too.*

P3: *I'd say the same.*

Friends (whether or not working in mental health care) are overall perceived as the safest persons to talk to. Psychotherapists in our focus groups prefer talking to them, because there is already a relationship of trust, implicating they will not be judgmental or not as judgmental. The following quote illustrates this:

P: *Yes, I think I'd... be more likely... to call a friend... than to say it in a professional context…*

One participant stated the following:

P: *And I didn't discuss it then in supervision. I... discussed it... for myself, I mean with psychiatrist and psychologist friends, among my own group of friends, but not in the workplace itself.*

Observations of Interactions during the Focus Groups

How group members react to each other, and the kind of atmosphere they create together, affects the outcome of the group discussion. In some groups there was a lot of laughter, seeming to indicate that psychotherapists were somewhat uncomfortable with the topic, as the following excerpt illustrates.

M: *Can you just take pleasure in... just... a sexually attractive man. That you say... Come on in... without the rest...*

P1: *Come on in…*

[everyone laughs, hilarity]

P2: *Come on in… I'm just going to sit on your lap.*

P3: *Come on in… I'm not going to jump you.*

P2: *… that's … what I was saying… what makes me blush.*

[everyone laughs]

In other groups there were rather rejecting responses from certain group members, which affected the feeling of safety. This became apparent when some group members backed down: they initially indicated that they might possibly do something hypothetically, but later on emphasized that it had never happened.

M: *Those .. attractive, friendly men... don't you sometimes secretly... put nicer clothes on or sit up straighter... or what...*

P1: *I think I'd do that subconsciously.*

P2: *No, no.*

P1: *Come on... not the clothes, but kind of... maybe... I'd say my behaviour.*

P2: I'd tend to feel a bit more uncomfortable with those men that with others, I think. And I'd rather try to make myself a bit smaller maybe, to... you know... shrink away.

P1: It's not because you find a man attractive and friendly that you necessarily have to feel uncomfortable with him there, I'd say. That's what I think. It's possible...

P2: No, but if you do have... strong feelings for the man... like... oh... then I think I'd be more likely to...

P3: ... keep it professional.

P1: Yes, yes. Ok, yes. So I haven't experienced that yet... either... I don't know how I'd behave then...

Furthermore, silence in a group can have a detrimental effect on the feeling of safety. In one group this silence, together with a rather firm statement of never doing something like that, resulted in a psychotherapist who initially described his sexual attraction making no further disclosures.

P1: […] And then they came to me and I followed them up. It's been 15 years now. And, yes... sexual attractiveness has certainly played a role. (…) For sure! Erm, in the sense that I had the impression on many occasions that sexual attraction was clearly present, mutually, like... I wouldn't mind getting involved with you. […].

M: What do the others think when they hear that?

[long silence]

M: Does anything sound familiar?

[long silence]

P2: […]. Erm, when you say, well,… a therapeutic relationship where sexual attractiveness has certainly played a role… Never on my part!

Finally, discussing these sensitive topics with peers is usually preceded by a process of 'sensing each other'. Psychotherapists use this 'sensing' to try to find out if there is enough safety to share their emotions and experiences. This also became apparent in the focus groups' discussions, in the sense that most sensitive disclosures were made at the end. Furthermore, it was explicitly mentioned in one focus group.

P1: But even this evening I'm noticing a process of exploration in myself... what is it possible to share here.

P2: Yes.

P3: hmm.

M: Yes.

P1: And it's good that that can happen.

One participant mentioned in this respect that in this process of sensing each other, whereby safety is gradually built up, little is needed to negate this safety.

P: Well, it is like… the safety within that intervision group… that… There it stands or falls, huh. When even something small changes and … you feel.. just… how fragile that safety is.

Discussion

The results of this Belgian study provide evidence that experiencing sexual feelings towards clients is still taboo in the psychotherapeutic relationship. Although intimacy between a psychotherapist and client or finding a client good-looking tends to be easier to discuss, there

is hesitance to talk about more profound sexual feelings. In the conducted focus groups it was observed that several factors contribute to this hesitance. Firstly, attitudes about intimacy and sexuality in the psychotherapeutic relationship shape opinions about what is constituted as professional and ethically correct or incorrect behaviour. These opinions can be decisive in whether or not to discuss particular experiences or feelings. Secondly, the hesitance is motivated by feeling unsafe. Some psychotherapists do not feel comfortable enough to disclose their emotions and experiences, which is especially true for rather young and inexperienced therapists. Other psychotherapists fear more the reaction of their environment, which is especially true for psychiatrists. The participating psychotherapists also indicated that values, norms and events in society, such as media attention for sexual assault stories, the atmosphere in work meetings (e.g. being overly informal or solution focused) and the trustworthiness of persons increase or diminish this feeling of being unsafe. Due to the hesitance to talk directly about sexual feelings, it became apparent in the focus groups that in some cases the more accepted intimate feelings or finding a client good-looking were actually used to describe more sexual or romantically oriented feelings. Furthermore, focus groups showed that some negative reactions of group members or extreme silence could lead to participants backing down.

An important finding of this study is that a ‘double layer’ can be noticed concerning this topic (Harrington, 1992). In the first layer it seems fairly easy to discuss this topic. Psychotherapists indicate they have good-looking clients, they laugh about it, and often these kinds of conversations take place in a light-hearted atmosphere. However, there is a second layer, where there is still much hesitance. It concerns more profound sexual feelings that trigger the psychotherapist. Especially when psychotherapists have the opinion that the feelings might affect the professional relationship, they indicate it becomes more difficult to talk about them.

Accordingly, another elementary finding is that in some cases it seems that more profound sexual feelings are ‘disguised’ by more acceptable issues, making them easier to talk about, such as emphatically describing the sexual features of the client or intimate and confusing feelings that are elicited. This finding might be important for supervisors or other relevant supporting peers, to be alert when such issues are described. Referring to the ‘double layer’ mentioned earlier, it might be necessary in some cases to ‘reveal the disguise’ in order to explore the second layer of more profound feelings with the psychotherapist. Furthermore, it might be helpful to have sufficient insight into the attitude of psychotherapists concerning the place intimacy and sexuality can have in the psychotherapeutic relationship. When psychotherapists prefer to make a clear distinction between intimacy and sexuality, they seem indirectly not to allow a grey zone where it is possible to struggle with certain feelings and determine their appropriateness. These psychotherapists can be especially inhibited in exploring their own feelings and experiences, making them very vulnerable.

A key element in openness to talking about this topic is a safe environment. A remarkable finding in this context is that friends, rather than colleagues, are perceived as the safest persons to turn to when in need of a conversation to talk about emotions or experiences regarding sexual feelings towards clients. The workplace in general and direct colleagues in particular are even seen as unsafe and rather judgmental, as also became apparent in the interaction in some focus groups. Compared to other therapists, this feeling of being unsafe is more pronounced among psychiatrists, which is probably related to higher professional, authoritative and scientific expectations towards medical doctors (Gooden, Smith, Tattersall, & Stockier, 2001).

Furthermore, talking about sexual feelings towards clients seems to be easier for older and more experienced psychotherapists than for their younger and less experienced colleagues. Probably this is related to the fact that more time and effort has been put into working on personal issues through supervisions and intervisions, in combination with personal life experiences, resulting in enough self-confidence to allow one's own vulnerability when talking about such sensitive topics. Additionally, the fear for negative job consequences might be higher among younger and less experienced therapists, possibly leading to more hesitance to talk about it. These findings are also confirmed by Arcuri and McIlwain (2014), who mention that younger and less experienced psychotherapists are less confident, pointing to a possibly underdeveloped 'professional self-esteem', which can enhance concerns about competence.

Finally, norms, values and events in society were found to influence condemnation and consequently the feeling of safety. In this respect we refer to the concept of "(reverse) double standard", indicating that persons are not equally judged on their sexual conduct, based on gender, initiation and power (Howell, Egan, Giuliano, & Ackley, 2011). In this study, particular the recent wave of #MeToo stories where important persons in positions of power were accused of sexual assault seem to have increased this feeling that it is unsafe to talk about this topic. Unfortunately, due to these events, the difference between sexual feelings and sexual behaviour is less clearly seen. The more sexual feelings towards a more vulnerable person are identified with sexual assault, the less anyone wants to talk about such feelings. The less sexual feelings are acknowledged and discussed as a distinct topic from sexual assault, the more sexual feelings only become identified, almost by default, with sexual assault (Pope et al., 1993, p. 24).

A strength of this study is that it contributes to more in-depth scientific information on this taboo topic, which is seldomly investigated. The use of focus groups is both a strength as well as a limitation. It is a strength, because this method allows the observation of group interactions that for example have led to instances of backing down. Furthermore, it showed the narrative that is used to formulate certain emotions and experiences. Nevertheless, it is also a limitation, because social desirable answers (e.g. due to conformity) cannot be excluded. Another limitation is that some groups constituted of very few participants, and only very few psychoanalysts and person-centred psychotherapists participated. Furthermore, due to practical constraints, only two focus groups with psychiatrists were held. Moreover, no focus groups with only male participants were held, which is unfortunate, because it is well known that men experience and express their sexuality in a different way to women (Baumeister, Catanese, & Vohs, 2001; Krueger & Casey, 2015; Petersen & Hyde, 2010).

In conclusion, to pave the way to more openness regarding sexual feelings in the psychotherapeutic relationship, it seems very important to pay attention to both the feeling of (dis)comfort and confidence within the psychotherapist themself, as well as to (un)safety in the environment. There should be awareness that young, less experienced psychotherapists and psychiatrists are especially vulnerable in this area. More concretely, the self-development of rather young and inexperienced psychotherapists concerning their own sexuality, self-confidence, etc., preferably with adequate guidance should be promoted. Additionally, the existence of sexual feelings in this context should be communicated more often as a human phenomenon occurring in many psychotherapists, which will especially benefit those of whom society has very high expectations. Furthermore, it is recommended, when discussing this topic, to create a safe atmosphere, where trust is built up, and there is room to discuss these feelings more profoundly (avoiding too overly informal or solution-focused

atmospheres). Finally, supervisors or other relevant supporting (senior) peers can be very important, but should be alert to 1) psychotherapists' 'disguised' more profound sexual feelings, such as light-hearted jokes about a sexual attractive client, describing the sexual features of a client, or more profound intimate feelings for a client and 2) be aware that psychotherapists preferring a clear distinction between intimacy and sexuality might encounter difficulties in exploring their own sexual feelings and experiences. There should also be awareness that therapists preferably discuss their sexual feelings with older and more experienced peers. Ultimately, more openness about this topic will be beneficial for the psychotherapeutic relationship, the psychotherapist and the client.

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The Authors declare that there is no conflict of interest.

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