INTIMACY AND SEXUALITY
IN THE PSYCHOTHERAPEUTIC RELATIONSHIP

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Dissertation, submitted to obtain the academic degree of Doctor in Social Health Sciences

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De ziel die zichzelf zoekt in de liefde, waar het vlees en de geest verwikkeld raken in hun gecompliceerde dialoog, raakt pas vertrouwd met de dageraad en het schemerdonker, als de dag niet alleen maar dag is en de nacht niet alleen maar nacht.

_Umberto Galimberti_
Preface

This scientific work is written to obtain the academic degree of Doctor in Social Health Sciences at the Vrije Universiteit Brussel. This work arose from a fascination with sexuality and the desire to address sensitive taboo topics. Within the spearheads of the Mental Health and Wellbeing Research Group, this has resulted in the research topic “Intimacy and Sexuality in the Psychotherapeutic Relationship”, coordinated by Prof. dr. Johan Bilsen.

By having done this research, I hope to have contributed in some way to the improvement of therapists’ wellbeing and ultimately the psychotherapeutic relationship when therapists encounter intimate and sexual feelings for clients. Given the implications of the results for education and practice of therapists, I hope the findings will be reflected outside academia as well. Ideally, these findings give input for further debate and reflection upon this topic among scientists, therapists, educators, supervisors, and other relevant stakeholders in the work field of psychotherapy.
General introduction

1. Introduction
2. Background
3. Problem definition of this dissertation
4. Terminology and concepts, as used in this dissertation
5. (No) Theoretical perspective
6. Aims
7. Method
8. Outline
1. Introduction

This dissertation is about intimacy and sexuality in the psychotherapeutic relationship, more specifically about the feelings, behavior, and attitudes of psychotherapists. The main focus is on sexuality, but intimacy is also addressed, as they are interwoven to one another. First, more background information will be given on this topic. The implications for clients when therapists have a sexual relationship with them will be briefly mentioned, as well as the state of affairs regarding policy and legislation to avoid the occurrence of such sexual relationships. Also, a short overview about the available scientific literature on intimate and sexual feelings. Besides prevalence rates also more context information will be given about issues that hinder to adequately deal with such feelings. This background information fuels the relevance to conduct this dissertation, as is outlined in the problem definition. Then, the terminology and concepts used in this dissertation are described. It will be explained who is entitled to practice psychotherapy (psychotherapists) in Belgium, as the legal framework about this has only recently been made. Also, it is explained how the terms intimacy and sexuality should be understood in this dissertation. Then, we will justify our choice not to start from a theoretical framework. After presenting the aims and the methodology used to achieve these aims, a further outline of this dissertation is described.

2. Background

Sexual relationships in psychotherapy: implications for clients

Overall, there is consensus that sexual contact between therapists and clients is often harmful for clients, leading to reactions such as ambivalence, cognitive dysfunction, emotional lability, emptiness and isolation, impaired ability to trust, guilt, increased suicidal risk, etc. [1]. Findings, based on reporting of therapists who treated clients who had such sexual contact with their previous therapist, suggest that about 75 - 90% of clients suffered harm, even when the sexual involvement began after termination of therapy, 1.8-11% of clients were hospitalized afterwards, 1-14% tried to commit suicide, and 0.3-1% committed suicide. However, among a minority it was experienced as beneficial (4.3-16%), some married the therapist (3%), and for some clients it had no effect (9%) [2-4].
Sexual relationships in psychotherapy: policy and legislation

Due to the implications for clients, in the ethical guidelines of all large professional associations, sexual relationships or even non-sexual dual relationships, being a combination of a professional and another (often more personal) kind of relationship, are not allowed. Although these relationships are not allowed with current clients, some associations do not prohibit it with former clients, after a waiting period of at least two years after termination of therapy. However, it is strongly discouraged [5-8].

Also, governmental polices and legislation are developed to hinder therapists of engaging in a sexual relationship with a client. Countries all over the world deal differently with sexual misconduct of health care professionals (as sexual relationship are seen). Since decades reporting sexual misconduct is mandatory in North America, Australia and New Zealand, and those who report these incidents are protected. Furthermore, there are penal codes for involved professionals. In Europe, the implementation of policies and laws to deal with sexual misconduct has lagged about 20-25 years behind [9]. Only more recently several European countries started to develop such polices and laws. Germany and the Netherlands have meanwhile implemented a penal code that classify sexual misconduct by health care professionals as a crime, but this is not the case in Belgium [9, 13].

The Flemish government, more specifically the Flemish Agency of Care and Health (FACH), decided that from 2015 all accredited types of healthcare institutions in Flanders would be obliged to implement a policy on sexual misconduct. This implicated that these institutions had to formulate and implement clear guidelines in their institutions and are obliged to report sexual misconduct to a central registry, in order to prevent sexual misconduct and to react when occurring [9-12].

Reports can also be made by a client, fellow therapists, or other persons being aware of a therapists’ misconduct. First, when a therapist violates a code of ethics (or this is suspected), a disciplinary procedure can be initiated. In Belgium, for psychologists, this can be done at the disciplinary board of the Psychology Committee; for psychiatrists, this can be done at the Provincial Council of the Medical Order. This procedure can lead to a warning or suspension of the therapist, or removal from the list of the professional association. Second, when a therapist commits a criminal offense (or this is suspected), this (suspected) crime can be
brought to the attention of the public prosecutor. However, when information about a therapists’ misconduct is a secret that is entrusted by profession, the professional secrecy (art. 458 Sw.) might complicate this reporting. Such secrets might be entrusted to therapists by clients disclosing about the (sexual) misconduct of a previous therapist or to supervisors by therapists-in-training confiding about their (sexual) misconduct to clients. Nevertheless, an exception can be made to this professional secrecy under certain conditions, when it concerns serious facts regarding vulnerable persons (art. 458bis Sw.).

Intimate and sexual feelings in psychotherapy: prevalence and context

Experiencing intimate and sexual feelings are intrinsic aspects of our human condition. The professional intimacy, typical of psychotherapeutic sessions, may contribute to the development of such more personal feelings. The therapist and client are often together without others; they meet frequently and discuss emotional issues that people seldom talk about or only with their most trusted intimates [14-16].

While sexual relationships of psychotherapists with their clients, not allowed by professional associations, are rather low (ranging from 1 to 7%) [17-21], empirical studies show that sexual attraction of therapists towards clients roughly ranges from 60 to 90%, and around a quarter reported also sexual fantasies about a client. Overall, more often male therapists and younger therapists report these sexual feelings than respectively female or older therapists [18-20, 22-24]. Problematic relationships or life stressors are not found to be related to sexual feelings towards clients [25].

When experiencing intimate and sexual feelings towards a client, it often elicits a gamut of other emotions, mostly negative, such as feeling guilty, discomfort, anxious, and confused [19, 20, 24-26]. Furthermore, some therapists create more distance and coolness to the client, in response to these feelings [25-27].

Studies indicate that therapists’ education and training about intimate and sexual feelings is overall rather limited, resulting in not being adequately prepared to appropriately address those feelings [16, 19, 20, 23, 25, 28, 29]. One of the most important recommendations in managing well these intimate and sexual feelings, is discussing these feelings with senior peers or in supervision [26, 28-30]. However, several studies indicate that therapists do not disclose
these issues out of fear of not receiving support, or even being condemned, or because they are simply too embarrassed to talk about it [20, 25, 31].

An important factor that hampers to speak more freely about intimate and sexual feelings and why it elicits negative feelings such as discomfort and fear, is due to the association with engaging in a (not allowed) sexual relationship [32]. The slippery slope concept is often used in this respect, referring to a gradual erosion of correct behavior. Therefore, the development of sexual feelings for a client, can be perceived as precursors of a sexual relationship, because they hold the risk of sliding down the slippery slope [16, 27, 33]. Consequently, therapists have the idea that sexual feelings have to be concealed, rather than openly discussed [27].

However, this slippery slope concept is heavily criticized. It is argued that although it is true that some therapists move down the slippery slope, resulting for instance in a sexual relationship with a client, there is no evidence that sexual feelings or other more informal behavior per definition will lead to abusive behavior of the therapist [16, 27]. Furthermore, this concept is not supported by empirical studies. As indicated earlier, many therapists are sexually attracted to their clients, but only a small minority actually engage in a sexual relationship.

Despite the criticism and lack of empirical evidence, the association between sexual feelings and sexual involvement is still present. They are trapped together in a so called ‘catch-22’ [32]:

*The more sexual feelings about a patient becomes associated with therapist-patient sexual contact, the less anyone wants to acknowledge the feelings or discuss the topic in a personal context; the less sexual feelings are acknowledged and discussed as a topic distinct from therapist-patient sexual contact, the more these feelings become identified, by default, with therapist-patient sex.*

In the wave of #MeToo-stories, where important persons in impowered relationships are accused of sexual misconduct, and in the aftermath of a renowned Flemish psychiatrist that confessed several sexual relationships with clients, both causing great commotion, this association is probably reinforced instead of diminished.
3. Problem definition of this dissertation

Scientific research on intimacy and sexuality in psychotherapy is (understandably) often conducted out of concern for the clients' wellbeing. The therapists' wellbeing, on the other hand, is rather understudied in this regard, while this is also important, because therapists’ wellbeing can have implications on the psychotherapeutic relationship and the client.

All the scientific studies about this topic are mainly conducted in the eighties and nineties, unfortunately without follow-up in the following decades, which is desirable because the population of therapists, ethical perspectives, education and training, legislation and policies, etc. change over time. Most studies are also conducted in North America. European studies are limited to a few British studies. In Belgium this topic is never thoroughly investigated on a large scale. Nevertheless, cultural differences may also play a substantial role in the approach of intimate and sexual feelings in the work field of psychotherapy. Due to this lack of recent empirical research the debate about intimate and sexual feelings in the psychotherapeutic relationship is rather absent. Therefore, reliable and representative empirical data about this topic is needed.

As intimate and sexual feelings in the psychotherapeutic relationship is also seldom thoroughly discussed among therapists itself, little is known about how therapists in Flanders manage such feelings when encountered in the therapy room as well. Furthermore, the hesitance to discuss this topic has never been properly investigated. However, it is important to make these issues more transparent and thus stimulate more openness about it, in order to improve the wellbeing of therapists and ultimately the psychotherapeutic relationship. Out of fear, therapists might now be inhibited to practice psychotherapy in their best possible way. For example, even well-intended and seemingly benign behavior might be perceived as holding the potential to escalate, such as hugging a grieving client. Therapists might be gripped by these negative consequences. By studying intimate and sexual feelings in the psychotherapeutic relationship, we can contribute to mitigate these effects.

Finally, therapists are a product of their basic education and specific psychotherapy training. Therefore, it is relevant to investigate in Flanders how basic education and psychotherapy training deal with intimate and sexual feelings in therapy. Furthermore, since 2015 mental healthcare institutions (MHCI) are required to implement a Sexual Boundary Violation (SBV)-
policy. Therefore, it is important to know to what extent such a policy is implemented in MHCI and which possible factors are related to non-compliance. While this topic is not directly related to intimate and sexual feelings of therapists, it is embedded in the broader context of intimacy and sexuality in the psychotherapeutic relationship, where the mandatory SBV-policy is one of the few regulations that the government has initiated in this regard. These results and insights can eventually function as a basis for the formulation of recommendations for education and other stakeholders in the field.

4. Terminology and concepts, as used in this dissertation

Psychotherapists
The title of psychotherapist is not currently legally protected in Belgium. This means that everyone can currently call themselves a psychotherapist. However, in September 2016 the law of April 4, 2014, regulating the mental health professions entered into force [34]. This law protects the ‘practice of psychotherapy’, meaning that a person may only practice psychotherapy if a number of conditions are met.

Someone who started his/her bachelor studies to obtain a ‘healthcare professional title’, only from the academic year 2017-2018 must meet the following conditions:

- have recognition as a doctor, clinical psychologist or clinical remedial educationalist (=having a healthcare professional title),
- have completed additional training in psychotherapy of at least 70 ECTS at a college or university (although no list of accredited trainings exists),
- have completed a professional internship in psychotherapy.

Different conditions apply to persons who start their bachelor studies before the academic year 2017-2018. Persons with and without a healthcare professional title who completed their psychotherapy training before the academic year 2015-2016 or started/continued their training in the academic year 2016-2017, have ‘acquired rights’ to practice psychotherapy. Those with a healthcare professional title are allowed to practice psychotherapy autonomously, but those without such title should now practice psychotherapy under supervision of someone with a healthcare professional title. In addition, persons who have already practiced psychotherapy before the law entered into force and who are not entitled
to an acquired right (i.e., not completed a psychotherapy training), remain allowed to practice psychotherapy.

In Flanders, various psychotherapeutic training programs can be followed such as systemic training, person-centered training, behavioral training and psychoanalytic training, for which a master in clinical psychology, a master in clinical remedial education, or a master in medicine (following specialization psychiatry) is required to start these training programs. Besides these psychotherapeutic training programs, there are other programs where such master level as yet is not a prerequisite, for example integrative/interactional psychotherapy training, etc.

As one can imagine, with this complex legislation and ongoing changes, it is difficult to know what exactly is meant with ‘psychotherapists’ while doing research about the psychotherapeutic relationship. To increase readability of this dissertation we will use:

- ‘Psychiatrists’ for medical doctors, who are following or have completed the medical specialization psychiatry, whether or not with an additional qualification to give psychotherapy;
- ‘Psychotherapists’ for persons, irrespective of their basic education, who are following or have completed a psychotherapy training programs;
- ‘Therapists’ as an overarching name for psychiatrists, and psychotherapists.

Clients

In this dissertation we will use the term ‘client’ instead of ‘patient’ to refer to a person who receives psychotherapeutic care from therapists, because this term is usable within the work field of psychotherapy. It points to a more person-centered model of healthcare instead of a paternalistic model, as it has its origin in the humanistic approach [35]. Compared to the term ‘patient’, the term ‘client’ is thought to be more empowering, implying greater equality between participants in personal healthcare decision-making. The term ‘patient’ implicates more passivity and disempowerment. Overall, it is used for persons being treated in a medical context. The term used (client or patient) is not unimportant, especially in psychotherapy. It has implications for the psychotherapeutic relationship because the word usage reflects the perceptions and expectations of the working alliance of both the therapist and the person receiving psychotherapeutic care [36, 37].
Intimacy and sexuality
The concepts of intimacy and sexuality have a variety of descriptions and interpretations, which are more or less distinguished from each other depending on the context in which they are used. What most conceptualizations have in common is that sexuality can encompass intimacy [38-42]. Sexual desire can be understood as multifaceted and not necessarily only erotically oriented, as it also includes aspects such as nurturing, characterized by warm and loving contact [43-45]. Heemelaar [46] states that the concept of sexuality focuses on gender identity, gender differences, and lust perception of oneself or the other, while the concept of intimacy mainly refers to the feeling of mutual trust and warmth, and eroticism can be regarded as the art of seducing another (or seducing yourself with fantasy) into the sexualization of an intimate situation. Figure 1 shows how intimacy, sexuality and eroticism are related to one another in Heemelaars’ conceptualization.

Figure 1
*Intimacy, sexuality and eroticism*

![Diagram showing the relationship between intimacy, sexuality, and eroticism.](source: [46])

However, in the perception of a person, the three concepts can exist separately or overlap, depending on the particular situation of that moment. Perception is a key element in the attribution to the concepts. What one experiences as intimacy, the other simply experiences as sexuality without intimacy. Everything about intimacy and sexuality revolves around its subjective experience, making it very difficult to define it. It also sheds light on the feeling of being sexually abused. In a similar situation, some persons can feel sexually abused when
others do not feel it in that way. The report of abuse comes out of the blue for the accused person, so to say.

Probably, due to the subjective experience of intimacy and sexuality, the words used in narratives to describe intimate and sexual situations differ among persons. Moreover, intimacy can be used as a euphemism to indicate sexuality, as also shame still can be present for some when sexuality is discussed [47].

Sexuality is also often related to intimacy, in the sense that it can be ‘born in the womb of intimacy’. Related to the psychotherapeutic relationship, the therapist creates a professional intimate atmosphere for the client, where the client feels safe to share his/her emotions and thoughts. To accomplish this, the therapist must be truly interested in the client, caring about the client, be authentic, and be him/herself [48]. Therefore, although the relationship focuses primarily on the clients’ needs, sexual feelings might emerge in both the therapist and client, when this initial professional intimacy becomes increasingly personal in nature [15].

The main focus of this dissertation is on sexuality, broadly understood. It also includes intimacy and eroticism when it overlaps with sexuality, in accordance with the definition of Heemelaar [46]. From this perspective, sexual feelings can be purely sexual (e.g., longing for sex), or combined with intimate feelings (e.g., longing for romance), or combined with erotic feelings (e.g., sexual fantasies). Likewise, sexual behavior and sexual relationships encompasses the interaction between two persons which can be purely sexual (e.g., sexual contact), or combined with intimate feelings and behavior (e.g., romantic relationship), or combined with erotic feelings and behavior (e.g., flirting).

Due to the subjectivity of experiences and the use of euphemisms, and because it is relevant to understand the emerging of sexual feelings within the intimate context of the psychotherapeutic relationship, also intimacy is included in this dissertation. Sometimes the words intimacy and sexuality will be used interchangeably, though it is avoided as much as possible.

Concerning the term ‘Sexual boundary violation’ in this dissertation, it encompasses sexual behavior of therapists that is determined as incorrect sexual behavior by external parties, such as the government and professional associations, as is set out in their regulations (e.g., policy, legislation, guidelines).
5. (No) Theoretical perspective

Often intimacy and sexuality in the psychotherapeutic relationship is discussed from a boundary perspective or from a more psychoanalytic perspective of transference and countertransference, which can be useful.

In the boundary perspective a distinction is made between boundary crossings and boundary violations. A boundary crossing mean that an ethical boundary has been traversed, but not in an inappropriate or harmful way. They are benign, such as the therapeutic use of self-disclosure, extending the time of a treatment, or accepting a small gift of a client. A boundary violation, by definition, involves a transgressing that is considered to hold a significant potential for exploitation or harm, such as a sexual relationship with a client [16, 27, 33].

In the transference perspective, transference refers to client’s perceptions and experiences of the therapist. These perceptions and experiences involve a carryover from the past, and a displacement onto the therapists. Countertransference can be defined as therapists’ internal and external reactions to the client based on the therapists’ unresolved conflicts and vulnerabilities [26]. From this transference-perspective the development of sexual feelings is caused by therapists’ unresolved personal problems, and engaging in a sexual relationship is a mismanagement of this countertransference [16].

However, using these perspectives would reduce these feelings and behavior of therapists to an ethical issue and as exclusively being related to personal unresolved conflicts that need to be addressed via own counselling. It would rather impede participation in a study like this aimed to freely explore these experiences.

Therefore, this dissertation has no intention to approach this topic from a theoretical background nor from a particular discipline, such as moral sciences, psychology, sociology, etc. Instead, this dissertation uses a pragmatic research paradigm, which is more problem centered [33]. Intimate and sexual feelings as well as behavior are studied as it is experienced and reported by therapists in relation to the client in the psychotherapeutic context.
6. Aims

This dissertation wants to explore the field of intimacy and sexuality in the psychotherapeutic relationship, in Flanders, which is guided by three main aims.

**Aim 1: To estimate the occurrence of intimate and sexual feelings and behaviors of therapists, and therapists’ attitudes in this respect (Part I)**

Research questions:

- What is the occurrence of intimate and sexual feelings and behaviors of therapists in the psychotherapeutic relationship? What are the socio-demographic and professional-related characteristics of the therapists where such feelings and behaviors occur?
- Which opinions do therapists have concerning intimate and informal behavior towards clients? Can specific attitude groups of therapists be distinguished based on these opinions? What are the socio-demographic and professional-related characteristics of these specific attitude groups?

**Aim 2: To gain more in-depth information about how therapists address such intimate and sexual feelings (Part II)**

Research questions:

- How do therapists manage sexual feelings in the therapy room?
- Which factors contribute to the hesitance to discuss sexual feelings towards clients?

**Aim 3: To explore how therapists’ basic education and psychotherapy training, and mental health care institutions deal with intimate and sexual feelings and behavior (Part III)**

Research questions:

- What do therapists learn in their basic education and psychotherapy training about intimate and sexual feelings in the therapeutic relationship? What could be improved?
- To what extent do MHCI implement an SBV-policy? What is their knowledge about this policy and what are their opinions about it? Which possible factors are related to non-compliance to implementation?
7. Method

In order to answer the research questions in this dissertation, three different studies were conducted, in parallel, over a period of three years. The main outlines of the methodology of each study are briefly described below. More detailed information can be found in the appropriate chapters.

Study 1: Survey among therapists
A large-scale anonymous quantitative survey was conducted (November 2016-June 2018) among therapists to determine 1) occurrence of intimate and sexual feelings, thoughts, and behaviors of therapists, 2) therapists’ attitudes in this regard, and 3) the extent to which this topic was given attention in education and training. This study was approved by the Medical Ethics Committee UZ Brussels – VUB (B.U.N. 143201524243).

Study population
Therapists were included in this study if they were in practice or in their last year of training at the time, and members of the following large psychotherapy associations in Flanders: Flemish Association for Person-Centered Psychotherapy (N = 288); Flemish Association for Behavioral Therapy (N = 568); Flemish Association for Psychoanalytic Psychotherapy (N = 205); and Flemish psychiatrists registered with the National Institute for Health and Disability Insurance (NIHDI) (N = 910).

Other Flemish psychotherapy associations were not included in this study, mainly because these associations could not participate to this study in such a way that all their members could be reached, which could affect its representativeness.

Research instrument
The questionnaire was based on previous studies, discussions with clients, experts and persons working in the field, and within the research group involved in this study. A small pilot test was done among researchers and therapists-in-training. The questionnaire consisted of:

- The occurrence of a variety of intimate and sexual feelings and behaviors, during the course of their career as well as in the last 12 months, including the start of friendships and sexual relationships;
- Opinions about general acceptability with regard to intimate, sexual and informal behavior, to explore their attitude;
The content of their basic education and psychotherapy training regarding intimacy and sexuality in the psychotherapeutic relationship;

Socio-demographic, profession- and educational-related characteristics.

**Data collection**

To enhance response rate, both 1) an online version of the questionnaire was sent via a link in an e-mail by the professional organizations and/or an announcement in their digital newsletter, as well as 2) a hard copy of the questionnaire was sent by regular post with a return freepost addressed envelope to the researchers. At least one reminder was sent after the online as well as after the post survey. The questionnaires were accompanied with an information letter from the researchers, and a recommendation letter of key figures pointing to the importance of the study and encouraging the therapists to participate. Anonymity was established by excluding data collection that could lead to the identification of the respondents.

In total, of the 1971 therapists that were contacted, 786 therapists completed and returned the questionnaire (response rate 40%). Per type of therapist, response rates varied, from 35.2% (Psychiatrists), to 46.8% (Flemish Association for Behavioral Therapy), 48.8% (Flemish Association for Psychoanalytic Psychotherapy) and 56.6% (Flemish Association for Person-Centred Psychotherapy).

**Study 2: Focus groups among therapists**

A qualitative focus group study was conducted (February 2018-May 2019) among therapists to gain more in-depth understanding of their experiences and the managing of intimate and sexual feelings. This study was approved by the Medical Ethics Committee UZ Brussels – VUB (B.U.N. 143201524243).

**Study population**

Focus groups were open to all Flemish speaking therapists, who were in practice or in their last year of training.

**Research instrument**

Using a semi-structured discussion guide, the main question for participants was 1) to think about an intimate or sexually explicit experience with a client and 2) which emotions and
thoughts it evoked. To help participants in their reflection process and start up the conversation an unusual approach was used. Each of them received a set of 26 cards in an envelope. On each card a certain emotion or thought was printed, either positively or negatively of nature. Furthermore, it was asked what ideally should change within their work field or education to improve the situation for therapists who actually encounter sexual feelings for a client. The discussion guide was inspired on previous qualitative studies and reflections within the research group.

*Data collection*

An appeal to participate at the focus groups was done at the end of the survey (study 1) and key figures in the field (mainly training coordinators) were approached to do an appeal within their own network. It was aimed to conduct small size focus groups (between three to six persons), because of the rather sensitive topic. Taking into account the distribution of therapists’ characteristics (such as age, experience, basic education and specific psychotherapy training), the number of focus groups was not determined in advance, but rather guided by saturation of data, constraints of time and resources, and finding participants [49, 50]. This resulted in 8 focus groups, of which two groups contained psychiatrists only, two groups contained interactional/integrative therapists only, three groups contained systemic therapists only, and one group was mixed. Of the in total 36 participants that attend the focus groups, 28 were female therapists and 8 were male therapists. Fourteen therapists were between 20-39 years, 17 were between 40-59 years, and 5 were 60 years or older. Focus groups were audiotaped and transcribed for analysis. As is evident, informed consent of participants was obtained before the start of the focus groups, and privacy and confidentiality of participants were guaranteed.

**Study 3: Survey among MHCI**

This online survey study gathered information of mental health care institutions (November 2018-January 2019) about the extent to which the mandatory policy on sexual boundary violation was implemented in MHCI, their knowledge about the obligatory character of this policy, their opinions about such policy, and possible factors related to non-compliance to implementation. Approval of the Medical Ethics Committee UZ Brussels - VUB was unnecessary, because the survey queried data at institutional rather than personal level.
Study population

All different types of MHCI in Flanders, accredited by the FACH and with an adult patient population, were included in this study (N=162). It includes ambulatory mental healthcare, short- and long-term residential psychiatric care, residential psychiatric care and living, residential assisted living, and residential psychiatric care for persons with an addiction. The contact details of all 162 executives of the accredited MHCI who were expected to have the most knowledge of or to be responsible for the implementation of the SBV policy at the MHCI were retrieved from the FACH.

Research instrument

The questionnaire consisted of questions about 1) knowledge of obligations, 2) opinions on SBV policy, 3) implementation of the specific SBV policy requirements, 4) actual occurrences of SBV incidents in the MHCI, and 5) type of MHCI. These questions were based on the Flemish government decree and the manual that was made available to help institutions start up their policy, previous literature on this topic and informal conversations with experts in the field. Furthermore, a pre-test was done among executives, working in an MHCI with a patient population of minors.

Data collection and response

This anonymous online questionnaire sent to all 162 executives of MHCI by e-mail, followed by three reminders. In total 56 executives filled out the online survey (response rate 35%).

8. Outline

After this introduction, the three main objectives, related to the aims, are discussed in part I, part II, and part III. Each of these parts consists of two chapters that are based on articles that have been published or submitted to peer-reviewed scientific journals. Each chapter can be read independently. As this dissertation conducted three studies, table 1 shows how the chapters are based on the different studies.
Table 1
*Chapters in this dissertation, based on different studies*

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<th>Part I</th>
<th>Study 1</th>
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<td>3. Managing</td>
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<td>4. Taboo</td>
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Part I, relating to the first aim, consists of two chapters, where chapter 1 presents the occurrence of intimate and sexual feelings and behaviors of therapists, and the socio-demographic and profession-related characteristics of therapists who encounter them. Chapter 2 describes therapists’ attitudes concerning intimate and informal behavior in the psychotherapeutic relationship.

Part II, relating to the second aim, consists of two chapters, and explores how therapists manage these feelings when they occur (chapter 3). Furthermore, it explores more in-depth which factors contribute to the hesitance to discuss encountered sexual feelings towards clients in the work field (chapter 4).

Part III, relating to the third aim, consists of two chapters. One chapter focuses on what therapists learn about intimate and sexual feelings towards clients in their basic education and psychotherapy training (chapter 5), and the other chapter describes the extent to which an SBV-policy is implemented in MHCI (chapter 6).

This dissertation ends with a general discussion, where the methodology of the three studies will be reviewed, main findings are summarized and discussed, and implications for practice and future research are given.
REFERENCES


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Part I: Occurrence of intimate and sexual feelings and behaviors of therapists, and therapists’ attitudes in this respect
1. Intimacy in psychotherapy: an exploratory survey among therapists

**Manuscript details:**

ABSTRACT

A certain level of intimacy is necessary in psychotherapeutic relationships for them to be effective, but it can sometimes develop further into more intimate feelings and behaviors related to friendship and sexuality, into friendship, or even into sexual relationships. In this study, a self-administered questionnaire was sent to psychotherapists in Flanders (Belgium), asking about the occurrence of these situations. It provides an overview of the current state of affairs, and comparative data to view for generational and cultural differences with previous studies. A response rate of 40% was obtained (N=786): 69% of respondents were female therapists and none were transgender. A total of 758 therapists stated that they had actually provided psychotherapy and were included for further analysis. Starting a sexual relationship with a current and/or former client, as well as a friendship during therapy, was rather exceptional (3 to 4%) but starting a friendship after therapy was not that uncommon (13%). About seven out of ten therapists found a client sexually attractive, a quarter fantasized about a romantic relationship, and a fifth gave a goodbye hug (22%). In general, more male therapists reported sexual feelings and behaviors than female therapists. Older therapists more often behaved informally and started friendships with former clients compared to younger colleagues. Psychiatrists reported sexual feelings and fantasies less often than non-psychiatrists, and behavioral therapists who reported this less frequently than person-centered and psychoanalytic therapists. Overall, prevalence rates of intimate feelings and behaviors related to friendship and sexuality are lower than in previous studies.
INTRODUCTION

Psychotherapeutic relationships need a certain level of intimacy between the psychotherapist and client in order to be effective. As therapists are only human, this intimacy related to the therapeutic relationship can sometimes develop further into intimate feelings and behaviors related to friendship and sexuality, into the start of a real friendship, or even into a sexual relationship [1, 2]. The “codes of conduct” of all major professional associations discuss the (in)appropriateness of such intimacy [3-6]. In line with the Hippocratic oath, they state that a sexual relationship with a current client is not allowed, and most of them also advise that sexual relationships with former clients should be avoided. There are no direct guidelines for friendships in therapy. Some mention “not letting the relationship become private in nature”. Furthermore, there is no information about concrete feelings and behaviors that possibly indicate the development of a friendship, such as telling a client about personal problems, accepting gifts from clients, or hugging a client. This is not surprising, as the appropriateness of such intimate feelings and behaviors is difficult to capture in general rules and depends greatly on several contextual factors such as, for example, the intent of the therapist, the characteristics and pathology of the client, the potential for harm, etc. [7-9]. Ultimately, it is up to the therapists themselves to carefully evaluate the appropriateness of their feelings and behavior in each unique situation with a client [8].

Over the past decades, several studies have been conducted on the occurrence of intimate feelings and behavior, friendships, and sexual relationships in the psychotherapeutic relationship (with focus on the characteristics of psychotherapists). These studies were conducted mainly in the eighties and nineties, with most of them in North America and a few in Great Britain [10-19]. However, there are no recent studies, and no studies have been done until now in continental Europe. Nevertheless, it might be useful to have comparative data to investigate possible differences with previous generations of therapists and to look for cultural differences between North America, Great Britain, and continental Europe. More current data can also serve as baseline information for future research on this topic, especially in (continental) Europe, as attitudes and customs change over time, and within cultures.

Furthermore, there is almost no information at all available in previous studies about how therapists evaluate the occurrence of such intimate feelings and behaviors. Information about a possible negative impact on therapists’ well-being and functioning might be important for
relevant stakeholders (e.g., in educational training) to develop initiatives to better prepare and support therapists in these matters.

Finally, the scientific evidence that intimate feelings and behaviors beyond the necessary therapeutic intimacy ultimately result (not) automatically in a sexual relationship with a client, is seldomly investigated in empirical studies [20]. This is important because the belief in such an automatically occurring slippery slope can prevent therapists from talking freely about intimate feelings and behavior when they occur [21].

This study investigates the occurrence of intimate feelings and behavior (related to friendship and sexuality), and the start of friendships and sexual relationships in the psychotherapeutic relationship in Flanders (Belgium), and investigates associations with demographic and educational variables of psychotherapists. It also investigates how the occurrence of such feelings is evaluated by the therapists, and whether or not the belief of an automatically occurring slippery slope is confirmed by the facts on the field. The research hypotheses are that 1) the occurrence of Intimate Feelings and Behavior related to friendship and sexuality (IFB) in psychotherapeutic relationships is rather common, while the occurrence of friendships and sexual relationships with current and/or former clients is rather exceptional; 2) some IFB are experienced negatively and are thus a possible burden for therapists; 3) the occurrences are related to therapists’ characteristics, such as gender, age, basic education, and specific type of psychotherapy training; and 4) the occurrence of IFB and friendships, is not by default a precursor to starting sexual relationships.

METHOD

Study Design and Participants

A cross-sectional study was conducted from November 2016 to June 2018. A self-administered questionnaire was sent to licensed psychotherapists (referred to below as therapists) in Flanders, the Dutch-speaking part of Belgium.

The study population consisted of all psychiatrists (N = 910) and all members of three of the four major accredited psychotherapy associations in Flanders: the Flemish Association for Person-Centered Psychotherapy (N = 288), Flemish Association for Behavioral Therapy (N = 568), and Flemish Association for Psychoanalytic Psychotherapy (N = 205). The fourth
accredited association of systemic therapy did not participate in this study. All therapists were included who were in practice or in their last year of training at the time of the study. Therapists can be members of more than one professional association.

**Procedures**

The whole study population was included in this study. We used different modes to reach the study population and the recruiting strategy was adjusted slightly for each group, in order to optimize response rate. First, an online version of the questionnaire was sent in a link in an e-mail by the professional organizations and/or an announcement in their digital newsletter. Some weeks later, a hard copy of the questionnaire was sent by regular mail with a return freepost addressed envelope. At least one reminder was sent after the online and mail survey. The questionnaires were accompanied with an information letter from the researchers, and a recommendation letter from key figures pointing out the importance of the study and encouraging the therapists to participate. Participants were explicitly asked to return the questionnaire only once. Anonymity was ensured (see ethics).

**Questionnaire**

The first part of the questionnaire consisted of 15 items describing intimate feelings and behaviors (IFB) related to friendship and sexuality towards clients (table 1). Respondents were asked to which extent these 15 items occurred on an ordinal 5-point scale (“never”, “seldom”, “sometimes”, “regularly” and “often”) and how this occurrence was evaluated on a scale from 1 (very negative) to 6 (very positive). These items were based on earlier scientific studies on this topic and a checklist to evaluate the risk level for sexual misconduct [11, 12, 15, 17, 22]. Initially 85 items were classified as relevant. The definitive selection of the 15 IFB items and their formulation was made in cooperation with experts and persons working in the field.

The second part of the questionnaire asked whether or not therapists, in their own perception, had started a friendship or sexual relationship with adult clients, and with how many clients, during their active career, and during the last 12 months. A distinction was made between friendships and sexual relationships that started at the time of the therapy and after the therapy had ended. Adult clients also included adult family members of children in treatment.
The third part consisted of demographic information about the therapist, such as gender, sexual orientation and age, and educational information such as the therapist’s basic education and psychotherapy training.

The questionnaire was pilot tested among researchers and therapists in training, which led to some small adaptations of the questionnaire, mostly concerning the formulation of sentences.

**Statistical Analysis**

The descriptive analysis was done by giving frequencies and percentages of characteristics of respondents, the occurrence and evaluation of IFB items, the occurrence of friendships, and sexual relationships. To present a meaningful distribution over the different categories and to investigate main patterns in occurrences, as well as for the benefit of a clear visual overview of the occurrence and evaluation per IFB item in one table (table 1), the ordinal 5-point scale for occurrence was recoded into three options: “never” (never), “sometimes” (seldom and sometimes), and “regularly” (regularly and often); the ordinal 6-point scale for evaluation was recoded into three options, namely “negative” (1-2), “neutral” (3-4) and “positive” (5-6). Findings for all categories of these two variables are given in supplemental files.

Furthermore, we investigated associations between demographic and educational characteristics of the therapists on the one hand, and the occurrence of IFB items, friendships, and sexual relationships on the other. For these analyses, the following adaptations were made:

1) The 15 IFB items were reduced to three main components, using a principal component analysis with varimax rotation. The occurrence of each main component was calculated by the number of respondents who reported that at least one of the IFB items that loaded on that specific component occurred.

2) No distinction was made between whether the sexual relationship started at time of the therapy or when the therapy had already ended, because of a low total N.

3) For the type of psychotherapy training, therapists who were trained in only one of the three major psychotherapy trainings covered were included.

To investigate these associations, we used a two-tailed chi-square test or a Fisher’s exact test (bivariate approach). Post-hoc comparisons were made for comparison between three groups, to check which groups differ significantly. Furthermore, a logistic regression
(multivariate approach) was done for outcome variables with a sufficient N (one in ten rule) [23]. Besides the main effects, interaction effects were also tested.

Finally, for investigating the association between IFB components, friendships and sexual relationships, a Fisher’s exact test was used.

IBM SPSS Statistics, version 25.0, was used for all analyses. We did not impute missing data.

**Ethics**

This study was approved by the Medical Ethics Committee UZ Brussels - VUB (B.U.N. 143201524243). Data of the respondents are stored according to the European General Data Protection Regulation (GDPR). Anonymity was established by excluding data collection that could lead to the identification of the respondents. For example, the survey did not contain questions about place of residence and workplace, and the age of the respondent was asked in broad age categories. For the online survey, the survey website settings were configured to exclude the collection of online respondents’ email addresses or capturing of IP addresses. For the hard copy, no respondent identification code was printed on the questionnaire. The completed questionnaires were only sent to the researchers and sent directly.

The respondents were well informed by the researchers about the aim and method of the study and the anonymity procedure. These were explained in an attachment to the e-mail, the introduction to the online version of the questionnaire and the covering letter with the mail survey. Furthermore, it was pointed out that by filling out and returning the questionnaire, the respondents declared that they were well informed and willing to participate to the study.

**RESULTS**

**Response Rate**

In total 786 therapists completed and returned the questionnaire (a quarter online, \( n = 176 \)). With regard to the paper versions, 37 empty questionnaires were returned to the researchers, of which 35 were due to wrong addresses. Response rates varied, from 35.2% (Psychiatrists), to 46.8% (Flemish Association for Behavioral Therapy), 48.8% (Flemish Association for Psychoanalytic Psychotherapy) and 56.6% (Flemish Association for Person-Centered
Psychotherapy). The overall response rate was 39.8%. Only therapists who reported having provided psychotherapy to adult clients were included for further analyses (N = 758).

Characteristics of the Respondents

Most of the 758 responding therapists were female (69.3%, n = 524; no transgenders), heterosexual (89%, n = 671), and in the age group of 20 to 39 years (42.7%, n = 323), or 40 to 59 years (40.2%, n = 304). In the oldest age group, there were more men than women (60 years of older: gender ratio: 1.6/1), while in the younger age groups the opposite was true (20-39 years: gender ratio 0.5/1, and 40-59 years: gender ratio 0.2/1). Psychologists (n = 415) made up 54.8%, psychiatrists 39.4% (n = 298) and therapists with another basic education 5.8% (n = 44). Of the 758 therapists, 172 (22.8%) indicated having followed or completed person-centered training, whether or not in combination with other training. Likewise, 302 (40%) had followed or completed behavioral training, and 149 (19.7%) psychoanalytic training. Although the systemic therapy association did not participate in this study, 153 (20.3%) of the respondents, mostly psychiatrists, reported having followed or completed systemic therapy training. Regarding the missing data of the above characteristics, two therapists did not indicate their gender, four their sexual orientation, one their age, one their basic education, and three their type of psychotherapy training.

Occurrence of Intimate Feelings and Behavior, Related to Friendship and Sexuality (IFB)

The occurrence of IFB varied substantially per IFB item (table 1). However, for most of the IFB items, at least 20% of therapists reported it happening sometimes or regularly. For a third of the IFB items more than 50% of therapists indicated that they occurred. The majority of respondents stated that they had found a client sexually attractive sometimes or regularly (70.6%). Around a quarter of therapists fantasized about a romantic relationship with a client (22.8%) or about sexual contact (26.8%). Accepting gifts from clients during the course of the therapy was reported (79.9%), and therapists felt clients were like friends (72.1%).

Evaluation of Intimate Feelings and Behavior (IFB)

In more than half of the investigated 15 IFB items at least 20% of therapists indicated they evaluated it negatively (table 1). Almost half of therapists indicated that sexual tension (45.7%) and feeling sexually aroused (49.6) during therapy was evaluated negatively.
Table 1  
*Intimate feelings and behavior related to friendship and sexuality (N = 758)*

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency of occurrence</th>
<th>Evaluation of occurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never</td>
<td>Sometimes</td>
</tr>
<tr>
<td>1. I find a client sexually attractive</td>
<td>222 29.4%</td>
<td>519 68.8%</td>
</tr>
<tr>
<td>2. I feel that there is sexual tension between me and the client during therapy</td>
<td>320 42.5%</td>
<td>432 57.4%</td>
</tr>
<tr>
<td>3. I fantasize about what it would be like to have a romantic relationship with a client</td>
<td>581 77.2%</td>
<td>171 22.7%</td>
</tr>
<tr>
<td>4. I fantasize about sexual contact with a client</td>
<td>552 73.2%</td>
<td>201 26.7%</td>
</tr>
<tr>
<td>5. I feel sexually aroused during the conversation with a client</td>
<td>606 80.5%</td>
<td>147 19.5%</td>
</tr>
<tr>
<td>6. I want a client to find me attractive</td>
<td>448 59.7%</td>
<td>283 37.7%</td>
</tr>
<tr>
<td>7. I accept clients that I already know from my personal life</td>
<td>588 78.0%</td>
<td>162 21.5%</td>
</tr>
<tr>
<td>8. I give a client a goodbye hug at the end of a session</td>
<td>584 77.6%</td>
<td>162 21.5%</td>
</tr>
<tr>
<td>9. I confide in a client about my personal concerns</td>
<td>632 83.8%</td>
<td>121 16.0%</td>
</tr>
<tr>
<td>10. I accept gifts from a client that are given during the course of therapy</td>
<td>151 20.1%</td>
<td>557 74.1%</td>
</tr>
<tr>
<td>11. I find that I am emotionally quite involved with a client</td>
<td>29 3.9%</td>
<td>562 74.6%</td>
</tr>
<tr>
<td>12. A client feels like a friend</td>
<td>210 27.9%</td>
<td>513 68.1%</td>
</tr>
<tr>
<td>13. I make informal contact with a client outside the context of therapy</td>
<td>668 88.6%</td>
<td>86 11.4%</td>
</tr>
<tr>
<td>14. I schedule my appointments with a client in such a way that they can be extended</td>
<td>399 53.0%</td>
<td>327 43.4%</td>
</tr>
<tr>
<td>15. A client came to my home (unrelated to the practice) to provide me with a service</td>
<td>713 94.8%</td>
<td>39 5.2%</td>
</tr>
</tbody>
</table>

*Note. a Due to missing data N varies from 751 to 758 per item. b N is based on therapists indicating items occurred sometimes or regularly. Missing data varies from 3 to 17%.*
Occurrence of Friendships and Sexual Relationships

Of the 752 therapists who answered these questions, 114 (15.1%) reported having started a friendship with a client during their career, of which 3.7% during therapy and 13.4% after therapy (table 2). Most therapists started a friendship with one or two clients. Of the therapists who had given psychotherapy the past 12 months and answered these questions (N = 687), 22 of them had started a friendship with a client that year (3.2%), of whom six at time of the therapy, 15 after therapy, and one both at the time and after therapy (not in the table). A small minority of therapists reported starting a sexual relationship with clients during their career (23 therapists: 3%). Most of the therapists who had started a relationship had done so with one client (table 1). Of the therapists who had provided psychotherapy in the past 12 months and answered these questions (N = 686), 3 of them had started a sexual relationship with a client that year (0.4%), of whom two at time of the therapy, and one after therapy (not in table).

Table 2
Starting friendships and sexual relationships (N = 752)

<table>
<thead>
<tr>
<th>Time period of starting</th>
<th>Friendship</th>
<th></th>
<th></th>
<th>Sexual relationship</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>95% CI</td>
<td>n</td>
<td>%</td>
<td>95% CI</td>
</tr>
<tr>
<td>At the time of therapy</td>
<td>13</td>
<td>1.7</td>
<td>.8 – 2.7</td>
<td>6</td>
<td>.8</td>
<td>.2 – 1.4</td>
</tr>
<tr>
<td>After therapy</td>
<td>86</td>
<td>11.4</td>
<td>9.2 – 13.7</td>
<td>13</td>
<td>1.7</td>
<td>.8 – 2.7</td>
</tr>
<tr>
<td>Both at the time and after therapy</td>
<td>15</td>
<td>2.0</td>
<td>1.0 – 3.0</td>
<td>4</td>
<td>.5</td>
<td>.0 – 1.1</td>
</tr>
<tr>
<td>Total</td>
<td>114</td>
<td>15.1</td>
<td>12.6 – 17.7</td>
<td>23</td>
<td>3.0</td>
<td>1.8 – 4.3</td>
</tr>
<tr>
<td>Number of clients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>64</td>
<td>8.5</td>
<td></td>
<td>15</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>19</td>
<td>2.5</td>
<td></td>
<td>5</td>
<td>.7</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>11</td>
<td>1.5</td>
<td></td>
<td>2</td>
<td>.3</td>
<td></td>
</tr>
<tr>
<td>4+</td>
<td>20</td>
<td>2.7</td>
<td></td>
<td>1</td>
<td>.1</td>
<td></td>
</tr>
</tbody>
</table>

Note. Due to missing data N=752 instead of 758. CI confidence interval.

Occurrence of Intimate Feelings and Behavior (IFB), Friendships and Sexual Relationships According to Characteristics of the Therapist

A principal component analysis with varimax rotation was conducted on the 15 IFB items to reduce these items to main components (table 3). The items that cluster on the same component suggest that component 1 represents “sexual feelings and fantasies”. All items
contain words like sexual, romantic or attraction. Component 2 “informal behavior” describes four behaviors of the therapist concerning social contact with a client that are beyond the scope of the psychotherapeutic relationship. Component 3, “emotional involvement” consists of three items that reflect over-involvement with clients. Feelings of sympathy for the client or wanting to help the client out developed more than usually can be expected. Two items, namely “giving a client a goodbye hug” and “accepting gifts that were given during the course of the therapy”, did not load on any component, and were not taken into account for further analysis.

Table 3
Principal Components Analysis with Varimax Rotation for IFB items (N=734)

<table>
<thead>
<tr>
<th>Items</th>
<th>Sexual feelings and fantasies</th>
<th>Informal behavior</th>
<th>Emotional involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>I fantasize about sexual contact with a client</td>
<td>.79</td>
<td>-.02</td>
<td>-.04</td>
</tr>
<tr>
<td>I feel that there is sexual tension between me and the client during therapy</td>
<td>.75</td>
<td>.06</td>
<td>.15</td>
</tr>
<tr>
<td>I find a client sexually attractive</td>
<td>.74</td>
<td>.04</td>
<td>.05</td>
</tr>
<tr>
<td>I fantasize about what it would be like to have a romantic relationship with a client</td>
<td>.72</td>
<td>-.06</td>
<td>.05</td>
</tr>
<tr>
<td>I feel sexually aroused during the conversation with a client</td>
<td>.63</td>
<td>.12</td>
<td>-.00</td>
</tr>
<tr>
<td>I want a client to find me attractive</td>
<td>.58</td>
<td>.22</td>
<td>.22</td>
</tr>
<tr>
<td>I make informal contact with a client outside the context of therapy</td>
<td>.01</td>
<td>.62</td>
<td>.06</td>
</tr>
<tr>
<td>I confide in a client about my personal concerns</td>
<td>.04</td>
<td>.61</td>
<td>.19</td>
</tr>
<tr>
<td>A client came to my home (unrelated to the practice) to provide me with a service</td>
<td>.09</td>
<td>.60</td>
<td>-.09</td>
</tr>
<tr>
<td>I accept clients that I already know from my personal life</td>
<td>-.05</td>
<td>.51</td>
<td>.04</td>
</tr>
<tr>
<td>I accept gifts from a client that are given during the course of therapy</td>
<td>.11</td>
<td>.39</td>
<td>.11</td>
</tr>
<tr>
<td>I find that I am emotionally quite involved with a client</td>
<td>.16</td>
<td>-.04</td>
<td>.72</td>
</tr>
<tr>
<td>I schedule my appointments with a client in such a way that they can be extended</td>
<td>-.13</td>
<td>.06</td>
<td>.61</td>
</tr>
<tr>
<td>A client feels like a friend</td>
<td>.30</td>
<td>.22</td>
<td>.51</td>
</tr>
<tr>
<td>I give a client a goodbye hug at the end of a session</td>
<td>.09</td>
<td>.29</td>
<td>.35</td>
</tr>
</tbody>
</table>

Eigenvalues: 3.44, 1.77, 1.09
% of variance: 21.05, 11.50, 9.49
A: .79, .38, .40

Note. Factor loading over 0.40 appear in bold. The Kaiser-Meyer-Olkin measure verified the sampling adequacy for the analysis (KMO = 0.80). An initial analysis was run to obtain eigenvalues for each factor in the data. Four factors had eigenvalues over Kaiser’s criterion of 1. However, the scree plot showed inflexions that would justify retaining three components, so three components were retained.
Both the bivariate analysis (table 4) and the multivariate approach (table 5) show that more male therapists reported occurrences of items on the component “sexual feelings and fantasies” and “emotional involvement” than female therapists. Furthermore, the multivariate approach shows that behavioral therapists are less likely to experience items on the component “sexual feelings and fantasies” than person-centered and psychoanalytic therapists, but they were more likely to experience items on the component “emotional involvement” and were more likely to start friendships after therapy, at least compared to psychoanalytic therapists. The multivariate approach also shows that the youngest age group (20 to 39 years) is less likely to report occurrences of items on “informal behavior” and starting friendships after therapy than the older age groups. Finally, the bivariate analysis shows that more male therapists than female therapists, and more older than younger therapists reported sexual relationships with clients. Further analysis revealed that all therapists of 60 years and above (n = 16) who started a sexual relationship were male therapists. Further, sexual relationships were more often reported by therapists with basic education other than psychology or psychiatry. The five therapists with other basic education were: two social workers, one criminologist, one remedial educationalist, and one whose education was not reported.

The Association between the Occurrence of Sexual Relationships and the Occurrence of IFB-Components and Friendships

Therapists who started a sexual relationship with a client were more likely to have experienced items on the component “sexual feelings and fantasies” (p=0.007), on the component “informal behavior” (p=0.014) and on the component “emotional involvement” (p=0.036). Furthermore, they were more likely to have started a friendship during therapy (p<0.001) and after therapy (p<0.001). However, the majority of therapists that experienced items on the component “sexual feelings and fantasies” (96.3%), on the component “informal behavior” (95.1%) and on the component “emotional involvement” (96.5%) did not engage in a sexual relationship with a client. Likewise, the majority of therapists that started a friendship during therapy (67.9%) and after therapy (85%) did not do so either.
### Table 4

**IFB-main components, starting friendships and sexual relationships, according to characteristics of therapists (N=758)**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Sexual Feelings and Fantasies (N=599)</th>
<th>Informal Behavior (N=289)</th>
<th>Emotional Involvement (N=632)</th>
<th>Friendships During Therapy (N=28)</th>
<th>Friendships After Therapy (N=100)</th>
<th>Sexual Relationships (N=23)</th>
<th>None of all these (N=44)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male therapists (n=231)</td>
<td>212 (91.8%)</td>
<td>111 (48.1%)</td>
<td>204 (88.7%)</td>
<td>19 (8.2%)</td>
<td>45 (19.5%)</td>
<td>21 (9.1%)</td>
<td>4 (1.7%)</td>
</tr>
<tr>
<td>Female therapists (n=524)</td>
<td>386 (73.7%)</td>
<td>177 (33.8%)</td>
<td>426 (81.5%)</td>
<td>9 (1.7%)</td>
<td>55 (10.6%)</td>
<td>2 (0.4%)</td>
<td>40 (7.7%)</td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heterosexual (n=670)</td>
<td>528 (78.8%)</td>
<td>257 (38.4%)</td>
<td>68 (81.9%)</td>
<td>25 (3.8%)</td>
<td>84 (12.6%)</td>
<td>19 (2.9%)</td>
<td>41 (6.2%)</td>
</tr>
<tr>
<td>Non-heterosexual (n=83)</td>
<td>69 (83.1%)</td>
<td>30 (36.1%)</td>
<td>560 (83.8%)</td>
<td>2 (2.4%)</td>
<td>15 (18.1%)</td>
<td>4 (4.8%)</td>
<td>3 (3.6%)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-39 years (n=323)</td>
<td>249 (77.1%)</td>
<td>86 (26.7%)</td>
<td>269 (83.5%)</td>
<td>1 (0.1%)</td>
<td>15 (4.7%)</td>
<td>1 (0.3%)</td>
<td>22 (6.9%)</td>
</tr>
<tr>
<td>40-59 years (n=304)</td>
<td>231 (76.1%)</td>
<td>131 (43.1%)</td>
<td>248 (81.6%)</td>
<td>10 (3.3%)</td>
<td>43 (14.2%)</td>
<td>6 (2.0%)</td>
<td>19 (6.3%)</td>
</tr>
<tr>
<td>60+ years (n=130)</td>
<td>119 (92.2%)</td>
<td>71 (55.)</td>
<td>114 (89.1%)</td>
<td>17 (13.1%)</td>
<td>43 (33.1%)</td>
<td>16 (12.4%)</td>
<td>3 (2.4%)</td>
</tr>
<tr>
<td><strong>Basic Education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrists (n=415)</td>
<td>339 (81.7%)</td>
<td>134 (32.3%)</td>
<td>348 (83.9%)</td>
<td>8 (1.9%)</td>
<td>56 (13.5%)</td>
<td>6 (1.5%)</td>
<td>29 (7.3%)</td>
</tr>
<tr>
<td>Other (n=297)</td>
<td>223 (75.1%)</td>
<td>142 (48%)</td>
<td>248 (84.1%)</td>
<td>18 (6.1%)</td>
<td>38 (12.9%)</td>
<td>11 (3.7%)</td>
<td>12 (4.1%)</td>
</tr>
<tr>
<td><strong>Psychotherapy Training</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Person-centered therapy (n=142)</td>
<td>120 (84.5%)</td>
<td>47 (33.1%)</td>
<td>116 (81.7)</td>
<td>3 (2.1%)</td>
<td>26 (18.4%)</td>
<td>6 (4.3%)</td>
<td>6 (4.3%)</td>
</tr>
<tr>
<td>Behavior therapy (n=282)</td>
<td>214 (75.9%)</td>
<td>99 (35.1%)</td>
<td>237 (84.3)</td>
<td>7 (2.5%)</td>
<td>38 (13.5%)</td>
<td>4 (1.4%)</td>
<td>23 (8.2%)</td>
</tr>
<tr>
<td>Psychoanalytic therapy (n=122)</td>
<td>104 (85.2)</td>
<td>38 (31.1)</td>
<td>91 (74.6)</td>
<td>2 (1.7%)</td>
<td>12 (9.9)</td>
<td>3 (2.5)</td>
<td>8 (6.6)</td>
</tr>
</tbody>
</table>

Note. Due to missing data, N for respondent characteristics varies from 744 to 756.

*a* Only therapists solely educated in person-centered, or behavior or psychoanalytic psychotherapy training are included (N=546). Combinations of these were excluded. Due to missing data, N for psychotherapy training varies from 542 to 546.  
* *p<.05, ** p<.01, *** p<.001
Table 5
Multivariate approach for IFB-main components, starting friendships and sexual relationships

<table>
<thead>
<tr>
<th>Component “Sexual Feelings and Fantasies”</th>
<th>Odds Ratio</th>
<th>95% CI</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>Ref</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4.276</td>
<td>2.25–8.14</td>
<td>&lt;.001</td>
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<tr>
<td>Basic Education</td>
<td>.014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychologists</td>
<td>Ref</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>.429</td>
<td>.24–.76</td>
<td>.004</td>
</tr>
<tr>
<td>Other</td>
<td>.717</td>
<td>.29–1.80</td>
<td>.478</td>
</tr>
<tr>
<td>Psychotherapy training</td>
<td>.029</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavior therapy</td>
<td>Ref</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Person-centered therapy</td>
<td>1.766</td>
<td>1.01–3.09</td>
<td>.047</td>
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<tr>
<td>Psychoanalytic therapy</td>
<td>1.979</td>
<td>1.06–3.71</td>
<td>.033</td>
</tr>
<tr>
<td>Component “Informal Behavior”</td>
<td>.003</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-59 years</td>
<td>Ref</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-39 years</td>
<td>.633</td>
<td>.43–94</td>
<td>.022</td>
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<tr>
<td>60+ years</td>
<td>1.497</td>
<td>.88–2.54</td>
<td>.134</td>
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<tr>
<td>Component “Emotional Involvement”</td>
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<td></td>
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<tr>
<td>Gender</td>
<td></td>
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<tr>
<td>Female</td>
<td>Ref</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.927</td>
<td>1.13–3.30</td>
<td>.017</td>
</tr>
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<td>Psychotherapy training</td>
<td>.023</td>
<td></td>
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<td>.513</td>
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<td>Psychoanalytic therapy</td>
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<td>.007</td>
</tr>
<tr>
<td>Friendship After Therapy</td>
<td>.013</td>
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<td></td>
</tr>
<tr>
<td>Psychotherapy training</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Behavior therapy</td>
<td>Ref</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Person-centered therapy</td>
<td>1.090</td>
<td>.61–1.96</td>
<td>.774</td>
</tr>
<tr>
<td>Psychoanalytic therapy</td>
<td>.356</td>
<td>.17–.76</td>
<td>.008</td>
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<tr>
<td>Age</td>
<td>&lt;.001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-59 years</td>
<td>Ref</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-39 years</td>
<td>.284</td>
<td>.15–.55</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>60+ years</td>
<td>2.703</td>
<td>1.44–5.06</td>
<td>.002</td>
</tr>
</tbody>
</table>

DISCUSSION

Starting a sexual relationship with a current and/or former client or a friendship during therapy is rather exceptional (3 to 3.7%) in the career of psychotherapists in Flanders (Belgium), but starting a friendship after therapy was not that uncommon (13.4%). A much larger proportion of therapists reported intimate feelings and behavior (IFB) related to friendship and sexuality: about 7 out of 10 therapists found a client sexually attractive, a quarter fantasized about a romantic relationship, 80% accepted gifts from clients that were given during the course of the therapy, and a fifth gave a goodbye hug. For most IFB items at least 20% of therapists indicated it as a negative experience. In general, more male therapists
reported sexual related feelings and behaviors than female therapists. Therapists of 60 years and older more often indicated starting a friendship after therapy. Behavioral therapists significantly differed on starting friendships after therapy and on several IFB, especially compared to psychoanalytic therapists.

A first important finding of our study is that only a very small minority of therapists reported having started a sexual relationship with clients (3%), and mostly after termination of the therapy. This is similar to the British study (3.5%) and somewhat lower than in North American studies (4% to 9%) [10, 13-16, 18]. Furthermore, most of the responding therapists that started a sexual relationship did so with only one client, as also confirmed in the previous studies, making sexual relationships with clients mainly an exception over the whole career of some individual therapists. Starting friendships during therapy (3.7%) happens rarely, but friendships after therapy (13.4%) were not that uncommon. Previous North American studies found higher percentages ranging from 28% to 58% for starting friendships with a former client [11, 15, 17].

A second important finding, perhaps the main finding, is that, in contrast with starting sexual relationships and friendships, a wide variety of IFBs are rather common among therapists. At least 20% of therapists reported encountering most of the 15 IFB items, and at least 50% of therapists reported this for 5 IFB items. Similar-North American empirical studies even found substantially higher percentages for several IFBs, for instance regarding accepting clients from their personal life (22% versus 61 to 64%) [10-13, 15, 17]. The principal component analysis reduced the 15 IFB items to three main components. When comparing the three IFB components a difference in prevalence can be noticed. The component “sexual feelings and fantasies”, as well as “emotional involvement” are highly prevalent among all therapists (about 70 to 90%). Perhaps this is not so surprising because psychotherapeutic settings create a favorable environment for the development of such intimate feelings. The therapist and client are often alone together and meet frequently over a relatively long period. A “psychological intimacy” is built up, where emotional issues are discussed that people seldom talk about or only with their most trusted intimates [24]. Moreover, a competent therapist is expected to be human and empathic, creating emotional closeness [1, 8, 25]. Although the occurrence of the third component, “informal behavior”, is not negligible either, it is substantially lower than the other IFB components. Perhaps this has to do with the fact that
feelings and emotions are regarded as more permissible and less potentially harmful than concrete behavior related to these feelings and emotions, indicating there is a high sense of morality among therapists.

The occurrence of most these IFB items was evaluated by at least 20% of therapists as a rather negative experience. Acknowledging and discussing these situations with peers and supervisors can be an important way of coping with these experiences, and ultimately enhance the well-being of therapists and the quality and effectiveness of the psychotherapeutic relationship. [8, 26]. Relevant stakeholders such as professional associations, educators, and supervisors should give this topic the attention it deserves.

A third rather surprising result is that, overall, with exception of the occurrence of feeling sexually attracted, sexually fantasizing and starting a sexual relationship, prevalence of IFBs in our study are lower than these found in North America and in British studies. This is surprising because it was expected that, compared to North America and the United Kingdom, continental Europe would have a more tolerant attitude towards feelings and behaviors related to sexuality and friendship, as it is more influenced by the southern cultures (such as Spain and Italy) where interactions are generally more cordial and physical. Possibly this unexpected result can be explained by the time period in which previous studies were conducted. It is quite possible that for example the prevalence rates in North America have also changed now, due to factors such as changing legislation, policies, and events that received considerable media attention (i.e., #MeToo).

With regard to therapists’ characteristics, our study shows that male therapists report “sexual feelings and fantasies” and starting sexual relationships more often than female therapists, which is also confirmed by earlier studies [10, 12, 13, 15, 18, 27]. Sexual relationships were started by about one out of ten male therapists, so it was not that exceptional within this particular group of therapists. There are several possible explanations for this finding. One might be that men naturally have more frequent and intense sexual desires, resulting in more sexual feelings and behavior [28, 29]. Possibly the need or ability to dominate and control can also play a role in cases of sexual abuse. Studies of gender differences have shown that men overall desire power more and possess higher levels of power [30-32].

The higher prevalence found among therapists of 60 years or above for starting friendships with former clients and showing “informal behavior”, compared to their younger colleagues,
was not found in previous studies. Perhaps this higher prevalence is due to the development of more confidence and competence through the years in controlling such situations.

Moreover, this study shows that psychiatrists less often reported “sexual feelings and fantasies” compared with psychologists and therapists with another basic education. No previous studies have found such differences based on basic education. Possibly, this is related to characteristics of psychiatrists’ clients, who generally have more serious pathologies and are more dependent, or it may be related to societal expectations of the role psychiatrists have to play as physicians, both of which make the development of such feelings and behavior less probable. Furthermore, psychiatrists might have different characteristics than non-psychiatrists as they have chosen to be trained as a physician, with more training in maintaining a certain clinical distance to clients compared to non-psychiatrists.

The type of psychotherapy training also seems to play a substantial role in the prevalence of “sexual feelings and fantasies”, “emotional involvement” and “friendships after therapy”. Behavioral therapists are less likely to experience “sexual feelings and fantasies”, but more often reported “emotional involvement” and friendships with former clients than person-centered and psychoanalytic therapists. A possible explanation is that psychological intimacy, as a possible source of sexual feelings and fantasies, is present to a lesser extent in the psychotherapeutic orientation of behavioral therapists, who more focus on the clients’ behavior and thoughts [35]. In psychoanalytic and person-centered training, more attention is given in the therapeutic process to the role of feelings, motives and desires of clients and therapists, possibly contributing to greater awareness and reporting of such feelings in this study, but also to more carefully maintaining strict boundaries with regard to emotional involvement with the client.

Finally, this study finds a link between the occurrence of intimate feelings and behaviors and starting sexual relationships, but it does not show that these intimate feelings and behaviors always lead automatically to sexual relationships. When such intimate feelings are associated by default with potential harmful sexual contact, this may hinder therapists to discuss such feelings and behavior with relevant others, for fear of a negative reaction [8, 26].

In Belgium this is the first study investigating the occurrence of friendships and sexual relationships, and related intimate feelings and behaviors (IFB) in psychotherapy among psychiatrists and licensed psychotherapists of Flanders, the Flemish speaking part of Belgium.
The achieved response rate of this study is satisfactory and comparable with previous studies [10-13, 15, 17, 18, 33, 34]. However, all figures in this study should be interpreted with caution. Therapists who are more conservative about sexuality or IFB, as well as therapists who have not adhered to the ethical principles of the professional associations, were possibly less willing to participate in this study, resulting in some selection bias. Taking into account the sensitivity of the subject, it cannot be ruled out either that some respondents gave socially desirable answers, which probably leads to an underestimation of results. Furthermore, the small numbers of some outcome variables limited statistical analyses. A disadvantage of the study is also that information about the characteristics of the client with whom therapists started a friendship or sexual relationship, the time period when this took place, and how long after therapy had ended, was not requested. Furthermore, it is unfortunate that we could not reach all members of the systemic professional psychotherapy association.

ACKNOWLEDGEMENTS

The authors gratefully acknowledge everyone who helped to prepare the postal survey, and of course all the respondents who were willing to participate in this study. Furthermore, we thank Helen White for her linguistic help and the Interfaculty Center Data Processing and Statistics for their support in methodology and statistics.
REFERENCES


**SUPPLEMENTAL FILE 1**

*Frequency of the occurrence, regarding intimate feelings and behavior (IFB) related to friendship and sexuality (N=758)*

<table>
<thead>
<tr>
<th>Items</th>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Regularly</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I find a client sexually attractive</td>
<td>222 (29.4%)</td>
<td>334 (44.3%)</td>
<td>185 (24.5%)</td>
<td>12 (1.6%)</td>
<td>1 (0.1%)</td>
</tr>
<tr>
<td>2. I feel that there is sexual tension between me and the client during therapy</td>
<td>320 (42.5%)</td>
<td>350 (46.5%)</td>
<td>82 (10.9%)</td>
<td>0 (0%)</td>
<td>1 (0.1%)</td>
</tr>
<tr>
<td>3. I fantasize about what it would be like to have a romantic relationship with a client</td>
<td>581 (77.2%)</td>
<td>155 (20.6%)</td>
<td>16 (2.1%)</td>
<td>1 (0.1%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>4. I fantasize about sexual contact with a client</td>
<td>552 (73.2%)</td>
<td>180 (23.9%)</td>
<td>21 (2.8%)</td>
<td>1 (0.1%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>5. I feel sexually aroused during the conversation with a client</td>
<td>606 (80.5%)</td>
<td>138 (18.3%)</td>
<td>9 (1.2%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>6. I want a client to find me attractive</td>
<td>448 (59.7%)</td>
<td>200 (26.6%)</td>
<td>83 (11.1%)</td>
<td>18 (2.4%)</td>
<td>2 (0.3%)</td>
</tr>
<tr>
<td>7. I accept clients that I already know from my personal life</td>
<td>588 (78%)</td>
<td>128 (17%)</td>
<td>34 (4.5%)</td>
<td>4 (0.5%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>8. I give a client a goodbye hug at the end of a session</td>
<td>584 (77.6%)</td>
<td>126 (16.7%)</td>
<td>36 (4.8%)</td>
<td>6 (0.8%)</td>
<td>1 (0.1%)</td>
</tr>
<tr>
<td>9. I confide in a client about my personal concerns</td>
<td>632 (83.8%)</td>
<td>108 (14.3%)</td>
<td>13 (1.7%)</td>
<td>1 (0.1%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>10. I accept gifts from a client that are given during the course of therapy</td>
<td>151 (20.1%)</td>
<td>339 (45.1%)</td>
<td>218 (29%)</td>
<td>31 (4.1%)</td>
<td>13 (1.7%)</td>
</tr>
<tr>
<td>11. I find that I am emotionally quite involved with a client</td>
<td>29 (3.9%)</td>
<td>196 (26%)</td>
<td>366 (48.6%)</td>
<td>134 (17.8%)</td>
<td>28 (3.7%)</td>
</tr>
<tr>
<td>12. A client feels like a friend</td>
<td>210 (27.9%)</td>
<td>303 (40.2%)</td>
<td>210 (27.9%)</td>
<td>25 (3.3%)</td>
<td>5 (0.7)</td>
</tr>
<tr>
<td>13. I make informal contact with a client outside the context of therapy</td>
<td>668 (88.6%)</td>
<td>77 (10.2%)</td>
<td>9 (1.2%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>14. I schedule my appointments with a client in such a way that they can be extended</td>
<td>399 (53%)</td>
<td>238 (31.6%)</td>
<td>89 (11.8%)</td>
<td>21 (2.8%)</td>
<td>6 (0.8)</td>
</tr>
<tr>
<td>15. A client came to my home (unrelated to the practice) to provide me with a service</td>
<td>713 (94.8%)</td>
<td>38 (5.1%)</td>
<td>1 (0.1%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

*aDue to missing data N varies from 751 to 758 per item.*
### Experience of the occurrence, regarding intimate feelings and behavior (IFB) related to friendship and sexuality

<table>
<thead>
<tr>
<th>Items</th>
<th>1 = very negative</th>
<th>2 = very negative</th>
<th>3 = very negative</th>
<th>4 = very negative</th>
<th>5 = very negative</th>
<th>6 = very positive</th>
<th>N per item varies, because only therapists who indicated there was an occurrence, answered the question about how this occurrence was evaluated.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I find a client sexually attractive (N=452)</td>
<td>16 (3.5%)</td>
<td>85 (18.8%)</td>
<td>163 (36%)</td>
<td>145 (32%)</td>
<td>30 (6.6%)</td>
<td>13 (2.9%)</td>
<td></td>
</tr>
<tr>
<td>2. I feel that there is sexual tension between me and the client during therapy (N=394)</td>
<td>46 (11.7%)</td>
<td>134 (34%)</td>
<td>137 (34.8%)</td>
<td>57 (14.5%)</td>
<td>17 (4.3%)</td>
<td>3 (0.8%)</td>
<td></td>
</tr>
<tr>
<td>3. I fantasize about what it would be like to have a romantic relationship with a client (N=644)</td>
<td>15 (10.6%)</td>
<td>36 (25.4%)</td>
<td>48 (33.8%)</td>
<td>29 (20.4%)</td>
<td>7 (4.9%)</td>
<td>7 (4.9%)</td>
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<tr>
<td>4. I fantasize about sexual contact with a client (N=173)</td>
<td>20 (11.6%)</td>
<td>38 (22%)</td>
<td>51 (29.5%)</td>
<td>49 (28.3%)</td>
<td>11 (6.4%)</td>
<td>4 (2.3%)</td>
<td></td>
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<tr>
<td>5. I feel sexually aroused during the conversation with a client (N=131)</td>
<td>25 (18.9%)</td>
<td>40 (30.3%)</td>
<td>44 (33.3%)</td>
<td>14 (10.6%)</td>
<td>3 (2.3%)</td>
<td>5 (3.8%)</td>
<td></td>
</tr>
<tr>
<td>6. I want a client to find me attractive (N=264)</td>
<td>10 (3.8%)</td>
<td>58 (21.9%)</td>
<td>100 (37.7%)</td>
<td>77 (29.1%)</td>
<td>15 (5.7%)</td>
<td>4 (1.5%)</td>
<td></td>
</tr>
<tr>
<td>7. I accept clients that I already know from my personal life (N=154)</td>
<td>5 (3.2%)</td>
<td>41 (26.6%)</td>
<td>49 (31.8%)</td>
<td>43 (27.9%)</td>
<td>13 (8.4%)</td>
<td>3 (1.9%)</td>
<td></td>
</tr>
<tr>
<td>8. I give a client a goodbye hug at the end of a session (N=158)</td>
<td>3 (1.9%)</td>
<td>15 (9.5%)</td>
<td>26 (16.5%)</td>
<td>62 (39.2%)</td>
<td>43 (27.2%)</td>
<td>9 (5.7%)</td>
<td></td>
</tr>
<tr>
<td>9. I confide in a client about my personal concerns (N=111)</td>
<td>2 (1.8%)</td>
<td>16 (14.4%)</td>
<td>31 (27.9%)</td>
<td>45 (40.5%)</td>
<td>13 (11.7%)</td>
<td>4 (3.6%)</td>
<td></td>
</tr>
<tr>
<td>10. I accept gifts from a client that are given during the course of therapy (N=547)</td>
<td>8 (1.5%)</td>
<td>55 (10.1%)</td>
<td>165 (30.2%)</td>
<td>218 (39.9%)</td>
<td>81 (14.8%)</td>
<td>20 (3.7%)</td>
<td></td>
</tr>
<tr>
<td>11. I find that I am emotionally quite involved with a client (N=673)</td>
<td>1 (0.1%)</td>
<td>52 (7.7%)</td>
<td>241 (35.7%)</td>
<td>263 (39%)</td>
<td>103 (15.3%)</td>
<td>13 (1.9%)</td>
<td></td>
</tr>
<tr>
<td>12. A client feels like a friend (N=517)</td>
<td>2 (0.4%)</td>
<td>17 (3.3%)</td>
<td>123 (23.7%)</td>
<td>268 (51.7%)</td>
<td>96 (18.5%)</td>
<td>11 (2.1%)</td>
<td></td>
</tr>
<tr>
<td>13. I make informal contact with a client outside the context of therapy (N=76)</td>
<td>1 (1.3%)</td>
<td>12 (15.6%)</td>
<td>23 (29.9%)</td>
<td>20 (26%)</td>
<td>17 (22.1%)</td>
<td>3 (3.9%)</td>
<td></td>
</tr>
<tr>
<td>14. I schedule my appointments with a client in such a way that they can be extended (N=326)</td>
<td>9 (2.7%)</td>
<td>60 (18.3%)</td>
<td>129 (39.3%)</td>
<td>89 (27.1%)</td>
<td>30 (9.1%)</td>
<td>9 (2.7%)</td>
<td></td>
</tr>
<tr>
<td>15. A client came to my home (unrelated to the practice) to provide me with a service (N=38)</td>
<td>4 (10.5%)</td>
<td>6 (15.8%)</td>
<td>9 (23.7%)</td>
<td>12 (31.6%)</td>
<td>5 (13.2%)</td>
<td>2 (5.3%)</td>
<td></td>
</tr>
</tbody>
</table>
2. Psychotherapists' attitudes to intimate and informal behavior towards clients

Manuscript details:

ABSTRACT

Background: To avoid harming or exploiting a client, sexual and non-sexual dual relationship are generally considered as unacceptable in the psychotherapeutic relationship. However, little is known about what therapists themselves constitute as (un)acceptable intimate and informal behavior.

Methods: A survey among psychotherapists in Flanders (Belgium) was conducted. Opinions about the acceptability of intimate and informal behavior were asked. Based on these opinions attitude groups could be determined.

Results: 786 therapists completed and returned the questionnaire (response rate 39.8%). Therapists could be divided into three attitude groups. Almost half of the therapists belonged to the ‘rather restrictive group’, a third to the ‘rather socially permissive group’, and a fifth to the ‘rather sexually permissive group’. Being categorized as ‘rather sexually permissive’ is predominantly related to being male and non-heterosexual, whereas being ‘rather restrictive’ or ‘rather socially permissive’ is mainly due to type of psychotherapy training. The ‘rather sexually permissive’ therapists more often found a client sexually attractive during the last year and fantasized more often about a romantic relationship with a client, but they did not more often started a sexual relationship.

Conclusions: Most therapists in Flanders are rather restrictive in their attitude to intimate and informal behavior, pointing to a high sense of morality. Having a rather sexually permissive attitude is predominantly related to more personal characteristics of the therapists, but these therapists did not start a sexual relationship more often.
INTRODUCTION

Psychotherapists are expected to behave ethically towards clients. The most important and generally accepted ethical principle is to avoid behavior that could harm or exploit a client, such as sexual relationships or non-sexual dual relationships, being a combination of a professional and another (often more personal) kind of relationship [1-4]. The question arises whether other intimate and informal behavior, such as giving a lift to a client, is to be considered harmful as well by definition. Although this behavior could be a precursor to sexual or non-sexual dual relationships, it may also just be innocent kindness or behavior aimed at building a rapport. So, what exactly constitutes harmful behavior is not always clear. There is no such thing as a reference list of prohibited and permitted behavior. Ultimately, each therapist will have to decide sincerely and individually what is and what is not ethically acceptable, depending on the uniqueness of each situation, the context, and specific characteristics of the client and on the basis of their own experience, knowledge, therapeutic orientation, personal opinion, etc. [5-7].

Although some studies in the 1980s and 1990s focused on the ethical acceptability of sexual and non-sexual dual relationships in psychotherapy [8-12], current research on this topic is very scarce, especially about the acceptability of other intimate and informal behavior that is not explicitly mentioned in ethical codes [12].

Studying the therapists’ opinions about the acceptability of such behavior will inform us about their attitude to this theme. More insight into these attitudes, their association with the therapists’ characteristics and actual intimate events, may help us to understand the therapists’ behavior and choices in their daily work with clients. These findings can also be valuable to reflect on the existing ethical codes and to fuel evidence-based educational programs.

Therefore, this study aims 1) to describe the opinions of therapists about the acceptability of intimate and informal behavior in Flanders (the Dutch-speaking part of Belgium), 2) to investigate whether specific attitude groups of therapists can be distinguished based on these opinions, 3) to investigate associations between attitude groups and a) characteristics of the therapist, and b) actual intimate and informal events.
METHOD

A cross-sectional study was conducted, from November 2016 to June 2018, among Flemish Dutch-speaking psychotherapists (hereinafter: therapists) who received a self-administered questionnaire.

Population

Therapists were included in this study if they were in practice or in their last year of training at the time, and members of the following large, accredited associations in Flanders (Belgium): Flemish Association for Person-Centered Psychotherapy (N = 288); Flemish Association for Behavioral Therapy (N = 568); Flemish Association for Psychoanalytic Psychotherapy (N = 205); and Flemish psychiatrists registered with the National Institute for Health and Disability Insurance (NIHDI) (N = 910). The accredited association of systemic therapy did not participate in this study.

Data collection

The presidents of the aforementioned groups were contacted to distribute the questionnaire among their members, thereby adjusting the recruiting strategy slightly for each group. Therapists received the questionnaire in different modes: first online through a link in an e-mail and/or an announcement in a digital newsletter and then, a few weeks later, by regular post with a return freepost addressed envelope to the researchers. Reminders were sent at least once, both after the online version and after sending the hard copy by post. An information letter from the researchers accompanied the questionnaire, which informed respondents thoroughly about the aim and method of the study and the anonymity procedure (see ethics). Furthermore, it was pointed out that respondents only had to fill out and return the questionnaire once, and by doing so they declared that they were well informed and willing to participate to the study. Finally, key figures highlighted the importance of the study and encouraged participation in a recommendation letter that also accompanied the questionnaire.

Questionnaire

To explore the attitude of therapists towards intimate and informal behavior (hereinafter abbreviated to IIB), we asked their opinion about the general acceptability of 11 statements on a 4-point scale, going from completely unacceptable, rather unacceptable, rather
acceptable to completely acceptable. Furthermore, we investigated the occurrence of 5 intimate and informal events that happened in the past 12 months.

These statements and events were based on previous studies [9, 10, 12], and on discussions with a client, an ombudsperson, therapists and educators of several theoretical orientations (who were thereafter not included in this study).

Furthermore, data on the demographical context of the therapists, such as gender, sexual orientation and age, and on some educational items, such as basic education and psychotherapy training, was collected.

Analysis

The answers to the IIB statements were subjected to a k-means cluster analysis to distinguish attitude groups of therapists regarding IIB. Options with two to four groups were explored, and the best interpretable option was chosen. Chi-square tests were used to compare group differences on the statements, and to label the groups.

To investigate associations between demographic and educational variables of the therapists and the attitude groups they belonged to, as well as between the attitude group and recent intimate and informal events, chi-square tests were also used or fisher exact tests when suitable.

IBM SPSS Statistics, version 25.0, was used for all analyses.

Ethics

This study was approved by the Medical Ethics Committee UZ Brussels – VUB (B.U.N. 143201524243). To establish anonymity, measures were taken with regard to the content of the questionnaire and the data collection. With regard to the content, no questions were asked that, in combination, could lead to identification of the respondent, such as the specific age or workplace of the respondents. With regard to the data collection, no identification code was printed on the hard copy questionnaire or envelope, nor were IP addresses or email addresses captured by the survey website settings. Furthermore, the completed questionnaires were sent directly to the researchers, who had no contact data of the participants.
RESULTS

Response rate

Of the 1971 therapists that were contacted, 786 therapists completed and returned the questionnaire (response rate 39.8%), by post (n=610) or online (n=176). 37 postal questionnaires were returned blank to the researchers, mainly due to wrong addresses.

Regarding the occurrence of intimate and informal events, only therapists who at that time had given therapy during the last 12 months were included in this analysis (N=698 of the 786 therapists).

Characteristics of respondents

Of the 786 responding therapists, 69% were female (n=541), 89% were heterosexual (n=696), 43.6% were in the age group of 20-39 years (n=342) and 39.6% in the age group 40 to 59 years (n=311). In the oldest age group, there were more men than women (60 years or older: gender ratio: 1.6/1), while in the younger age groups the opposite was true (20-39 years: gender ratio 0.5/1, and 40-59 years: gender ratio 0.2/1). Concerning basic education, 53.6% were trained as psychologists (n=421) and 40.8% as psychiatrists (n=320). Therapists who followed or completed person-centered therapy training (n=173) made up 22.1%, whether or not combined with another training; 39.3% (n=308) were behavioral therapists and 19.2% (n=150) were psychoanalytic therapists. Although the systemic therapy association did not participate in this study, 156 (19.9%) of the respondents, mostly psychiatrists, reported having followed or completed a systemic therapy training.

Therapists’ opinion of the acceptability of IIB statements

Most responding therapists found the behavior described in each of the 11 IIB statements (completely or rather) unacceptable (table 1). However, almost a third found it rather or completely acceptable to give a lift to a client waiting at a bus shelter (30%), or to start a romantic relationship with an ex-client, two years after the end of the therapy (28.3%). A fifth (21.3%) found it rather or completely acceptable to laugh at a joke made by a client who insinuates sexual contact with the therapist. One out of ten thought it was acceptable to
accept someone as a client they already knew from their personal life (10.4%), and to continue therapy sessions when the therapist is in love with the client (12.6%). Almost all therapists agreed that flirting with a friendly client (97.1%), accepting a Facebook friend request (98.3%), and letting the client help with a private task at the therapist’s home (98.6%) is unacceptable.

Table 1

<table>
<thead>
<tr>
<th>Statements</th>
<th>Completely unacceptable</th>
<th>Rather unacceptable</th>
<th>Rather acceptable</th>
<th>Completely acceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Giving a lift to a client waiting at a bus shelter</td>
<td>201 (25.8%)</td>
<td>344 (44.2%)</td>
<td>213 (27.3%)</td>
<td>21 (2.7%)</td>
</tr>
<tr>
<td>2. Starting a romantic relationship with an ex-client, 2 years after the end of therapy</td>
<td>233 (29.9%)</td>
<td>325 (41.8%)</td>
<td>199 (25.6%)</td>
<td>21 (2.7%)</td>
</tr>
<tr>
<td>3. Laughing at a joke made by a client who is insinuating sexual contact with the therapist</td>
<td>265 (34.1%)</td>
<td>346 (44.6%)</td>
<td>142 (18.3%)</td>
<td>23 (3%)</td>
</tr>
<tr>
<td>4. Adjusting the client’s collar and brushing fluff from their shoulder</td>
<td>390 (50.1%)</td>
<td>289 (37.1%)</td>
<td>88 (11.3%)</td>
<td>12 (1.5%)</td>
</tr>
<tr>
<td>5. Continuing the therapy sessions when the therapist is in love with the client</td>
<td>419 (53.8%)</td>
<td>262 (33.6%)</td>
<td>91 (11.7%)</td>
<td>7 (0.9%)</td>
</tr>
<tr>
<td>6. Inviting a client to join an activity in which there is a shared interest</td>
<td>427 (54.9%)</td>
<td>268 (34.5%)</td>
<td>75 (9.7%)</td>
<td>7 (0.9%)</td>
</tr>
<tr>
<td>7. Accepting someone the therapist knows from their private life as a client</td>
<td>388 (49.8%)</td>
<td>310 (39.8%)</td>
<td>77 (9.9%)</td>
<td>4 (0.5%)</td>
</tr>
<tr>
<td>8. Making a sexually suggestive joke</td>
<td>543 (69.8%)</td>
<td>187 (24%)</td>
<td>46 (5.9%)</td>
<td>2 (0.3%)</td>
</tr>
<tr>
<td>9. Flirting with a friendly client, without further ulterior motives</td>
<td>574 (73.8%)</td>
<td>181 (23.3%)</td>
<td>20 (2.6%)</td>
<td>2 (0.3%)</td>
</tr>
<tr>
<td>10. Accepting a Facebook friend request from a client</td>
<td>543 (70.1%)</td>
<td>218 (28.2%)</td>
<td>13 (1.7%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>11. Letting the client help with a private task at the therapist’s home</td>
<td>650 (83.3%)</td>
<td>119 (15.3%)</td>
<td>11 (1.4%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

Due to missing data N per statement varies from 776 to 780.

Three attitude groups, based on therapists’ opinions about the acceptability of IIB statements

A k-means cluster analysis based on therapists’ answers to the 11 statements revealed three interpretable groups of therapists in their attitude towards intimate and informal behavior (table 2). Labelling of groups was based on a cross-tabulation with the statements. The attitude groups can be labelled as follows: “rather restrictive”, “rather socially permissive”, and “rather sexually permissive”. Almost half of the therapists belong to the rather restrictive
group, a third to the rather socially permissive group, and a fifth to the rather sexually permissive group. Twenty-nine therapists were not classified in any of the three attitude groups, because of missing answers to at least one of the 11 statements.

Table 2
Three attitude groups, based on therapists’ opinion about the acceptability of IIB statements (N=757)1

<table>
<thead>
<tr>
<th>Statements</th>
<th>Acceptability per attitude group (%)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rather restrictive (N=356)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rather social permissive (N=244)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rather sexual permissive (N=157)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>p-value</td>
<td></td>
</tr>
<tr>
<td>Giving a lift to a client waiting at a bus shelter.</td>
<td>4.5</td>
<td>53.3</td>
</tr>
<tr>
<td>Starting a romantic relationship with an ex-client,</td>
<td>7.3</td>
<td>45.5</td>
</tr>
<tr>
<td>2 years after the end of therapy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laughing at a joke made by a client who is</td>
<td>9</td>
<td>11.9</td>
</tr>
<tr>
<td>insinuating sexual contact with the therapist.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusting the client’s collar and brushing fluff</td>
<td>3.1</td>
<td>16.4</td>
</tr>
<tr>
<td>from their shoulder.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuing the therapy sessions when the therapist</td>
<td>5.9</td>
<td>3.3</td>
</tr>
<tr>
<td>is in love with the client.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inviting a client to join an activity in which</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>there is a shared interest.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accepting someone the therapist knows from their</td>
<td>2</td>
<td>16.4</td>
</tr>
<tr>
<td>personal life as a client.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Making a sexually suggestive joke.</td>
<td>1.4</td>
<td>2.5</td>
</tr>
<tr>
<td>Flirting with a friendly client, without further</td>
<td>0.3</td>
<td>0.4</td>
</tr>
<tr>
<td>ulterior motives.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accepting a Facebook friend request from a client.</td>
<td>0</td>
<td>1.6</td>
</tr>
<tr>
<td>Letting the client help with a private task at the</td>
<td>0.3</td>
<td>1.2</td>
</tr>
<tr>
<td>therapist’s home.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1Due to missing data N per statement varies from 776 to 780. *Combines rather acceptable and completely acceptable.

The label ‘rather restrictive’ is justified by the lowest percentages on almost all statements. The label ‘rather sexually permissive’ is justified because more than half of the group (63.7%) found it acceptable to laugh at a joke made by a client insinuating sexual contact, almost half of the group found it acceptable to start a romantic relationship with an ex-client two years after the end of therapy (49%) and to continue therapy sessions when the therapist is in love with the client (41.4%), almost a quarter (22.9%) found it acceptable to make a sexually suggestive joke, and more than one out of ten therapists in this group thought flirting was acceptable (12.7%). The group ‘rather socially permissive’ is an intermediate group. Overall, it
has higher frequencies than the ‘rather restrictive group’, but lower frequencies than the ‘rather sexually permissive group’, although on some more socially oriented statements the frequencies are comparable, for example giving a lift to a client (53.3%), accepting a client from their personal life (16.4%), inviting a client to join an activity in which there is a shared interest (18%).

**Attitude groups according to characteristics of therapists**

With regard to the ‘rather restrictive group’, more therapists from the middle age group, 40 to 59 years (57.7%), belonged to this group compared to the oldest group of 60 years and above (46.8%) or the youngest group (37.3%), and more psychoanalytic therapists (62.7%) compared to person-centered therapists (49.6%) and behavioral therapists (36.5%) (table 3).

With regard to the ‘rather socially permissive group’, female therapists (34.8%) belonged to this group more often than male therapists (26.8%); therapists from the youngest age group (38.9%) more often than the older age groups (26.7% and 28.2%), and behavioral therapists (42.6%) more often than person-centered (27.7%) and psychoanalytic therapists (17.8%).

With regard to the ‘rather sexually permissive group’, male therapists (30.2%) and non-heterosexual therapists (31.3%) belonged to this group more often than female therapists (16.5%) and heterosexual therapists (19.6%) respectively; the younger and older therapists (23.8% and 25%) more often than the middle age group of 40 to 59 years (15.7%); and psychologists (24.3%) more often than psychiatrists (16.6%) and therapists with another basic education than psychology or psychiatry (16.7%).

Further analyses revealed that in the middle age group of 40 to 59 years, there were more psychoanalytic therapists than person-centered and behavioral therapists (52% versus 45.4% and 25.5%), and in the youngest age group of 20 to 39 years, more behavioral therapists than person-centered and psychoanalytic therapists (64.7% versus 38.6% and 25%).
Table 3
Attitude groups according to characteristics of therapists (N=757)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Rather restrictive (N = 356)</th>
<th>Rather social permissive (N = 244)</th>
<th>Rather sexual permissive (N = 157)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Male therapists (n=235)</td>
<td>101 (43)</td>
<td>63 (26.8)</td>
<td>71 (30.2)</td>
<td></td>
</tr>
<tr>
<td>Female therapists (n=520)</td>
<td>253 (48.7)</td>
<td>181 (34.8)</td>
<td>86 (16.5)</td>
<td></td>
</tr>
<tr>
<td>p-value</td>
<td>0.086</td>
<td>0.035</td>
<td>&lt;0.001</td>
<td></td>
</tr>
<tr>
<td>Sexual orientation</td>
<td></td>
<td></td>
<td></td>
<td>0.024</td>
</tr>
<tr>
<td>Heterosexual (n=670)</td>
<td>316 (47.2)</td>
<td>223 (33.3)</td>
<td>131 (19.6)</td>
<td></td>
</tr>
<tr>
<td>Non-heterosexual (n=83)</td>
<td>38 (45.8)</td>
<td>19 (22.9)</td>
<td>26 (31.3)</td>
<td></td>
</tr>
<tr>
<td>p-value</td>
<td>0.453</td>
<td>0.062</td>
<td>0.021</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>20-39 years (n=332)</td>
<td>124 (37.3)</td>
<td>129 (38.9)</td>
<td>79 (23.8)</td>
<td></td>
</tr>
<tr>
<td>40-59 years (n=300)</td>
<td>173 (57.7)</td>
<td>80 (26.7)</td>
<td>47 (15.7)</td>
<td></td>
</tr>
<tr>
<td>60+ years (n=124)</td>
<td>58 (46.8)</td>
<td>35 (28.2)</td>
<td>31 (25)</td>
<td></td>
</tr>
<tr>
<td>p-value</td>
<td>&lt;0.001</td>
<td>0.003</td>
<td>0.019</td>
<td></td>
</tr>
<tr>
<td>Basic education</td>
<td></td>
<td></td>
<td></td>
<td>0.088</td>
</tr>
<tr>
<td>Psychologists (n=400)</td>
<td>173 (43.3)</td>
<td>130 (32.5)</td>
<td>97 (24.3)</td>
<td></td>
</tr>
<tr>
<td>Psychiatrists (n=314)</td>
<td>162 (51.6)</td>
<td>100 (31.8)</td>
<td>52 (16.6)</td>
<td></td>
</tr>
<tr>
<td>Other (n=42)</td>
<td>21 (50)</td>
<td>14 (33.3)</td>
<td>7 (16.7)</td>
<td></td>
</tr>
<tr>
<td>p-value</td>
<td>0.079</td>
<td>0.972</td>
<td>0.034</td>
<td></td>
</tr>
<tr>
<td>Psychotherapy training</td>
<td></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Person-centered therapy (n=137)</td>
<td>68 (49.6)</td>
<td>38 (27.7)</td>
<td>31 (22.6)</td>
<td></td>
</tr>
<tr>
<td>Behavioral therapy (n=277)</td>
<td>101 (36.5)</td>
<td>118 (42.6)</td>
<td>58 (20.9)</td>
<td></td>
</tr>
<tr>
<td>Psychoanalytic therapy (n=118)</td>
<td>74 (62.7)</td>
<td>21 (17.8)</td>
<td>23 (19.5)</td>
<td></td>
</tr>
<tr>
<td>p-value</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
<td>0.827</td>
<td></td>
</tr>
</tbody>
</table>

1Due to missing data, N for respondent characteristics varies from 753 to 756.
2Only therapists solely educated in person-centered, or behavioral or psychoanalytic psychotherapy training are included (N=546). Combinations of these were excluded. Due to missing data, N for psychotherapy training is 532.

Occurrence of intimate and informal events during the last 12 months, according to attitude group

Of those therapists who have given psychotherapy during the last 12 months (N = 698), more than half of them (57%) reported that they had been quite emotionally involved with a client during that year, more than a quarter (28.7%) found a client sexually attractive, and about one out of ten therapists indicated that they had accepted clients from their personal life (9.8%), or to have fantasized about what it would be like to have a romantic relationship with a client (7.9%), 3.2% started a friendship with a client at time of therapy or after the therapy had ended, and 1.9% made informal contact with clients outside the context of therapy. Three therapists started a sexual relationship with a client at time of therapy or after the therapy had ended (table 4).
Three of the intimate and informal events were related to attitude (table 4). Therapists with a ‘rather sexually permissive’ attitude (42.5%) reported higher occurrences of finding a client sexually attractive compared to ‘rather restrictive’ (29.2%) and ‘rather socially permissive’ therapists (20.3%), and for fantasizing about a romantic relationship with a client (14.2% versus 6.6% and 6%). ‘Rather restrictive’ therapists (5.3%) reported a lower occurrence of accepting clients they already knew from their personal life than ‘rather socially permissive’ and ‘rather sexually permissive’ therapists (13.8 and 13.4%).

Table 4
Occurrence of intimate and informal events, during the last 12 months, according to attitude group (N=698)1

<table>
<thead>
<tr>
<th>Intimate and informal events</th>
<th>Total frequency</th>
<th>Frequency per attitude group (N=670)2</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>Rather restrictive (N=319)3</td>
</tr>
<tr>
<td>I find that I am emotionally quite involved with a client</td>
<td>395</td>
<td>57</td>
<td>57.1</td>
</tr>
<tr>
<td>I find a client sexually attractive</td>
<td>200</td>
<td>28.7</td>
<td>29.2</td>
</tr>
<tr>
<td>I accept clients that I already know from my personal life</td>
<td>68</td>
<td>9.8</td>
<td>5.3</td>
</tr>
<tr>
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1Due to missing data N per ‘intimate and informal events’ varies from 686 to 698. 2Due to missing data N is lower compared to total frequency (N=698). 3Due to missing data N in the ‘rather restrictive’ group varies from 317 to 319. 4Due to missing data N in the ‘rather social permissive’ group varies from 216 to 218. 5Due to missing data N in the ‘rather sexually permissive’ group varies from 131 to 134.
DISCUSSION

This study shows that therapists in Flanders (Belgium) are rather restrictive in their attitude to intimate and informal behavior (IIB) in the psychotherapeutic relationship. Flirting with a client, accepting a Facebook friend request from a client and letting the client help with a private task at home were defined as unacceptable by almost all therapists. However, almost a third found it acceptable to start a romantic relationship with a former client two years after the end of the therapy. One out of ten thought it was acceptable to continue therapy sessions when the therapist is in love with the client and to accept someone they already knew from their personal life as a client. Based on their opinion, the responding therapists could be divided into three attitude groups, namely rather restrictive therapists, rather socially permissive therapists and rather sexually permissive therapists. Belonging to one of the three attitude groups was related to gender, age and type of psychotherapy training of the therapist. The rather sexually permissive therapists found a client sexually attractive more often during the last year and fantasized more often about a romantic relationship with a client than the rather restrictive and rather socially permissive therapists, but they did not start a sexual relationship more often.

This is one of the first studies that extensively investigates attitudes of therapists regarding intimate and informal behavior in the psychotherapeutic relationship. Previous studies are outdated and have mainly focused on the aspect of sexual and non-sexual dual relationships. The response rate of this study is similar to the studies mentioned above [8-10, 12]. A limitation is that it cannot be ruled out that socially desirable answers were given, and neither can response bias be excluded. Furthermore, the direction of some associations is unclear. For example, does a rather sexually permissive attitude make therapists more vulnerable to feeling sexually attracted to a client or does this feeling change the attitude, or do therapists with a more sexually permissive attitude more readily report such feelings?

An important finding is that most of the intimate and informal behaviors presented in the 11 statements were perceived as unacceptable by the majority of therapists, which is consistent with previous studies about sexual and non-sexual dual behavior [9, 10]. In general, this points towards a rather cautious attitude among psychotherapists and a high sense of morality towards such behavior. However, 30 to 40% of the therapists found most of these behaviors ‘rather’ unacceptable instead of ‘completely’ unacceptable, indicating that there is some
willingness to consider these behaviors as acceptable in certain circumstances. Maybe it is not so surprising that therapists left some ‘negotiable space’ for acceptability, because of their deep awareness of the unique complexity of each situation where they have to determine how to flesh out their therapeutic relationship with a client [3]. Such relationships demand a nuanced approach.

Whereas some variance in the degree of acceptability was usually found, some behaviors were almost unanimously regarded as unacceptable, e.g., accepting a Facebook friend request from a client and letting the client help with a private task at home. Possibly this shows that a certain degree of intimacy and informality is only acceptable as long as it occurs within the realm of the psychotherapeutic relationship, and therapists by no means want to give clients the impression they can be part of their private life. This is consistent with the overall idea of avoiding dual relationships.

Furthermore, this study shows that only 1 out of 10 therapists find it acceptable to continue therapy when being/falling in love with the client, probably because it would interfere with the therapeutic process, caused by being distracted or overly involved [13]. However, starting a romantic relationship with a former client after a waiting period of two years is deemed to be acceptable by more than a quarter of therapists. Probably the rationale for not starting a sexual or romantic relationship with a current client does not remain intact concerning former clients who ended therapy ‘properly’ some time ago. Although the decision-making ability of former clients may still be impaired, the magnitude of that impairment seems to be in question [14]. This is in line with the ethical codes that in general discourage but do not prohibit relationships with former clients, although a waiting period of at least two years after termination of therapy is sometimes recommended [1-4].

Another main finding is that differences in having a rather restrictive or rather socially permissive attitude are mainly related to the type of psychotherapy training, whereas differences in having a rather sexually permissive attitude are mainly related to personal characteristics, such as being male and non-heterosexual. Differences in being rather sexually permissive possibly reflect the more general attitude differences in intimacy and sexuality based on gender and sexual orientation that we see in society [15-17]. The difference between types of psychotherapy training and having a rather restrictive or socially permissive attitude can probably be explained by differences in the extent to which -for instance- the concept of
boundaries is highlighted in these trainings. Traditionally, psychoanalytic therapists tend to be more restrictive and more trained in these concepts [9, 18].

Finally, an important finding is that therapists being categorized as ‘rather sexually permissive’ more often found a client sexually attractive or fantasized about a romantic relationship but did not started a friendship or sexual relationship more often than the ‘rather restrictive’ or ‘rather socially permissive’ therapists, seeming to indicate that experiencing and disclosing these intimate feelings not immediately means acting out on them.
REFERENCES


Part II: Intimate and sexual feelings addressed by therapists
3. Managing romantic and sexual feelings towards clients in the psychotherapy room

*Manuscript details:*

ABSTRACT

Being confronted with romantic or sexual feelings towards a client can be challenging for psychotherapists. Appropriately managing such experiences in a way that does not detract from the therapeutic relationship is not evident. To learn from therapists’ experiences with this, and possibly arrive at some helpful advice, this study explores how therapists perceive and use several management strategies. Both a survey and focus groups were conducted. Results show that, in general, the great majority of therapists who fantasize about a romantic relationship with a client never consider starting such a relationship, either during or after therapy. Therapists do dwell on the possible consequences for themselves and the client, and often they reflect profoundly on these experiences, while maintaining strict boundaries. Although therapists themselves highly recommend referring the client to a colleague if feelings become too intense, this rarely happens in practice. Therapists do not disclose their feelings to clients because, as they explain, it would be too stressful for the client and their surroundings. Although most therapists consider talking about their romantic and sexual feelings towards clients as something very important, only a third have actually disclosed their feelings in supervision, intervision, or in personal therapy. Therapists indicate there is still hesitance about this due to fear of condemnation. In conclusion, motives for referral of clients due to such feelings need more reflection and more efforts are necessary to create possibilities for therapists to talk about these experiences confidentially with peers or supervisors.
INTRODUCTION

Romantic and sexual feelings towards a client cannot be kept out of the psychotherapy room. At one point or another in their career, most therapists (60 to 90 %) will experience such feelings towards a client [1-3]. Nevertheless, it is not always easy for therapists to find an appropriate way to manage such feelings, to prevent them from negatively affecting the psychotherapeutic relationship and therapists’ wellbeing. Understandably, clear guidelines for how to actually manage such romantic and sexual feelings do not exist. Each situation is unique and might require a different approach. Contextual factors, such as therapists’ own experiences both in personal life and as a professional, specific characteristics of the client, etc. can differ substantially [4, 5]. However, it is generally recommended that therapists should reflect thoroughly on their feelings and, if necessary, seek guidance from senior colleagues or supervisors to assist the reflective process [2, 5-8]. The extent to which therapists nowadays actually manage such romantic and sexual feelings in their own practice (e.g., follow recommendations) and their perceptions about them are largely unknown. However, research into the topic might be helpful and give direction to some guidance and educational programs for therapists. Our study therefore aims to gain more insight in therapists’ perceptions of and use of management strategies for their romantic and sexual feelings towards clients.

METHOD

From November 2016 to May 2019, a cross-sectional survey and a focus group study were conducted to gather complementary data on this topic. The two studies were merged by bringing the separate results together in the discussion section during interpretation [9]. The studies were conducted among psychotherapists, in practice or in their last year of training, in Flanders, the Dutch-speaking northern region of Belgium.
Survey Study

Population

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

Data collection

The questionnaire was distributed through the participating accredited associations. Therapists received the questionnaire in an e-mail or using a link in a digital newsletter, and by regular post with a return freepost addressed envelope to the researchers. An accompanying letter from the researchers provided detailed information about the study (see ethics) and emphasized that the questionnaire should only be filled in once, even if it was received multiple times. To increase the response rate, a letter of recommendation to participate in the study was also added by key figures in the psychotherapeutic field in our country.

Questionnaire and analysis

In the questionnaire, if therapists indicated that they had fantasized about a romantic relationship with a client, they were asked to think about the last adult client about whom they fantasized (or were fantasizing), and to answer the following 11 statements about how they managed this situation (with yes or no):

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

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

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

Focus group study

Participants and data collection

In total 36 therapists participated in this qualitative study, distributed over 8 focus groups, with predominantly female therapists (n=28). Fourteen therapists were aged 20-39 years, 17 were aged 40-59 years, and 5 were aged 60 or older. Participants were recruited by an invitation letter from key figures in the psychotherapeutic field within their own network. They emphasized that participation was voluntary and had no (negative) consequences. It resulted in two homogenous groups with solely psychiatrists (mixed gender and age), three groups with solely female systemic therapists, of which one contained only relatively young
therapists (aged 20-39), two groups with only interactional or integrative psychotherapists, of which one containing female therapists only, and one rather mixed group. Before the start of each focus group, the research moderator, being the first author of this paper, informed the participants extensively about the aim, procedure and confidentiality of the study, which was then followed by signing the informed consent form by both the participant and the moderator. Then, therapists were asked to fill in a short form on demographic and educational information and finally asked for their consent to audiotape the conversation. After each focus group, the moderator wrote down her personal feelings and insights in a journal and debriefed the supervisor profoundly.

*Semi-structured discussion guide*

At the beginning of the focus group discussion, therapists were asked to think back to a situation where they encountered romantic or sexual feelings towards a client. They were given 5 to 10 minutes to reflect on their feelings individually. Then, each personal story was discussed in depth, including how they dealt with this situation. It was ensured that particular management strategies, also asked about in the survey, such as referral of clients to colleagues, disclosure of feelings to clients, and discussing these feelings with peers or in supervision, were also addressed in the focus groups. Therapists with no or little experience on this matter were also asked to give their opinion during the discussion.

*Data analysis*

To gain insight in the data gathered, a thematic analysis was used [10], with the support of the software package QSR International’s NVivo 12 [11]. After transcription of the audiotapes, the data was read and reread to form initial coding ideas (open coding). Then, a line-by-line analysis of each focus group was done, where the initial ideas were transformed into more specific themes and subthemes, by e.g., comparing codes across the data (axial coding). Finally, the core themes emerging from the open and axial coding were defined (selective coding). Data was analyzed until no novel information about this topic became apparent (until saturation). Reliability was strengthened by two authors doing the coding, regularly discussing together their findings (codes) to reach congruence. Furthermore, JB reviewed closely the whole process of data analysis. Finally, the interpretation and refinement of the emerging core themes were discussed with all co-authors, giving input from their different professional backgrounds (public health, sexology, psychiatry, and psychotherapy).
Ethics

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

RESULTS SURVEY

Response rate

In total 786 therapists completed and returned the questionnaire (response rate 39.8%), of whom 69% were female (n=541) and 43.6% were in the age group of 20-39 years (n=342). Of these 786 therapists, 105 reported having fantasized in the past about having a romantic relationship with (one of their) clients and filled in the 11 statements about how they managed such situation regarding the last client about whom they had or still have such fantasies. Only these 105 therapists were used for further analyses.

Managing romantic and sexual feelings

Only a small minority of the 105 therapists that fantasized about a romantic relationship also considered actually starting a romantic relationship, during (4.8%) or after the end of therapy (6.7%) (table 1). The majority thought about the possible consequences for themselves (65.4%) and their client (68%), and their respective surroundings. Almost three quarters of therapists (71.6%) ‘maintain strict boundaries’ due to their fantasy about a romantic relationship with this client. Referring a client to a colleague (6.7%) and disclosing feelings to the client (1%) were rather unusual. Furthermore, disclosing their feelings to others was not common. Just over a third discussed their feelings in supervision or intervisio (35.4%) and/or in personal therapy (31.6%).
Differences based on therapists’ characteristics (table 1) show that male therapists maintain strict boundaries (81.1%) and discuss their feelings in personal therapy (52.9%) significantly more often than female therapists (61.2% and 15.8% respectively). Middle aged and older therapists (aged 40 or above) more often reflected on the possible consequences for themselves (74.6%) and their client (78%), and more often maintain strict boundaries (82.8%) than their younger colleagues (53.3%, 54.5%, and 56.8% respectively). More psychiatrists (12.1%) than psychologists (1.6%) indicated that they considered starting a romantic relationship with a client during the period of therapy. Behavioral and psychoanalytic psychotherapists discussed their fantasy with family (2.9% and 4.8%) and colleagues (11.8% and 9.5%) less often than person-centered therapists (respectively 20.8% and 50%). No difference was found in disclosing this in supervision or intervision. None of the behavioral therapists disclosed their feelings in personal therapy, in contrast to (almost) half of the person-centered (40%) and psychoanalytic therapists (54.5%).

Based on therapists’ personal experiences (table 1), no differences were found in managing strategies between therapists who had the perception that the client also fantasized about a romantic relationship with them and therapists who had not that perception. Furthermore, no differences were found based on important problems or changes in their personal love life or professional life, except for the latter, regarding the strategy of maintaining strict boundaries. Therapists indicating that they had problems or changes in their professional life more often reported maintaining strict boundaries (84.8%) than those who did not indicate this (64.7%).
Table 1
Therapists’ managing strategies, related to therapists’ characteristics and personal experiences (N=105)\(^a\)

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**Characteristics:**

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Note: 
* Due to missing data N varies from 102 to 105. 
* Question was only answered when applicable; question 10 (N=79) and question 11 (N=38). 
* Due to the low N (N=6) the category 'other basic education' has been omitted. 
* Only therapists solely educated in person-centered, or behavioral or psychoanalytic psychotherapy training are included (N=79). Combinations of these were excluded. 

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

Both the actual management strategies of the psychotherapists when experiencing romantic and sexual feelings for a client and their opinions about how they should ideally react were discussed in the focus groups. Data analysis showed that most participants would never consider engaging in a relationship with a client. Instead they try to maintain strict boundaries and control their own personal feelings. Some therapists would end therapy and refer the client to a colleague, if necessary. Overall, therapists indicated reluctance to disclose their romantic or sexual feelings to the client, because it would burden the client too much. Talking to peers or supervisors when experiencing romantic and sexual feelings is generally considered to be important, although there is still much hesitancy about doing so, mostly because of their fear of being condemned for it.

(Not considering) starting a relationship

Consideration

Most therapists expressed the opinion that therapists should restrain from engaging in a relationship with a client. However, a few therapists indicated it was possible to follow their feelings and engage in a romantic or sexual relationship with a client, but only after the therapeutic relationship had ended. They also emphasized that it depends on the type of mental problems the client has. Only clients with minor problems are perceived as eligible for being a potential partner, whereas clients with a more serious psychiatric pathology are not.

P: They’re ill or someone who – to put it bluntly – has problems... That’s a big distinction (...) ... someone who’s ill... is what I’m saying... it would be inappropriate. You really might learn to encounter different sides of someone... that’s ... yes, that can happen. (...) Obviously any form of professional contact stops then.

Consequences

An important reason given for refraining from engaging in a relationship with a client was the negative consequences for clients.
Most therapists were of the opinion that there is a power imbalance between therapist and client. It was thought that such relationship could not develop to one where there is equality between partners, as this participant said:

P: But then there’s a difference in power, though. If they come to you for however many weeks... and expose their soul... and don’t know anything about you. That’s always going to... No, I don’t think it’s healthy.

This can have very negative consequences for clients, because clients could feel abused afterwards, as is illustrated in the following quote:

P: I’ve had various patients like that, who’ve actually had something going on with a therapist, and afterwards – not at the time – they felt like they were the seducers and that’s how... they managed to hook them... but afterwards they really did feel like victims. They really have been abused. They even felt raped, although they were the ones who made the first move.

Besides negative consequences for the client, negative consequences for therapists themselves were also taken into account in their decision to refrain from engaging in a relationship with a client, such as getting into personal difficulties and losing their job.

P: (…) You do have to be professional, otherwise it even threatens your livelihood... to put it very bluntly...

Being aware and reflecting on it

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

P: but then I feel like... it’s important to recognize this in myself and know that it’s there. That it may get in the way of certain processes.

Another participant mentioned:

P: There is also a lot of therapy that is really intense. But then...you know... suddenly it crops up and you say... huh... what’s happening? (…) Yes, you start
to analyze it then, and you might see a form of transference in it, but... The point is... what is it doing to me at that moment?

In another focus group it is illustrated by the following excerpt:

**P1:** (...) I really liked that client. I did... I was aware of it... that I really liked them. But you can’t... just stop feeling that way... because you’re aware of it.

**P2:** But isn’t that the important part?! Just... being aware of it.

**Maintaining (strict) boundaries**

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

**Controlling the situation**

Overall, ‘maintaining (strict) boundaries’ seems mainly to express a great willingness to behave with appropriate professionalism and not cross boundaries or harm clients, as illustrated in the following quote:

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

**M:** And what do you do then?

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

However, how these boundaries are actually guarded is never really clear. Nevertheless, one participant describes her effort to remain professional and in control.

**P:** I was like... I... I have to stay professional myself... I also want to be here for this person... (...) But I felt... I noticed that I was very... even if the person came up in conversation, that I really prepared myself well for that. Making sure you’re
properly grounded, that you’ve got your feet on the ground (...). So I... I call that... working on ‘still being there’ and... staying within my therapeutic role.

**Controlling one’s own feelings**

Also, several therapists indicated they want to keep control over the development of their own romantic and sexual feelings. As the following quote illustrates, it is also formulated as ‘being professional’:

\[ P: \text{Of course it always happens that some clients appeal to you more. But you’re a professional, aren’t you? You keep your distance. You close that door.} \]

In this context of controlling feelings, some therapists also find sexually fantasizing about clients has to be avoided, because they believe this could give rise to deeper feelings, as the following participant said:

\[ P: \text{Say I... have a pleasant feeling... then I can... Maybe my thoughts can... feed that feeling in such a way that I end up falling in love. (...) Or I can also say... this is my professional relationship... I think he’s a good-looking man, but that’s all... I shut it off.} \]

Another participant mentioned the following:

\[ P: \text{(...) If you let yourself fantasize about someone for too long, that in itself creates all kinds of feelings... that you also have to deal with. In all kinds of directions, you know?} \]

**Emotional wellbeing**

In order to keep control over the situation and one’s own feelings, it is perceived that being emotionally stable might be important. Compared to therapists with a strong relationship in their private lives, therapists who are not in a relationship, going through difficult times within their relationship or having a hard time in general are perceived as having more difficulties maintaining these boundaries. One participant said:

\[ P: \text{Because I think... if you... if you yourself are... going through a difficult period... and... and... and you feel really lonely... that it’s... risky then to... to... maintain your boundary, I think.} \]

Another therapist mentioned in this regard how important his wife was.
P: I don’t think I’d be able to do my job as a therapist if it weren’t for my wife. So if I were a single man... fft... no... I don’t think I’d be able to deal with the intimacy of... conversation therapy.

One therapist even mentioned avoiding older male clients in her practice, because she knew that she would have difficulty controlling these kinds of feelings due to the situation she was in in that specific period.

P: (...) I am single, actually... I’ve been single for three years. And yes, I do avoid it a bit... taking on... older men... as clients. I really do avoid it, yes.

M: And why is that?

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

Confidence

Besides the emotional wellbeing of therapists, feeling professionally experienced and confident also seems to matter in maintaining boundaries. More specifically, a few rather young and inexperienced therapists indicated a preference for keeping strict control of these feelings and the situation immediately, to avoid ending up in a situation they could no longer manage.

P: Up to now I think... But maybe that’s also due to my lack of experience... that I don’t want to get near that grey area. That I really want to stay where things are clearly ok. And otherwise not yet start experimenting with what actually would still be all right. I really don’t want to at all.

(Stop therapy and) refer client to another therapist

Although no one had ever actually done so, several therapists indicated they would stop therapy and refer the client to another therapist if romantic or sexual feelings became too intense. One participant mentioned she had considered referring her client, but as her feelings diminished, it was less opportune:

P: (...) Then I really did think very hard about... should I... shouldn’t I refer that person to someone else... come on... is this really okay?...you know... What are we doing here? Now that has faded away again. I mean... my feelings about it...
This excerpt from a focus group illustrates their opinion about referrals:

P1: Say I really did have feelings for them... and in my situation... say I really had feelings for that person... then I'd say... go somewhere else...

P2: Yes.

P1: I'd refer them to someone else. Oh, no... I can't do that.

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

P1: (...) Sometimes having to say... I have to refer you to someone else.

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

P2: It isn’t very protective if you say it like that, is it?

P1: I’d certainly never say that... ‘I’m in love with you’... I’m referring you to someone else.

M: What do you say then?

P1: How do you do it?

P2: I haven’t been in that situation yet.

P1: Me neither. So I really have to fantasize now... (...

P3: I’ve been thinking about that as well.

P1: It’s never happened to me!

In another focus group it became apparent as follows:

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

P1: You can just say ‘due to circumstances’...

P2: ... for reasons of my own that I can’t go into...

P1: I don’t think... That raises questions... or ‘due to circumstances’. The situation in my private life has changed for the moment and I have to refer several clients to other therapists...?
(Not) disclosing to a client

Overall, therapists indicated that romantic or sexual feelings should not be disclosed to a client. Besides being considered unprofessional to disclose this to the client, the reason mentioned for not disclosing these feelings to the client are the negative consequences for the client and his/her surroundings. It was thought that such information would burden the client and would not be helpful in the therapeutic process. It could be threatening for the client or the client could feel abused. Furthermore, it was mentioned that this knowledge might affect the client’s social circle, such as the relationship with their partner, or have implications for further therapeutic relationships. One participant mentioned the following:

P: (...) I don’t know. I think I’d be putting a huge burden on her. If I were to say... do you know that I dream about you sometimes. That I sometimes end up in bed with you then... Come on... (...) I think she’d feel abused. And... she’d have a point, so...

Another participant said:

P: Erm... in the sense that I had the impression that there were many occasions where that sexual attraction was clearly present... that it was mutual... like... I find you attractive. But knowing that if I were to give it a name, then... then... that’s so threatening for her.

This participant explicitly mentioned the consequences for the client’s surroundings and further implications on his/her life.

P: But what meaning does that gain for the one hearing that... and not just that person, but their partner too... (...) But then... and... thinking about subsequent... more serious consequences in therapeutic relationships... (...) I’m here because my previous therapist... had sexual feelings for me. (...) maybe I should watch what I say, because before I know it this one will start having feelings for me too.
Talking about romantic or sexual feelings with other relevant professionals

Important

Most participating therapists find it necessary that sexual feelings towards clients can be freely explored and discussed with other relevant professionals, although it was not that clear who these professionals would be: peers, for example, or a supervisor. The participants thought it might be helpful to explore boundaries and how to manage these feelings well, as one participant said:

P: (...) If that were to happen... I don’t think it would matter if it happened... but it would be... How do you deal with it... How far do you allow it... How far don’t you allow it... And... at that point you would have to be able to talk about it, certainly if you felt that... oh no... I might not have this entirely under control.

Another participant mentioned:

P: (...) But when it comes to feelings, whether they’re sexual or in another area... just... do something about them... come out with... talk to people... Phone after a conversation, if you need to. Don’t keep them to yourself. And there is growth in that too. It is... it doesn’t have to be negative or bad... not at all... it’s something human.

It is perceived as highly undesirable to carry this burden of feeling sexually attracted towards a client all alone, as following quote illustrates:

P: Or... whatever you do, talk to your supervisor or talk enough about it... with a colleague... (...) For me that... I think that’s the most important thing. Not to keep it to yourself.

In this regard, one participant described the need for extra reassurance from important others that having romantic or sexual feelings is just normal and can be experienced by any therapist. In the following quote, she describes the moment she told colleagues who were her friends that she had some sexual fantasies about a client.

P: (...) because of what you said about fantasy... you know... we were talking about it recently... oh... you know... with that person... I did have a fantasy... and the other person said: yes, exactly the same thing happened to me. Then you think:
Wow, okay, I’m normal. So there. And then you can laugh about it and whatever.

**Hesitance to discuss**

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

- **P1:** I don’t know. I can honestly say that I have not yet had feelings like these, but I don’t know if I would ever have dared to admit to them.
- **P2:** Yes, I was thinking the same thing the whole time... right... isn’t everyone else hiding something?
- **P1:** Yes, exactly!
- **P2:** Right, that’s what you’re thinking the whole time...

In another focus group, the following was said:

- **M:** Is that something you find easy to tell colleagues or is it more something you would keep to yourself?
- **P1:** No! I don’t think I’ve ever... talked to colleagues... like that (...)
- **P2:** But sometimes I do think... there are... things you feel and think... during a session... that you never tell anyone. Or hardly ever.
- **P1:** That’s true. That’s how it is. Yes.

**No need to discuss**

In contrast to the majority of therapists who expressed the need to talk about these experiences, there were also a few therapists who said they did not feel this need to discuss their feelings with other relevant professionals. These therapists do not experience these romantic feelings as something wrong or something that might jeopardize their therapeutic
work. They feel confident enough to handle such situation alone, as long as it does not get too intense. One participant said:

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

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

Another participant emphasized that the limited intensity of his feelings was the reason not to disclose this in supervision.

**P:** I didn’t talk to my supervisor about it because... it was just a fleeting thing... that person was there for two weeks. I only saw them three times, I think.

**DISCUSSION**

Romantic and sexual feelings towards clients are present in the psychotherapy room. This study, in which both a survey and focus groups among psychotherapists were conducted, investigated how they manage such feelings. The results of the survey show that the majority of therapists who fantasize about a romantic relationship with a client never consider starting such a relationship with a client, either during therapy (95%) or after therapy (93%). They do consider possible consequences for themselves (65%) and the client (68%). This was confirmed by the results of the focus groups. Furthermore, the majority mentioned maintaining strict boundaries due to their fantasy about a romantic relationship with a client (72%). Significant differences were found based on age, gender and having important problems or changes in professional life. The results of the focus groups additionally informed us that keeping (strict) boundaries in such situation was more difficult when the therapist was less emotionally stable. Referring the client to a colleague (7%) or disclosing their feelings to the client (1%) was rather unusual, according to the results of the survey, although the participants in the focus groups emphasized that if feelings became too intense, a client should be referred to another therapist. It was unclear how this should be communicated to the
clients. Talking about the therapists’ romantic or sexual feelings with clients was, in general, considered inappropriate, because it would burden the client and their surroundings. Even disclosing romantic and sexual feelings to other persons, such as supervisors or in intervision (35%) and/or in personal therapy (32%), was not that common either. Although it is perceived by the great majority of therapists as very important to talk about these feelings with relevant others (e.g., peers), discussion in the focus groups made very clear there is still much hesitance to do so, mainly for fear of condemnation by the same peers.

The strength of this study is that it contributes to more insight into how therapists nowadays manage romantic and sexual feelings towards clients, resulting in possible improvements to guidance for therapists on this issue. Furthermore, this study combines quantitative data with qualitative data from therapists with different professional backgrounds, therefore enriching the interpretation of the results. A limitation of the survey study is that the total N is rather small, which entails limitations for statistical analyses. Moreover, response bias cannot be excluded, where possibly both therapists who are more conservative and therapists who violated boundaries were less willing to participate. A limitation of the focus groups is that not all therapists had actually experienced romantic or sexual feelings, and that (inherent to qualitative research) the findings are not generalizable.

A first important finding of the survey study is that most therapists with romantic fantasies towards clients do not consider engaging in a relationship with a client. They do think over the possible consequences of a romantic relationship for themselves, their client, and their respective social surroundings. This also became apparent in the focus groups. They find it important to recognize and reflect thoroughly on these romantic feelings, and they realize that due to the power imbalance, the client might feel abused afterwards. Furthermore, as was clearly indicated in the focus groups and in other studies, they also refrain from engaging in a relationship, being afraid it would cause personal troubles or job loss [12].

Furthermore, the data from the survey study showed that about three quarters of therapists with romantic fantasies towards clients applied strict boundaries with these clients, which was also confirmed in the focus groups as an important thing to do. More male therapists reported maintaining strict boundaries than female therapists. A possible explanation may be that male therapists are afraid their romantic behavior might be interpreted more easily as inappropriate than the same behavior by their female colleagues. Furthermore, middle aged
and older therapists more often reported maintaining strict boundaries than their younger colleagues. Focus group participants indicated that due to less experience, young therapists are less secure in handling romantic and sexual feelings towards clients. The development of general confidence and competence over the years, and possible earlier experiences in handling romantic or sexual feelings within the therapeutic context, probably result in feeling more relaxed and competent when it comes to managing such situations [6, 13]. Another finding from our focus groups is that being less emotionally stable, e.g., having personal relationship problems or lacking a relationship and intimacy, makes it more difficult to keep control over the situation and their own feelings. Other studies, based mainly on qualitative results and clinical evaluations of offenders of sexual boundary violators, also inform us that stressors in personal and professional life are contributing factors for boundaries to start crumbling, leading to mismanagement of romantic and sexual feelings [4, 6, 14-16]. Because the results of this survey do not conclusively confirm this finding and other large-scale quantitative studies are scant, more empirical research on this topic is recommended.

Concerning the referral of the client to a colleague when feelings become too intense, it was observed that this referral was a suggestion from therapists to each other rather than something they actually do (7%), when comparing the survey and focus group results. Although they are not in favor of continuing therapy when in love with the client [17], they seem unprepared for referring clients when encountering strong romantic or sexual feelings [18]. Participants in the focus groups were unclear how to exactly manage the referral of the client. Most therapists indicated they would not disclose their feelings in this matter to the client, in order to not burden the client with this knowledge, as is also confirmed in earlier studies [7, 8].

In line with earlier studies [7, 19, 20], our focus group participants very explicitly and repeatedly emphasized the importance of recognizing and openly discussing romantic and sexual feeling towards clients with colleagues. However, our survey study showed that only just over a third of therapists with romantic fantasies towards clients discussed them with a supervisor or in intervision, and/or in personal therapy. These results are rather low, also compared to earlier survey studies with percentages roughly around 50% [2, 21, 22]. The most probable explanation, also emerging from our discussions in the focus groups, is the work environment which is still perceived as too unsafe to talk openly about such feelings.
In conclusion, when it comes to managing romantic and sexual feelings towards clients in the psychotherapy room, it is recommended to invest in good support and guidance for rather young and inexperienced therapists, and also take care of therapists who are single or going through difficult times in life. Furthermore, referring a client to another colleague when feelings get too intense needs to be further reflected on, in terms of both views about this and how it is actually dealt with. Finally, more effort is needed to let therapists talk about their romantic or sexual feelings with supervisors, in intervision, or in personal therapy.
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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 uncomfortable 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.
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 [1-7]. In this context such sexual or also romantic attraction of the therapist might be considered as erotic countertransference [8].

Countertransference is defined by Hayes et al. [9], 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 [10]. 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 [9]. 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 [9, 11-13]. Unfortunately, for many years, sexual feelings towards clients have been and still are largely taboo topics within the mental health professions [14-16].

Sexual feelings often elicit negative emotions, such as shock, discomfort, shame, anxiety, confusion, anger, and guilt [1, 4, 6, 7, 17]. Also, there is fear of condemnation of colleagues and supervisors, or being afraid they would not react supportive when these feelings are expressed [6, 7, 18].

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 [14, 19]. One study found that experiencing sexual attraction (22%) and having sexual fantasies (33%) were perceived as unethical by a sizable minority of therapists [2]. 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 [20].
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 [21-24]. 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 [25]. 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 [14]. Only around 50% of therapists sought supervision or consultation to discuss their sexual feelings [1, 17, 26].

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 [27]. 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 [28, 29]. 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 (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 [30]. 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 the first author. Before the start of each focus group, the first author went through the informed consent document with the participants, which then was signed by both the first author 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 [31]. 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 through 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 [7, 32-34], and reflections on this topic with the co-authors and co-researchers 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 relationship, 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 socially 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 [35] to explore the data according to the principles of thematic analysis [36]. First, independently two researchers 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 [28]. 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, from varied points of view, because of their different professional backgrounds, to enhance the plausibility and coherence of the themes. Themes did not only emerge 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. [28]. 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 [29, 37, 38]. The whole process of data analysis was closely reviewed by the supervisor.

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 behavior, 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 behavior or ethical appropriateness, will therefore influence their behavior 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 emphasized 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 uncomfortable 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 uncomfortable 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.

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

Another participant reported in this respect:

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

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:

\[P: \text{When you’re older...that you dare to do more... under supervision... When I’m being supervised and there’s something sensitive or related to this topic that I want to discuss... I think I’d have found it more difficult to do this 10 years ago...}\]

In this regard, another participant mentioned the following:

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

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 uncomfortable 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 judgmental environment more often. They perceive that they are more severely judged by their environment for their feelings and behavior 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.
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 behavior.

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 hesitation to talk about more profound sexual feelings. In the conducted focus groups, it was observed that several factors contribute to this hesitation. Firstly, attitudes about intimacy and sexuality in the psychotherapeutic relationship shape opinions about what is constituted as professional and ethically correct or incorrect behavior. These opinions can be decisive in whether or not to discuss particular experiences or feelings. Secondly, the hesitation 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 hesitation 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 [39]. 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 hesitation. 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 [40].

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 introversions, 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 [33], 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 [41]. 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 behavior 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 [13].

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 socially 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-centered 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 [30, 42, 43].

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.
REFERENCES


[31] Colucci E. "Focus groups can be fun": The use of activity-oriented questions in focus group discussions. Qualitative Health Research 2007; 17:1422-33.


### SUPPLEMENTAL FILE 1

**Characteristics of participants (N=36), per focus group**

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*Psychotherapy training and type of practice add up to more than 36, because some participants had followed more than one type of psychotherapy training or worked at several places.*
SUPPLEMENTAL FILE 2
Guiding questions focus groups

**Opening**
Tell us your name, your work experience, and your professional background.

**Key Question**
Think back to a particular experience with a client, regarding intimate or sexual feelings for a client. What did it evoke? *(If you have no such particular experience with a client, try to imagine what it could evoke. Maybe you know close colleagues who experienced such feelings, ...)*

**Procedure**
Handing out an envelope containing cards with different words (emotions and thoughts) printed on it. Explanation: Choose a number of cards that reflect your emotions and thoughts in that experience. Some cards are more negative and others more positive. Choose what fits best for you, this can be both positive and negative. Some of these cards are empty. You can write your own emotions and thoughts on those empty cards. You will now have a few minutes to reflect on this.

**Topics**
- Differences based on gender
- Differences based on professional background
- Differences based on being single or in a (good) personal relationship
- Impact of personal issues or other life stressors
- Importance of appearance
- Importance / impact of fantasy
- Ethics / What is constituted as professional behavior?
- Topic in education and training?
- Management of feelings
- Talking about feelings to others. To whom?
- Taboo topic? Socially desirable answers? Hesitance to discuss?

**Advice**
Name the three most important issues/things that need to change in the world of psychotherapy that would improve the wellbeing of therapists who experience intimate and sexual feelings for clients.

**Ending**
What do you think is the most important issue that has emerged today? Are there any additions? Is there something we should have talked about that didn’t happen?
Part III: Dealing with therapists’ intimate and sexual feelings and behavior, in basic education and psychotherapy training, and in policy of mental health care institutions
5. Intimate and sexual feelings in psychotherapy: educational topic or still taboo?

Manuscript details:


125
ABSTRACT

This mixed-method study aims to investigate the topic of intimate and sexual feelings within psychotherapy in basic education and psychotherapy training programs in Flanders, Belgium. Both a survey (N=786) and 8 focus groups (N=36) were conducted among psychotherapists. The majority indicates that dealing with intimate and sexual feelings towards clients was not or hardly part of either their basic education or specialized psychotherapy training. Talking about such feelings with peers or supervisors also remains difficult because of concerns about being judged. However, the more therapists indicated this topic was in some way addressed in their training, the less it was perceived as a taboo topic. Therapists advocate a more open discussion and reflection on this topic. Education and training, as well as support from renowned key figures in their field, are regarded as important keys to initiate change.
INTRODUCTION

Psychotherapists are challenged by various, sometimes strong, feelings and experiences in their psychotherapeutic work, such as antipathy, fear or romantic feelings. Being unprepared to address these adequately could jeopardize not only the psychotherapist’s wellbeing, but of course also the psychotherapeutic process [1]. However, when it comes to the management of intimate and sexual feelings, several survey studies (mainly from the nineties) have pointed out that these issues were seldom addressed in education programs of psychotherapists. About half of them (40 to 50%) stated to have received little or no education on this topic [1-9]. The few more recent studies on this topic show little improvement. Still about 40% of the students reported that sexual attraction towards clients is not part of their psychotherapy training (Williams et al., 2016).

Furthermore, most therapists who received training on this topic, found it rather inadequate, fragmented, and mainly focusing on ethical aspects. To be adequate, training should openly address this topic as a regular part of the education program, and on a continuous basis, in various number of contexts (e.g., informal discussion, seminar, practicum), and addressing various aspects, emotional as well as cognitive aspects, as was mentioned by queried therapists itself [5, 6] and concluded based on studies on this topic [2, 9, 10].

Finally, preparedness to address these intimate feelings towards patients in supervision or counseling, also highly depends on a positive psychotherapy training environment: acceptance, not being condemned, a safe atmosphere, and emotional support of open-minded supervisors [3, 6, 9-14].

Unfortunately, these studies are outdated and all related to non-European countries. Because perceptions and curricula change over time and this topic is rather culturally sensitive, it is completely unknown to what extent these findings are also reflected nowadays in a West-European country like Belgium. It is also not clear from earlier studies whether or not there are differences in integrating this topic in education programs, depending on the kind of basic education of the therapists (e.g., psychologists versus psychiatrists), or type of specialized psychotherapy training (e.g. psychoanalytic versus behavioral psychotherapy). Neither do we know, if addressed in education and training, what kind of aspects regarding intimate feelings are then discussed, and especially, how this is experienced and evaluated by the therapists. All this information is necessary to gain profound and differentiated insight in how, and how
adequately the topic of intimate and sexual feelings is addressed in the different education and training programs of therapists, and how it might be improved.

METHOD

Design and setting

The study was conducted in Flanders (the northern Dutch-speaking half of Belgium), using a pragmatist paradigm (real-world practice oriented) [15]. A convergent mixed methods study is used, by means of a cross-sectional survey study and a focus group study, where data were collected in parallel, analyzed separately, and common concepts were merged [15]. In this approach, survey data will be used to determine the extent to which particular topics related to intimate and sexual feelings are addressed in basic education and psychotherapy training programs, as well as the extent to which sexual feelings for a client are perceived as something that can be talked about in a work context. The focus group data will explore on a more individual level how the participating therapists experience their education/training concerning intimate and sexual feeling in psychotherapy (e.g., limitations) and which point for improvement can be made. The reason for collecting both quantitative and qualitative data is to obtain different but complementary data on the same topic and enhance reliability of the findings.

Survey

Study population

The study population consisted of all members of three large psychotherapy associations in Flanders: Flemish Association for Person-Centered Psychotherapy (N = 288), Flemish Association for Behavioral Therapy (N = 568), and Flemish Association for Psychoanalytic Psychotherapy (N = 205). All psychotherapists who were in practice or in their last year of training at the time of the study were included. Psychotherapists can be a member of more than one professional association. Members have a basic education in psychology, psychiatry or otherwise (not further specified in this study). However, because most psychiatrists also provide psychotherapy without, until recently, being obliged to have completed additional training in psychotherapy [16], we have also included all psychiatrists in Flanders registered at
the National Institute for Health and Disability Insurance (N = 910) as a separate group in our study.

Data collection

An anonymous survey was conducted from November 2016 to June 2018, with a self-administered questionnaire for psychotherapists and psychiatrists (referred to below as ‘therapists’) in Flanders. The survey was sent repeatedly. It was e-mailed to the therapists by their professional associations and/or announced in their digital newsletter. Additionally, all therapists received a hard copy of the questionnaire several times, sent by regular mail with a return freepost-addressed envelope to the researchers. The survey was accompanied by an information letter from the researchers explaining the aim, process and anonymity procedure of the study, and a recommendation letter of key figures, to underline the importance of participating in this study. Furthermore, respondents were explicitly asked to fill in the questionnaire only once.

Questionnaire

The questionnaire consisted of questions about socio-demographic (e.g., age, gender), and profession- and educational-related characteristics (e.g., work experience, type of basic education and type of psychotherapy training). It also asked, on a 4-point scale (‘none’, ‘little’, ‘quite a lot’, and ‘a lot’), to what extent 5 particular educational topics related to intimate and sexual feelings were addressed in their basic education as well as in their specialized psychotherapy training. More specifically, two rather general questions were asked, about: a) setting your own boundaries when giving therapy, and b) making it possible to discuss your own emotions in general that arise as a result of giving therapy. Additionally, three rather specific questions were asked about dealing with intimate and sexual feelings, namely: c) dealing with a client’s sexual feelings towards the therapist, d) dealing with the therapists’ feelings of friendship towards a client, and e) dealing with the therapists’ sexual feelings towards a client. These 5 particular educational topics are based on literature on sexual feelings in psychotherapy, which e.g., often emphasize the importance of maintaining boundaries, and discussing these sexual feelings with relevant professional others [9, 10, 13, 17, 18]. The selection of educational topics and the formulation of them was done in close collaboration with experts and persons working in the field. Finally, it was also asked to what extent sexual feelings can be discussed in the work field, on a 4-point scale (‘easily’,
‘tentatively’, ‘barely’, ‘impossible’). A pilot test was conducted among researchers and psychiatrists in training, to evaluate the questionnaire. Based on this evaluation, small adaptations were made, mainly textual.

**Data analyses**

Descriptive analyses (frequencies and percentages) were done to determine the extent to which the 5 educational topics were dealt with in basic education (psychology and psychiatry), as well as in the included types of psychotherapy training (psychoanalytic psychotherapy, person-centered psychotherapy, and behavioral psychotherapy).

Differences based on basic education and type of psychotherapy training were tested with a chi-square analysis. For this analysis, the ordinal 4-point scale was recoded into two options ‘absent or limited present’ and ‘(quite) a lot’. Because therapists may have followed or completed more than one type of psychotherapy training, only therapists trained solely in one of the three types of psychotherapy training are included in this analysis to ensure that the outcome can be attributed to the correct type of psychotherapy training.

To determine whether or not the content of the curricula of basic education and psychotherapy training have changed over time, a chi-square analysis was done with the variable ‘work experience’ (as it was not asked in the questionnaire when they graduated). The 5 answer categories of work experience (‘0-5 years’, ‘6-10 years’, ‘11-20 years’, ‘21-30 years’, ‘31 years or above’) were recoded into two categories, namely 0 to 10 years of work experience and 11 years of work experience or more.

The relationship between characteristics related to education and the extent sexual feelings were perceived as discussable in the work field was investigated using a bivariate approach (chi-square test). To compare significant differences between three subgroups post-hoc analyses were done. Furthermore, a multivariate approach (logistic regression) was used, where age and gender were also included in analyses, because age and gender might be confounding factors.

IBM SPSS Statistics, version 25.0, was used for all analyses.
Focus groups

Participants and recruitment

In total 36 participants (28 female and 8 male therapists) attended the 8 focus groups (in-person) that were organized, of whom 14 were between 20-39 years, 17 were between 40-59 years, and 5 were 60 years or older. The focus groups consisted of psychiatrists (n=8), psychologists (n=10) and persons with other basic education (n=18). Except for three psychiatry students, all of them were following or had completed psychotherapy training. Two groups contained psychiatrists only, two groups contained interactional/integrative therapists only, three groups contained systemic therapists only, and one group was mixed. An invitation to participate in the focus groups was made through key figures within their own professional network.

Data collection and research instrument

Data collection took place from February 2018 to May 2019. First, participants signed the informed consent and filled out a short form to collect demographic and professional characteristics. Then the focus group was conducted. One of the main questions for therapists in these focus group discussions was to think back on a situation where they encountered intimate or sexual feelings in the therapeutic relationship. These personal stories from therapists were a starting point for further in-depth exploration of this topic, including how it was brought up in their basic education and psychotherapy training, and what should be improved. During these discussions, specific attention was paid to the aspect of deontology and hesitance to talk about this topic. The focus group guide was developed through detailed discussion between the researchers and tested among a group of volunteers (supplemental file 2 – chapter 4). All focus group discussions were audiotaped. After each focus group field notes were taken about the process, participants, and significance of data.

Data analysis

After transcribing the audiotapes of the focus groups, the data were explored using the software package QSR International’s NVivo 12 [19], according to the principles of inductive thematic analysis (Braun & Clarke, 2008). First, we immersed to the data by re-listening to the audiotapes and reading the transcripts and its corresponding field notes several times, writing down initial ideas and notes of anything that appeared to be significant and of interest (open
coding). All initial codes were listed in a codebook which included the code name, definition and instructions on how to recognize data to be captured by the code. In this first step, only the code ‘education/training’ was present, capturing all what therapists mentioned about their education/training. Then a line-by-line analysis of each transcript was conducted based on the codebook, transforming the initial codes into more specific codes, throughout a systematic comparison of the data. This was done by constantly adding new codes and merging existing codes into new ones, until an agreed saturated meaningful set of themes became apparent (axial coding). For example, for the code ‘education/training’ it resulted in four subcodes, namely ‘overfocus on behaving ethically’, ‘not addressed/taboo’, ‘not nuanced’, and ‘distance/no own learning processes’. The codebook was adjusted to these new emerging codes. Thirdly, the core themes around which the related themes are clustered were developed (selective coding). Data analysis was stopped when no new insights emerged.

Several strategies were used to ensure trustworthiness, as recommended by Morrow [20]. Firstly, all researchers reflected on the characteristics and work experience of the moderator. Also, her pre-existing beliefs on intimacy and sexuality in psychotherapy was discussed. Secondly, the moderator used a reflective journal during data collection to write down personal feelings, insights, and biases, which were then discussed with the supervisor. Thirdly, the iterative coding was conducted independently by two researchers who both made analytic memos during this process. The codebook, emerging codes, general patterns, and analytic memos were regularly discussed to achieve congruence, leading to more nuanced interpretations of the data, small adjustments to the codebook and code application. To enhance reflexivity and check the interpretations of the emerging themes, these themes were also deeply discussed on a regular base with all co-authors having different professional backgrounds (psychiatry, psychiatric nursing, sexology, public health sciences). This resulted in some changes to the names of the (sub)themes and the interconnections between the themes. Finally, the whole analytic process was closely supervised by an experienced researcher.
Mixed method

After analyzing the quantitative and qualitative results separately, as described above, common concepts across the results were looked for. For each common concept the quantitative and qualitative results were compared, determining in what ways the results (dis)confirm or expand each other. These common concepts are displayed in a joint display. In the discussion section the results of this comparison are further interpreted [15].

Ethics

Study approval was received from the medical ethical committee of the Vrije Universiteit Brussel (B.U.N. 143201524243). Concerning the survey, it was clearly mentioned that by filling in and returning the questionnaire, after reading the information letter from the researchers, the respondent declared that they were well informed and willing to participate to the study. Furthermore, anonymity was explicitly ensured. No data were collected that could lead to the identification of the respondents, such as place of residence, workplace, or IP-addresses. For the focus group, an informed consent form was signed before the start of the study. Both the privacy of all participants and the confidentiality of their input in the focus group discussions were guaranteed throughout the study.

RESULTS SURVEY

Response rate

In total 786 completed questionnaires were returned by the therapists. Response rates varied by type of therapist, based on their membership of the professional association: 35.2% of psychiatrists, 46.8% of behavioral therapists, 48.8% of psychoanalytic psychotherapists and 56.6% of person-centered psychotherapists. The majority of responding therapists were female (69%, n=541), and in the age group of 20 to 39 years (43.6%, n=342), or 40 to 59 years (39.6%, n=311).
Educational topics dealt with in basic education

A minority of respondents stated that the educational topics were addressed (quite) a lot in their basic education (table 1). Less than half of therapists reported that setting their own boundaries when giving therapy (43.6%) and making it possible to discuss emotions that arise due to giving therapy (33.8%) is addressed (quite) a lot, and a small minority of therapists stated that dealing with sexual feelings in the client (14.1%), their own feelings of friendship (13.3%) towards the client, and their own sexual feelings (6.6%) was (quite) a well-covered educational topic. No differences were found based on type of basic education, except for dealing with therapists’ feelings of friendship. It was more often reported to be addressed (quite) a lot by therapists with another basic education (27.3%) than psychologists (9.8%) and psychiatrists (16.1%). Furthermore, looking specifically at the complete absence of educational topics, it is noticed that absence is reported by more than a third to more than half of therapists, among all types of basic education for dealing with therapists’ sexual feelings or feelings of friendship, and clients’ sexual feelings.

Educational topics dealt with in psychotherapy training

About three quarters of therapists stated that they had received (quite) a lot of training in setting their own boundaries (76.8%) and making it possible to discuss their own emotions (75.9%). Behavioral therapists significantly less often reported that these educational topics were addressed (quite) a lot compared to psychoanalytic therapists and person-centered therapists. With regard to dealing with sexual feelings of the client (32.5%), feelings of friendship (34.7%), and sexual feelings of the therapist towards the client (21.1%), a minority of therapists indicated that this topic was addressed (quite) a lot in their education. Again, behavioral therapists differed significantly from the other types of psychotherapists, reporting less training in these topics (table 2).
Table 1  
*Educational topics, degree of presence in basic education, in general and by type of basic education (N=784)*

<table>
<thead>
<tr>
<th>Topics</th>
<th>All therapists</th>
<th>Psychologists (N=421)</th>
<th>Psychiatrists (N=318)</th>
<th>Other (N=44)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%PD&lt;sup&gt;1&lt;/sup&gt;</td>
<td>%QaL&lt;sup&gt;2&lt;/sup&gt;</td>
<td>%PD&lt;sup&gt;1&lt;/sup&gt;</td>
<td>%QaL&lt;sup&gt;2&lt;/sup&gt;</td>
<td>%PD&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>a. Setting your own boundaries when giving therapy.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>12</td>
<td>10.2</td>
<td>13.6</td>
<td>18.2</td>
<td>0.997</td>
</tr>
<tr>
<td>A little</td>
<td>44.4</td>
<td>46.1</td>
<td>42.9</td>
<td>38.6</td>
<td></td>
</tr>
<tr>
<td>Quite a lot</td>
<td>32.8</td>
<td>34.7</td>
<td>30.9</td>
<td>29.5</td>
<td></td>
</tr>
<tr>
<td>A lot</td>
<td>10.7</td>
<td>9</td>
<td>12.6</td>
<td>13.6</td>
<td></td>
</tr>
<tr>
<td>b. Making it possible to discuss your own emotions that arise as a result of giving therapy.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>16.2</td>
<td>14.7</td>
<td>16.4</td>
<td>27.3</td>
<td>0.159</td>
</tr>
<tr>
<td>A little</td>
<td>69.1</td>
<td>49.5</td>
<td>45.9</td>
<td>43.2</td>
<td></td>
</tr>
<tr>
<td>Quite a lot</td>
<td>32.8</td>
<td>24.5</td>
<td>28.9</td>
<td>22.7</td>
<td></td>
</tr>
<tr>
<td>A lot</td>
<td>7.7</td>
<td>6.9</td>
<td>8.8</td>
<td>6.8</td>
<td></td>
</tr>
<tr>
<td>c. Dealing with a client’s sexual feelings towards the therapist.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>38.3</td>
<td>37.6</td>
<td>39</td>
<td>38.6</td>
<td></td>
</tr>
<tr>
<td>A little</td>
<td>47.6</td>
<td>49.5</td>
<td>45.7</td>
<td>43.2</td>
<td></td>
</tr>
<tr>
<td>Quite a lot</td>
<td>12.3</td>
<td>11.7</td>
<td>13</td>
<td>13.6</td>
<td></td>
</tr>
<tr>
<td>A lot</td>
<td>1.8</td>
<td>1.2</td>
<td>2.2</td>
<td>4.5</td>
<td></td>
</tr>
<tr>
<td>d. Dealing with the therapist’s feelings of friendship towards a client.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>34.7</td>
<td>36</td>
<td>33.9</td>
<td>27.3</td>
<td>0.001</td>
</tr>
<tr>
<td>A little</td>
<td>52</td>
<td>54.3</td>
<td>50</td>
<td>45.5</td>
<td></td>
</tr>
<tr>
<td>Quite a lot</td>
<td>11.8</td>
<td>9</td>
<td>14.2</td>
<td>20.5</td>
<td></td>
</tr>
<tr>
<td>A lot</td>
<td>1.5</td>
<td>0.7</td>
<td>1.9</td>
<td>6.8</td>
<td></td>
</tr>
<tr>
<td>e. Dealing with the therapist’s sexual feelings towards a client.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>53.8</td>
<td>54.4</td>
<td>53.9</td>
<td>45.5</td>
<td>0.100</td>
</tr>
<tr>
<td>A little</td>
<td>39.6</td>
<td>40.1</td>
<td>38.8</td>
<td>40.9</td>
<td></td>
</tr>
<tr>
<td>Quite a lot</td>
<td>5.5</td>
<td>5</td>
<td>5.7</td>
<td>9.1</td>
<td></td>
</tr>
<tr>
<td>A lot</td>
<td>1.1</td>
<td>0.5</td>
<td>1.6</td>
<td>4.5</td>
<td></td>
</tr>
</tbody>
</table>

Note. Due to missing data, N varies from 779 to 784.  
<sup>1</sup>Percentage per degree.  
<sup>2</sup>Percentage, based on "(quite) a lot".
Table 2

**Educational topics, degree of presence in psychotherapy training, in general and by type of psychotherapy training (N=554)**

<table>
<thead>
<tr>
<th>Topics</th>
<th>All therapists</th>
<th>By type of psychotherapy training</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%PD</td>
<td>%QaL</td>
</tr>
<tr>
<td>a. Setting your own boundaries when giving therapy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>2.9</td>
<td>0</td>
</tr>
<tr>
<td>A little</td>
<td>20.3</td>
<td>8.1</td>
</tr>
<tr>
<td>Quite a lot</td>
<td>45.3</td>
<td>33.3</td>
</tr>
<tr>
<td>A lot</td>
<td>31.5</td>
<td>58.5</td>
</tr>
<tr>
<td>b. Making it possible to discuss your own emotions that arise as a result of giving therapy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>3.8</td>
<td>0</td>
</tr>
<tr>
<td>A little</td>
<td>20.3</td>
<td>5.7</td>
</tr>
<tr>
<td>Quite a lot</td>
<td>42.2</td>
<td>41.5</td>
</tr>
<tr>
<td>A lot</td>
<td>33.7</td>
<td>52.8</td>
</tr>
<tr>
<td>c. Dealing with a client’s sexual feelings towards the therapist.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>22.6</td>
<td>4.9</td>
</tr>
<tr>
<td>A little</td>
<td>44.8</td>
<td>32.5</td>
</tr>
<tr>
<td>Quite a lot</td>
<td>24.1</td>
<td>39.8</td>
</tr>
<tr>
<td>A lot</td>
<td>8.5</td>
<td>22.8</td>
</tr>
<tr>
<td>d. Dealing with the therapist’s feelings of friendship towards a client.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>17.7</td>
<td>1.6</td>
</tr>
<tr>
<td>A little</td>
<td>47.7</td>
<td>39.8</td>
</tr>
<tr>
<td>Quite a lot</td>
<td>27.3</td>
<td>40.7</td>
</tr>
<tr>
<td>A lot</td>
<td>7.4</td>
<td>17.9</td>
</tr>
<tr>
<td>e. Dealing with the therapist’s sexual feelings towards a client.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>36.5</td>
<td>11.4</td>
</tr>
<tr>
<td>A little</td>
<td>42.4</td>
<td>45.5</td>
</tr>
<tr>
<td>Quite a lot</td>
<td>15.7</td>
<td>30.1</td>
</tr>
<tr>
<td>A lot</td>
<td>5.4</td>
<td>13</td>
</tr>
</tbody>
</table>

Note. 1. Only therapists trained solely in psychoanalytic therapy, person-centered therapy, or behavioral therapy are included in this analysis. Therapists who did a combination of these are excluded. 2. Due to missing data, N varies from 286 to 288. 3. Percentage per degree. 4. Percentage, based on “(quite) a lot”. PA = Psychoanalytic therapy, PC = Person-centered therapy, and B = behavioral therapy.
As for the complete absence of the investigated educational topics, it was noted that only a small minority of either psychoanalytic or person-centered psychotherapists indicated that the educational topics were completely absent from their education (both < 5%), except for dealing with therapists’ sexual feelings towards the client (respectively 11.4% and 14%). A different result is found for behavioral psychotherapists. Around a third of these therapists reported that dealing with clients’ sexual feelings (39%) and dealing with therapists’ feelings of friendship (31.9%) were absent from their education, and more than half mentioned not having learned how to deal with therapists’ sexual feelings towards a client (58.3%) (table 2).

**Evolution of educational topics, dealt with over time**

When comparing therapists with limited experience (0-10y) and more experience (11y+), significant differences were noticed for both psychologists and psychiatrists, showing that therapists with more experience more often reported having learned (quite) a lot about particular topics (not in table). This was the case for the topic “making it possible to discuss their own emotions” (psychiatry: p=0.004), “dealing with clients’ sexual feelings” (psychology: p=0.017; psychiatry: p=0.003), “dealing with therapists’ feelings of friendship towards a client” (psychology: p=0.043), and “dealing with therapists’ sexual feelings towards the client” (psychiatry: p=0.024). Due to the low total number of therapists with other basic education, consisting of diverse forms of education, no analyses were conducted on these groups of therapists.

With regard to specific psychotherapy trainings, no significant differences were noticed between therapists with limited experience and more experience among both psychoanalytic and person-centered therapists. For behavioral therapists, a significant result was found for the topic “making it possible to discuss their own emotions” (p=0.017), where therapists with rather limited experience stated more often that they were trained in this topic than therapists with more extensive experience.
Relation between educational characteristics and the extent to which sexual feelings can be discussed in the work field

In total, about half of respondents indicated that it is barely possible to discuss experiencing sexual feelings towards adult clients within the work field of therapists (50.8%, n=396) and 4.1% (n=32) stated it was impossible. Less than half indicated it was possible to discuss it tentatively (40.4%; n=315) and 4.7% (n=37) indicated it was easy to discuss (not in table).

Based on educational characteristics, significant differences can be seen (table 3). Persons with basic education (34.1%) other than psychiatry or psychology experience less difficulties discussing this topic than psychiatrists (57.1%) and psychologists (55.3%). Moreover, the type of psychotherapy training was significantly related to the extent it was discussable, whereby person-centered therapists experience less difficulties (40.5% versus 58.8%) and behavioral therapists more difficulties (62.9% versus 49.5%). When therapists indicated that dealing with sexual feelings towards the client was an educational topic in their basic education (38.5%) or psychotherapy training (35.2%), they more often reported that they could easily or tentatively discuss sexual feelings than therapists without this topic in their basic education (56.1%) or psychotherapy training (59.3%). Moreover, all the relevant educational topics, in both basic education and psychotherapy training, were significantly related to experiencing less difficulties discussing sexual feelings in the work field when they were reported as (quite) addressed in education (p< 0.05). Besides educational characteristics, the demographic characteristic age was also related to perceived difficulty in discussing sexual feelings within the work field: relatively young therapists (60.2%) find it harder to discuss this than older therapists (52.6% and 46.2%) (table 3). However, a multivariate approach shows that, of all the variables summed up in table 3, only the educational topic “dealing with the therapists’ sexual feelings towards clients” in the psychotherapy training remains significant (Odds Ratio: 2.684; 95% CI: 1.786-4.033, p<0.001).
Table 3
Characteristics of therapists reporting that sexual feelings are impossible to discuss or barely open to discussion (N=779)

<table>
<thead>
<tr>
<th></th>
<th>Impossible or barely to discuss</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td><strong>Overall results</strong></td>
<td>778</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male therapists</td>
<td>301</td>
</tr>
<tr>
<td>Female therapists</td>
<td>125</td>
</tr>
<tr>
<td>Age</td>
<td>779</td>
</tr>
<tr>
<td>20-39 years</td>
<td>162</td>
</tr>
<tr>
<td>40-59 years</td>
<td></td>
</tr>
<tr>
<td>60+ years</td>
<td>61</td>
</tr>
<tr>
<td>Basic education</td>
<td>779</td>
</tr>
<tr>
<td>Psychologists</td>
<td>181</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>15</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
</tr>
<tr>
<td>Psychoanalytic therapy</td>
<td>778</td>
</tr>
<tr>
<td>Yes</td>
<td>352</td>
</tr>
<tr>
<td>No</td>
<td>49.7</td>
</tr>
<tr>
<td>Person-centered therapy</td>
<td>778</td>
</tr>
<tr>
<td>Yes</td>
<td>356</td>
</tr>
<tr>
<td>No</td>
<td>62.9</td>
</tr>
<tr>
<td>Behavior therapy</td>
<td>778</td>
</tr>
<tr>
<td>Yes</td>
<td>233</td>
</tr>
<tr>
<td>No</td>
<td>49.5</td>
</tr>
<tr>
<td>Topic “dealing with therapists’ sexual feelings” in basic education</td>
<td>778</td>
</tr>
<tr>
<td>None or a little</td>
<td>20</td>
</tr>
<tr>
<td>Quite a bit or a lot</td>
<td>592</td>
</tr>
<tr>
<td>Topic “dealing with therapists’ sexual feelings” in psychotherapy training</td>
<td>45</td>
</tr>
<tr>
<td>None or a little</td>
<td>20</td>
</tr>
<tr>
<td>Quite a bit or a lot</td>
<td>45</td>
</tr>
</tbody>
</table>

Note. 1Only therapists trained in psychoanalytic therapy, person-centered therapy, behavioral therapy, or a combination of them, are included in this analysis.

RESULTS OF FOCUS GROUP DISCUSSIONS

Data analysis showed that therapists in the focus groups generally have the opinion that the topic of experiencing sexual feelings towards clients is lacking in basic education and psychotherapy training, and overly focused on ethical aspects. Educational topics on sexuality are perceived as rather technical and provocative. Therapists also recommend presenting the occurrence of sexual feelings as a normal phenomenon, providing more information about transference and countertransference, and increasing reflection and expression on this topic. They still perceive this as a taboo topic, even in education and training. Finally, they suggest that sexuality, more generally, should be an integral part of both the curriculum of basic
education and psychotherapy training, and the entire educational process from childhood onwards.

**Sexual feelings towards clients hardly addressed in basic education and/or psychotherapy training**

A large proportion of therapists indicate that the topic ‘sexual feelings towards clients’ is seldom dealt with in their education and/or training. They especially felt there was limited attention to what these kinds of feelings might further evoke, i.e., how they affect the therapist, and how to manage them. In a dialogue between participants, one participant said “No, that topic was not extensively covered”, at which other participants supplemented that it was not addressed from the therapists’ perspective. This also became apparent in another focus group, where a participant mentioned “What can be triggered in terms of sexuality and eroticism in therapy, I’ve never encountered that in the whole course. It’s not included now. It wouldn’t be a bad thing to discuss it sometimes.”

**Main focus on ethics**

When sexual feelings were discussed in education and/or training, therapists in the focus group indicated it was often done in the context of what is right or wrong from an ethical viewpoint, e.g., taking care and not harming the client. "If we were told anything about it (sexual feelings towards clients) during our training, it had more to do with deontology and harassment, but there is a lot more to say about it, you know", said one participant and this was confirmed by others. It was often stated that sexual feelings towards clients in a professional psychotherapeutic relationship should be avoid, and sometimes (as a result) the suppression of these feelings was emphasized. One participant described it as follows:

*It was mainly professionalism that was emphasized during training. But also a bit of the theory behind it, that they’re vulnerable patients, and that you’re in a different position. And also that they really are human feelings that can be appropriate, but that you should suppress them.*

Another participant said the following:
A bit of context was given in my training, about what is ethical and unethical behavior. But not, to be entirely honest, I think when it came to sexuality etc. It was not mentioned.

Too technical or too provocative

Some therapists indicated that when sexuality was a topic in education, for example in the specific context of how to discuss sexual issues with clients, it was often experienced as being too technical, too functional, or even too provocative due to the lack of terminology provided to discuss these topics in a respectful and nuanced way with clients. One participant mentioned the following:

At best sexuality is a topic you get to study for one day or something. A little about sexuality and then I’d say pretty technical stuff about sexual therapy and that kind of thing. Things you’re never going to do unless you’ve had thorough training in them.

Another participant expressed this as follows:

And what there is on offer is either too technical or it immediately goes too far. I remember I wanted to take a course on how do you put sexuality on the agenda with your clients. It was taught by someone and the first thing the guy said was “feel your own balls, feel your own vagina”. That was over the top...

Normal phenomenon

Some therapists endorsed it when basic education or psychotherapy training emphasized that it was common to encounter sexual feelings towards clients during a therapeutic career. Perceiving it as a normal phenomenon was found to be helpful in exploring and managing these feelings well when they occurred during therapy. However, in practice, this normalization hardly ever happens. This led to a clear advocacy for not judging such feelings or dismissing them as unprofessional. “Imagine you are faced with falling in love. That doesn’t necessarily mean that you’re not being professional. If we could get rid of that, it would be a big step forward”, said one participant.

Another participant mentioned the following:
It really helped me earlier on in my training that it was emphasized how normal it is. That you logically have to realize that you are going to feel something for someone one day or someone is going to feel something for you.

Renowned therapists that disclose their sexual experiences are seen as an important incentive to contribute to the perception that these experiences are merely human and that it should be possible to discuss them with peers instead of being judged for them. Furthermore, inspiring books and films are seen as helpful in making these experiences seem more commonplace and human. The following excerpt from a focus group refers to the renowned American author and psychiatrist Irvin Yalom, known for his non-fiction books and novels describing the experience of therapy, such as ‘Lying on the Couch’, ‘When Nietzsche Wept’, and ‘Creatures of a Day and Other Tales of Psychotherapy’.

I’ve thought about it a lot. About how you’d look at yourself and catch yourself. I really benefited from reading Yalom, because he gives insight into the conversations you don’t have. I think that’s so fascinating.

Another focus group referred to the American TV series ‘In Treatment’ (2008-2010), about a psychotherapist and his weekly sessions with patients, as well as with his own supervisor.

(Counter)transference

A few therapists mentioned the importance of learning about transference and countertransference, as it would help to understand better the mechanisms of what can happen in a psychotherapeutic relationship. One participant mentioned that she would have liked to have learned more about this: “With some clients, like that one I was talking about, I do think it would have been useful if I’d learned a bit more about transference and countertransference”, as one participant said. Another participant emphasized the importance of learning enough about this.

If you don’t believe in countertransference... That patients can mess with your head ... that you can get completely stuck ... So I think that something extra (about countertransference) really needs to be given in training and at present that’s not the case.
Reflection, introspection and expression

Some therapists indicated that being able to reflect on one’s own feelings and vulnerabilities is very valuable to help therapists manage these feelings and vulnerabilities when occurring during their work. Such abilities should already be discussed in basic education, according to these therapists. However, there is no attention at all to learning these abilities in basic education. There is also no safe forum provided where such personal processes can take place. One participant mentioned in this respect: “And your own process as a therapist is more important there than your education. You can study psychology at university for five years, but you still don’t know how to do the job”. Another participant, a psychiatrist, describes it as follows:

As a psychiatry graduate you suddenly need to know how to hold a peer-to-peer session, although you weren’t taught that in your training. How to share your own vulnerabilities? How you can ask for help without that directly shifting into the deontologically judgmental area. First there needs to be a safe forum where this sort of things can be discussed.

Psychiatrists in particular indicate that this is the added value of psychotherapy training after finishing basic education, since in general, there is more attention there to such introspection about feelings and vulnerabilities. However, they mention that not all psychiatrists do psychotherapy training and therefore lack the ability to introspect, as the following quote illustrates:

Not everyone is in learning therapy and maybe there’s a need or a way to make this easier to discuss. For psychiatrists, for example, a therapy course has not been obligatory up to now. Actually, it should be part of your training as a psychiatrist.

Even the focus group discussions during this study were a positive experience in this matter for several therapists. For some it was the first time they had ever explored and expressed their intimate and sexual feelings towards clients with colleagues. They think this format of peer group discussions would also be helpful for other therapists in further exploring these kinds of feelings. One participant said: “I think this is one of the first times I have talked about it so openly and that in itself strikes me and that’s a take-away for me. I think it does help. To think about it a bit more yourself. Yes”.

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Another participant mentioned:

*Making it possible to discuss it, the way you’re doing now... That works. Because it’s not necessarily a subject we deal with explicitly.*

In particular, having sufficient time to explore this topic thoroughly and the safe environment in these focus group discussions were cited as important elements that contributed to further exploring and disclosing these feelings, resulting in a positive experience. *"The fact that you can share things on this subject with colleagues. Actually, I found that very inspiring in itself. The fact that there was space to share something specific on this topic for once. Actually, I’ve never done it before”, mentioned one participant, which was then confirmed by all participants. Another participant of another focus group mentioned it as follows: “If this (the focus group) wasn’t so safe or anonymous, I wouldn’t talk about it. No”.

In contrast to the feeling of safety in the focus groups, many therapists in general perceived experiencing sexual feelings towards clients as a taboo topic in the work field. Some participants even indicated that the basic education and psychotherapy training are not safe places to talk about sexual feelings towards a client. They perceive this as a condemning and judgmental context, making them hesitant to talk about it. For example, one participant mentioned the following: “And in my training as a therapist... ffft... where I didn’t often felt really safe... I wouldn’t have talked about it so freely. No”. In another focus group, it was pointed out that having to pass the exam also influenced this hesitance. One participant said “*Because a training context isn’t always a safe context. And often it’s a very judgmental context as well”, at which another participant supplemented: “Yes, because at the end you’re going to pass or fail your exam”.

**Integrated in education and society**

Several therapists recommended integrating this topic of sexual feelings throughout the education or training, not limiting it to just one or a few isolated lessons. Furthermore, they suggested that it is a supervisor’s task to bring this topic up regularly, thus making it a less loaded subject. In one focus group, this is expressed as follows, by one participant: “*I think too that in training... You can devote a day to it, but you can’t have it as an ongoing theme. It would be a lot better to constantly taking it on board*”. Another participant mentioned:
I think it should be scheduled in peer-to-peer sessions or sessions with your mentor. So that people don’t have to take that step their selves when they are dealing with something, but it (ability to talk about it) is already there for them.

Finally, some therapists indicate that the difficulty of talking freely about sexual feelings in the therapeutic relationship must also be framed in a larger societal context, where expression of feelings about sexuality is still an inconvenient issue, and still insufficiently integrated into general education and daily life. Therefore, they plead for enhancing general education on sexuality as well. One participant pointed out that sexuality is often taught exclusively from a biological perspective: “That’s how it is at school. Sexuality is a subject on the timetable. Like, you know... you get the basics in biology. But the whole world of sex, relationships, intimacy, touching... that should be far better integrated... into the training...”. Another participant indicated that we are not given any language to discuss sexuality.

But we’re all so afraid to talk about feelings and intimate things. We haven’t been taught a language for it. And I think that’s a great drawback in our education system. They should start in kindergarten, really, shouldn’t they? As it were.

RESULTS OF MIXED METHOD

When comparing the quantitative and qualitative results, three common concepts were found. Data integration on these common concepts resulted in both confirming and expanding findings for each concept, whereas non-confirming findings were not found (table 4). Firstly, both studies confirmed that overall educational topics on sexual feelings are rather limited addressed in basic education and specialized psychotherapy training. The expanded findings further revealed that this is especially the case for education about how such feelings might affect the therapist, about (counter)transference, and about approaching these feelings as a normal phenomenon and that such education is no integrated part of the entire curriculum. Secondly, both studies confirmed that reflection and discussing vulnerabilities and emotions due to therapy rather limited occurred in basic education. The expanded findings includes that less experienced psychiatrists reported less often to have learned about reflection and discussing their own emotions than more experienced psychiatrists, and that psychiatrists perceive specialized psychotherapy training as the place to learn more about this.
Table 4

**Jointly display of survey, focus group and mixed methods results**

<table>
<thead>
<tr>
<th>Concepts</th>
<th>Survey</th>
<th>Focus groups</th>
<th>Mixed method</th>
</tr>
</thead>
</table>
| **Educational topics on sexual feelings addressed in BE/PT** | Extent to which sexual feelings of:  
*the client was (quite) a lot addressed:  
  o BE: 14.1%  
  o PT: 32.5%  
*the therapist was addressed:  
  o BE: 6.6%  
  o PT: 21.1% | *The topic of sexual feelings towards clients is seldom addressed in BE/PT.  
*There was limited attention on how experiencing sexual feelings might affect the therapist.  
*There is a main focus on ethics.  
*Sexual feelings towards clients should be normalized.  
*Learning more about (counter)transference would be helpful.  
*The topic of sexuality should be an integral part of the entire curriculum. | Confirming:  
Educational topics on sexual feelings are limited addressed in BE/PT.  
Expanding:  
When it is addressed, it is often from an ethical perspective. Instead, therapists advise 1) to have attention on how such feelings might affect the therapist, 2) to normalize these feelings, 3) to learn more about (counter)transference, and 4) to let it be an integrated part of the curriculum. |
| **Difference between BE and PT in reflecting/discussing on therapists’ emotions and vulnerabilities** | *Extent to which the educational topic ‘making it possible to discuss emotions that arise due to giving therapy’ is (quite) a lot addressed:  
  o BE: 33.8%  
  o PT: 75.9%  
*Psychiatrists with limited experience (0-10y) significantly less often reported that the topic ‘making it possible to discuss own emotions’ was addressed in their education than psychiatrists with more experience (11y+). | *Being able to reflect on one’s own feelings and vulnerabilities should already be learned in BE.  
*Particular psychiatrists indicate the added value of PT to learn how to introspect. | Confirming:  
Learning to reflect and discuss emotions due to therapy is rather absent in BE.  
Expanding:  
Less experienced psychiatrists report less often to have learned how to reflect and discuss on their emotions than more experienced psychiatrists. It is perceived as something to be learned in the PT. |
| **Discussing sexual feelings towards clients in the work field** | *Extent to which sexual feelings towards clients can be discussed in the work field:  
  o Barely possible: 50.5%  
  o Impossible: 4.1% | *Many therapists in general perceive experiencing sexual feelings towards clients as a taboo topic in the work field.  
*Some participants even indicate that BE/PT are not safe places to discuss this. | Confirming:  
For many therapists it is perceived difficult to talk about sexual feelings.  
Expanding:  
Some therapists even indicate it is difficult to discuss these feelings in BE/PT. |

*Note. BE=Basic Education; PT=Psychotherapy Training*
Thirdly, both studies confirmed that many therapists perceive difficulties to talk about sexual feelings in the daily work field, and the expanding finding indicates that for some therapists this is even the case in basic education and psychotherapy training.

**DISCUSSION**

This study investigated how the topic of intimate and sexual feelings is addressed in the different therapists’ education and training programs, by means of a survey and focus groups. Both quantitative and qualitative results confirmed that this topic is rather limited addressed in these programs, where it was mainly brought up within the context of ethically correct behavior. However, it is more often part of their psychotherapy training than of their basic education, where in their training overall more attention is given to aspects like reflecting and discussing therapists’ emotions and vulnerabilities. There even seems a decline over time on such issues in basic education, as less experienced therapists, probably graduating more recently, less often reported they learned about it than more experienced therapists. Furthermore, behavioral therapists were significantly less often trained in intimate and sexual feelings than psychoanalytic therapists and person-centered therapists. However, being well trained on this topic is important, as results showed that this is associated with less difficulties to talk about it.

The main finding of this study is that the topic of intimate and sexual feelings in psychotherapy is only limited addressed in both basic education and psychotherapy training. Because psychotherapy training is often referred to as an important place where therapists’ emotions concerning intimate and sexual feelings should be discussed, for instance with a supervisor [7, 21], it is striking to find that still the majority of therapists reported that this topic was only limited addressed in their training, despite it is constituted as being part of an adequate training already decades ago [6, 10]. This topic is still not an integrated part of their entire curriculum, and predominantly focusing on ethical aspects and not on the vulnerability of the therapists and their emotions that intimate and sexual feelings might evoke. Probably this contributes to experiencing this topic as a taboo (which will be discussed later on), even in the education and training programs.
Among the types of psychotherapy training investigated, behavioral therapists less often reported that this topic of intimate and sexual feelings was addressed during their training than person-centered and psychoanalytic therapists. While it is probably largely explained by the fact that behavioral therapists mainly focus on the client’s behavior and thoughts to initiate change, while person-centered and psychoanalytic therapists tend to consider their own thoughts and feelings as being part of the ongoing therapeutic process, it by no means implies that they cannot be confronted with such feelings.

A remarkable finding from the survey study is that less experienced therapists, probably graduating more recently, less often reported that this topic of intimate and sexual feelings is addressed in their basic education. Especially psychiatrists mentioned this. It suggests that these topics have received even less attention in basic education during recent years. Maybe it is expected that these topics are thoroughly dealt with in psychotherapy training [7, 21], therefore making it less important to deal with them already in basic education. From the focus groups it is also known that exploring and dealing with intimate and sexual feelings, and the emotions they might evoke, is typically regarded as something to be learned during psychotherapy training. Psychiatrists in particular mentioned the added value of taking psychotherapy training in this respect. Therefore, a psychotherapy training should be compulsory for all persons who want to (further) practice psychotherapy, in contrast with the Belgium law that makes this obligatory only for those who start their training [22].

Another important finding is that just over half the therapists indicated that experiencing sexual feelings towards a client is impossible or almost impossible to discuss in the work field. This indicates that for half of all therapists it is still experienced as a taboo topic, as was mentioned by the therapists in the focus groups and as is also quoted in other scientific literature [18, 23]. The good news is that basic education and psychotherapy training can play a key role in breaking the taboo. The survey study pointed out that when this topic of how to deal with sexual feelings in therapy was addressed, especially in psychotherapy training, therapists reported less difficulties discussing these feelings in the work field. Therefore, it is recommended to create an open and safe environment where intimate and sexual feelings are perceived to be a natural phenomenon during the course of someone’s career [18]. As suggested by the participating therapists of the focus groups, renowned and respected therapists can fulfil an important task as role models in this area by disclosing their
experiences herein [24]. They can debunk the myth that ‘good therapists’ never have sexual feelings about their clients, thus making the experience more human [25].

Finally, an unexpected finding was the view of therapists that the focus group discussions themselves were positive and helpful experiences. The time available to discuss this topic thoroughly and the agreed confidentiality in the group were mentioned in particular as essential aspects for exploration. The fact the group discussions were held in a scientific research instead of work context, probably also contributed to this feeling of safety. Nevertheless, as suggested by the therapists in this study and by students in the study by Ladany et al. [5], such group discussions on the work field could indeed offer a format where sexual feelings and opinions can be thoroughly explored in a predominantly non-judgmental way, enhancing the experience that having sexual feelings towards clients is human. For example, young therapists might find reassurance in experiences of sexual feelings among older therapists, at the time itself or in the future, when they encounter similar situations.

The strength of this study is that it combines quantitative and qualitative data, which enhances the reliability of the findings and leads to a more profound insight into how intimate and sexual feelings are addressed in basic education and psychotherapy training. Furthermore, the response rates for the psychotherapy associations (around 50%) are satisfactory. However, findings should be interpreted with caution. The survey studied the perceived extent to which this topic was addressed in education, not necessarily the real extent. The concrete curriculum of basic education and psychotherapy training were not investigated. Furthermore, selection bias cannot be excluded, particularly in the focus groups, where therapists with a more progressive attitude about intimacy and sexuality might be more willing to participate to this study. Finally, due to the qualitative nature of the focus groups, these findings cannot be generalized.

In conclusion, therapists should ideally complete psychotherapy training after their basic education when engaging in a psychotherapeutic relationship. Regarding therapists’ intimate and sexual feelings towards clients, all psychotherapy training should, besides teaching ethical aspects, also focus on how to deal with these feelings, referring to introspection and the exploration of these feelings in a more integrated way during the course of training. This demands a safe educational environment where experiencing sexual feelings is seen as a normal phenomenon. Due to the positive association between the presence of educational
topics on this matter in basic education and psychotherapy training and finding it easier to talk about sexual feelings in the work field, education and training hold an important key to initiate change.
REFERENCES


QSR International Pty Ltd. NVivo qualitative data analysis software, version 12. 2018.


6. Dealing with sexual boundary violation in mental healthcare institutions by government policies: the case of Flanders, Belgium

Manuscript details:

Vesentini, L., Dewilde, K., Matthys, F., De Wachter, D., Van Puyenbroeck, H., & Bilsen, J. Dealing with sexual boundary violations in mental healthcare institutions by government policies: the case of Flanders, Belgium. Manuscript under review in BMC Medical Ethics, IF_{2019} 2.451, Q1. This study was carried out with the help of Kim Dewilde in the context of her MSc-dissertation as a student in Healthcare Management and Policy at the Faculty of Medicine and Pharmacy at the Vrije Universiteit Brussel.
ABSTRACT

To prevent sexual boundary violations (SBV) in mental health care institutions overall governments require these institutions to report SBV incidents to a central registry and to develop institutional guidelines how to react. In Europe SBV policies are only recently developed or implemented, as is also the case in Flanders (Belgium). The implementation of a new institutional policy is always a challenge and can encounter resistance, especially when it concerns SBV, because they remain delicate and complex. This study evaluated the extent to which mandatory policies on SBV have been implemented in mental health care institutions in Flanders, and possible factors for non-compliance to implementation. An online survey was sent to the executives of all mental health care institutions in Flanders (N=162) of which 56 filled out the survey (response rate 35%). Results showed that the implementation of an SBV policy in mental health care institutions is unfortunately inadequate and not all SBV incidents were reported to the central registry. Type of institution and opinions on the SBV policy were related to the (non-)compliance of the implementation of the requirements. Recommendations are given to stimulate compliance and implementation of an SBV policy in institutions, and to enhance reporting and prevention of SBV incidents.
INTRODUCTION

Sexual Boundary Violations (SBV) are huge violations of human rights, especially in situations, such as in healthcare, where there is a disparity in power and status between the professional and the patient, and where the professional is seen as someone who can be totally trusted [1]. SBV in healthcare can be defined as any form of sexualized behavior committed within a professional role. It might include explicit sexual behavior such as (attempted) penetration or genital stimulation, as well as sexualized behavior in a broader sense, such as kissing, fondling, taking pictures of intimate body parts, presenting pornographic material, or sexualized remarks and (attempted) dating. While SBV often takes place in a seemingly consensual way, ultimately it is often experienced by a patient as negative, unwanted or forced [1]. Due to the emotional vulnerability of patients with mental problems, SBV within mental healthcare is even more precarious. Besides psychological consequences, such as feelings of shame, guilt and self-blame, the most salient aspect of SBV for involved patients is the abuse of their trust in situations where trust should be unconditional. The secure base is destroyed and without basic trust no effective therapy to help the client is possible [1].

How countries deal with SBV in healthcare institutions largely differs. In North America, Australia and New Zealand mandatory reporting of SBV is the rule, as well as protection for those who report such incidents. Furthermore, there are penal codes declaring SBV by professionals as a crime. In Europe, the implementation of laws and policies to deal with SBV has lagged about 20-25 years behind [1]. Nowadays, several European countries, including Flanders (Belgium), are also developing or recently developed policies on how to prevent SBV in healthcare institutions and how to deal with SBV when occurring. They mostly advise the formulation and implementation of clear guidelines in the institutions, as well as oblige the reporting of SBV incidents to a central registry. This reporting is considered as essential, because only when SBV incidents are known, a learning process can start. It contributes to more awareness and improvements in management and policy. Penal codes, declaring SBV of healthcare professionals to be a crime (punishment of these professionals with sexualized behavior towards a client) are still rather uncommon in Europe [1-4].

To be successful in preventing SBV, such government policy measures must of course be adequately adopted by the healthcare institutions. However, it is not clear to what extent healthcare institutions are aware of the existence and concrete content of such mandatory
government policy guidelines, neither to what extent they are prepared to accept and implement them. For example, we don’t know much about the attitudes of healthcare institution policy makers towards such measures, their perceived problems to implement them, or about their preparedness to officially report SBV incidents. After all, SBV incidents remain delicate and complex situations, not only evoking personal and group anxieties among healthcare workers but also possibly damaging the reputation of the institution itself. [5-9].

This study aims to investigate 1) the extent to which mandatory policies on SBV have been implemented in Mental Healthcare Institutions (MHCI), 2) knowledge about obligatory character of policies by the MHCI and opinions on such policies, and 3) possible factors related to non-compliance to implementation (e.g., type of MHCI, knowledge about obligatory character, opinions, presence of a reporting person). This will be done in Flanders (Belgium), as case where the government, as in other European countries, recently issued such SBV policy measures.

**METHOD**

**Flemish context**

The Flemish government (Belgium), more specifically the Flemish Agency of Care and Health (FACH), decided that from 2015 all accredited types of healthcare institution in Flanders would be obliged to implement an SBV policy, specifically requiring: 1) the development of a vision on how to deal with SBV in general, to be embedded in the institutional rules, 2) the development of a concrete procedure for how to react when an SBV incident occurs (the ‘reaction protocol’), 3) anonymous internal registration of suspected and confirmed SBV incidents, 4) official reporting of confirmed SBV incidents to the FACH, and 5) the appointment of a ‘reporting person’ in each MHCI, who ensures that the reaction protocol is followed. Although the development of an SBV policy is obligatory, institutions have the freedom to determine how the policy is fleshed out. A manual has been provided to help institutions to initiate their policy [4, 10, 11]. In this manual SBV was defined as every form of sexually oriented behavior, initiated by healthcare professionals, that is experienced by a client as negative, unwanted, or forced [11]. Currently, there is no penal code declaring SBV in healthcare as a crime.
Study design and study population

A cross-sectional study was conducted from 28 November 2018 until 25 January 2019. All different types of MHCI in Flanders (the Dutch-speaking northern part of Belgium), accredited by the FACH and with an adult patient population, were included in this study (N=162): 19 mental health outpatient services (ambulatory mental healthcare), 27 psychiatric hospitals (long-term residential psychiatric care), 34 psychiatric departments of a general hospital (short-term residential psychiatric care), 27 psychiatric treatment homes (residential psychiatric care and living), 43 sheltered living services (residential assisted living), and 12 rehab centers for addiction (residential psychiatric care for persons with an addiction).

Data collection

We retrieved from the FACH the contact details of all 162 executives of the accredited MHCI who were expected to have the most knowledge of or to be responsible for the implementation of the SBV policy at the MHCI. These were the general manager for mental healthcare services, psychiatric hospitals, and rehab centers for addiction, the general coordinator for psychiatric treatment homes and sheltered living services and the chief nurse for psychiatric departments of a general hospital. An e-mail with a link to an electronic survey was sent to these selected executives, followed by three e-mail reminders.

To compare the confirmed SBV incidents reported in the survey with the officially reported SBV incidents to the FACH (period 2016-2018), we also asked the FACH to send us the number of officially reports per type of MHCI.

Questionnaire

The survey consisted of questions about 1) knowledge of obligations, 2) opinions on SBV policy on an ordinal 5-point scale going from totally disagree to totally agree, 3) implementation of the specific SBV policy requirements (as described in the Flemish context), 4) actual occurrences of SBV incidents in the MHCI, and 5) type of MHCI. These questions were based on the Flemish government decree and the manual that was made available to help institutions start up their policy [4, 10, 11], previous literature on this topic [1, 7-9] and informal conversations with experts in the field. Furthermore, a pre-test was done among three executives, working in an MHCI with a patient population of minors, resulting in some minor, mainly textual adaptations to the questionnaire.
Analysis

Frequencies and percentages are given to describe knowledge of the obligations, opinions on an SBV policy, implementation of the specific SBV policy requirements, actual occurrences of SBV incidents, and the type of MHCI. To investigate the association between, on the one hand, the implementation of the specific SBV policy requirements and, on the other hand, the type of institution, knowledge of obligations, opinions on SBV policy, and the presence of a reporting person, a two-tailed chi-square was used, or a fisher exact when appropriate. For the analysis the ordinal 5-point scale of the variable ‘opinions on SBV policy’ was recoded into three options: ‘disagree’, ‘neutral’, and ‘agree’. IBM SPSS Statistics, version 23, was used for all analyses.

Ethics

In the e-mail that was sent to all executives of the MHCI, the aim and importance of this study was emphasized, and anonymity was ensured. Anonymity was guaranteed by configuring the settings of the survey website in such a manner that the respondent’s email- and IP-addresses were not collected. Moreover, questions about institution characteristics were limited to make identification of these institutions impossible. Furthermore, we explained that consent was given by respondents by filling out and returning this survey electronically. Respondents could contact the researchers at any time for more information or to comment on this study. After consulting the Medical Ethics Committee, we were informed that approval of this study by the Committee was unnecessary, because the survey queried data at institutional rather than personal level.

RESULTS

Response rate

In total 56 executives of MHCI filled out the online survey (response rate 34.57%): 42.1% (n=8) of all mental health outpatient services, 59.3% (n=16) of psychiatric hospitals, 26.5% (n=9) of psychiatric departments of a general hospital, 11.1% (n=3) of psychiatric treatment homes, 20.9% (n=9) of sheltered living services, and 91.7% (n=11) of rehab centers for addiction.
<table>
<thead>
<tr>
<th>Opinions</th>
<th>Totally disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Totally agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Power imbalances between colleagues are a barrier to reporting to the FACH</td>
<td>7</td>
<td>12.5</td>
<td>9</td>
<td>16.1</td>
<td>21</td>
</tr>
<tr>
<td>By not reporting to the FACH, an inspection is avoided</td>
<td>24</td>
<td>42.9</td>
<td>11</td>
<td>19.6</td>
<td>13</td>
</tr>
<tr>
<td>Little incidents are needlessly amplified when reporting to the FACH</td>
<td>16</td>
<td>28.6</td>
<td>21</td>
<td>37.5</td>
<td>13</td>
</tr>
<tr>
<td>Official reports to the FACH about a colleague will lead to a negative atmosphere</td>
<td>12</td>
<td>21.4</td>
<td>15</td>
<td>26.8</td>
<td>18</td>
</tr>
<tr>
<td>It is better to organize an internal dialogue among the parties involved than to follow a protocol</td>
<td>13</td>
<td>23.2</td>
<td>18</td>
<td>32.1</td>
<td>17</td>
</tr>
<tr>
<td>Other projects demand more priority (given the work pressure and limited time available)</td>
<td>25</td>
<td>44.6</td>
<td>19</td>
<td>33.9</td>
<td>8</td>
</tr>
<tr>
<td>There is little interest from the government in the need for an SBV policy</td>
<td>10</td>
<td>17.9</td>
<td>16</td>
<td>28.6</td>
<td>20</td>
</tr>
<tr>
<td>The development of an SBV policy is stimulated by former SBV incidents</td>
<td>1</td>
<td>1.8</td>
<td>9</td>
<td>16.1</td>
<td>12</td>
</tr>
<tr>
<td>A 'reporting person' lowers the barrier for discussing SBV</td>
<td>1</td>
<td>1.8</td>
<td>3</td>
<td>5.4</td>
<td>13</td>
</tr>
</tbody>
</table>
Knowledge about the obligatory character of the SBV measures

The majority of the responding executive staff in MHCI (80.4%) did know that they were obliged to develop an SBV policy, although a fifth was not. More than half of the executive staff knew that officially reporting SBV to the FACH (64.3%) was mandatory. Further analysis revealed that at the psychiatric departments of a general hospital (respectively 55.6% and 55.6%) and rehab centers for addiction (respectively 63.6% and 27.3%) this knowledge was lower compared to the other MHCI (not significant).

Opinions on SBV policy

As shown in table 1, a third of the executive staff members (33.9%) thought (agreed or totally agreed) that power imbalances between colleagues were a barrier to making official reports to the FACH. One out of seven responding executives thought a report was not made to avoid the visit of the FACH inspection (14.3%) and that it is better to organize an internal dialogue among the parties involved than follow a protocol (14.3%). Furthermore, 69.65% agreed that a reporting person lowers the barrier to discussing SBV. Further analysis revealed that there was no significant association between type of institution and opinion on SBV policy (not in table). Although not significant, it is of interest that more than half the responding executives of psychiatric departments of a general hospital (55.6%) agreed that power imbalances between colleagues is a barrier to reporting and 33.3% agreed there is little interest from the government concerning the need for an SBV policy. The majority of the executive staff members of psychiatric hospitals disagreed that an inspection is avoided by not reporting to the FACH (93.8%).

Implementation of specific SBV policy requirements

More than half of the responding executives stated that the MHCI developed a reaction protocol (58.9%). In 28.6% of the MHCI there was an internal system to register suspected SBV incidents and in 44.6% MHCI there was such a system to register confirmed SBV incidents. Almost half of the MHCI (48.2%) had the policy of officially reporting confirmed SBV incidents to the FACH and in 58.9% MHCI a reporting person was present (table 2).
<table>
<thead>
<tr>
<th>N-Value</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total MHCI where policy is present</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>32</td>
<td>21</td>
<td>33</td>
<td>16</td>
<td>26</td>
<td>27</td>
<td>33</td>
</tr>
<tr>
<td>%</td>
<td>57.1</td>
<td>37.5</td>
<td>58.9</td>
<td>28.6</td>
<td>44.6</td>
<td>48.2</td>
<td>58.9</td>
</tr>
<tr>
<td>Type of MHCI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric hospital (n=16)</td>
<td>93.8</td>
<td>37.5</td>
<td>93.8</td>
<td>50</td>
<td>56.3</td>
<td>81.3</td>
<td>75</td>
</tr>
<tr>
<td>Psychiatric department of a general hospital (n=9)</td>
<td>22.2</td>
<td>22.2</td>
<td>22.2</td>
<td>11.1</td>
<td>11.1</td>
<td>11.1</td>
<td>44.4</td>
</tr>
<tr>
<td>Psychiatric treatment home (n=3)</td>
<td>66.7</td>
<td>66.7</td>
<td>66.7</td>
<td>0</td>
<td>66.7</td>
<td>66.7</td>
<td>100</td>
</tr>
<tr>
<td>Mental health outpatient service (n=8)</td>
<td>62.5</td>
<td>62.5</td>
<td>62.5</td>
<td>12.5</td>
<td>25</td>
<td>37.5</td>
<td>37.5</td>
</tr>
<tr>
<td>Sheltered living services (n=9)</td>
<td>55.6</td>
<td>55.6</td>
<td>55.6</td>
<td>22.2</td>
<td>44.4</td>
<td>55.6</td>
<td>55.6</td>
</tr>
<tr>
<td>Rehab center for addiction (n=11)</td>
<td>27.3</td>
<td>36.4</td>
<td>36.4</td>
<td>36.4</td>
<td>63.6</td>
<td>27.3</td>
<td>54.6</td>
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<tr>
<td>P-value</td>
<td>0.004</td>
<td>0.582</td>
<td>0.008</td>
<td>0.176</td>
<td>0.135</td>
<td>0.011</td>
<td>0.285</td>
</tr>
<tr>
<td>Knowledge of obligations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obliged to develop SBV policy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (n=45)</td>
<td>66.7</td>
<td>40</td>
<td>68.9</td>
<td>31.1</td>
<td>48.9</td>
<td>57.8</td>
<td>64.4</td>
</tr>
<tr>
<td>No (n=11)</td>
<td>18.2</td>
<td>27.3</td>
<td>18.2</td>
<td>18.2</td>
<td>27.3</td>
<td>9.1</td>
<td>36.4</td>
</tr>
<tr>
<td>P-value</td>
<td>0.006</td>
<td>0.508</td>
<td>0.004</td>
<td>0.483</td>
<td>0.312</td>
<td>0.006</td>
<td>0.170</td>
</tr>
<tr>
<td>Officially reporting SBV incidents to the FACH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (n=36)</td>
<td>66.7</td>
<td>47.2</td>
<td>72.2</td>
<td>33.3</td>
<td>50</td>
<td>61.1</td>
<td>61.1</td>
</tr>
<tr>
<td>No (n=20)</td>
<td>40</td>
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<td>35</td>
<td>20</td>
<td>35</td>
<td>25</td>
<td>55</td>
</tr>
<tr>
<td>P-value</td>
<td>0.090</td>
<td>0.051</td>
<td>0.011</td>
<td>0.365</td>
<td>0.401</td>
<td>0.013</td>
<td>0.779</td>
</tr>
<tr>
<td>Presence of a reporting person</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (n=33)</td>
<td>72.7</td>
<td>45.5</td>
<td>69.7</td>
<td>39.4</td>
<td>54.4</td>
<td>54.5</td>
<td></td>
</tr>
<tr>
<td>No (n=23)</td>
<td>34.8</td>
<td>26.1</td>
<td>43.5</td>
<td>13</td>
<td>30.4</td>
<td>39.1</td>
<td></td>
</tr>
<tr>
<td>P-value</td>
<td>0.007</td>
<td>0.170</td>
<td>0.060</td>
<td>0.039</td>
<td>0.103</td>
<td>0.289</td>
<td></td>
</tr>
</tbody>
</table>

Note: Specific SBV policy requirements: 1 = Vision about how to deal with SBV; 2 = SBV vision is embedded in the institutional rules; 3 = Reaction protocol; 4 = Registration of suspected SBV incidents in internal system; 5 = Registration of confirmed SBV incidents in internal system; 6 = Officially report confirmed SBV incidents to the FACH; 7 = Presence of a reporting person.

*Fisher Exact
Of those MHCI where no reporting person was present (n=23), almost all could report their suspicion or concern to one or more persons or services in the MHCI: ombudsman’s office, prevention and protection service at work, director, immediate superior or confidant.

A minority (12%) of the MHCI would suspend the healthcare professional when SBV is suspected, but would never fire him/her, whereas when SBV is confirmed 39.3% MHCI would suspend and 53.6% would fire this healthcare professional.  

Factors related to non-compliance to implementation

**Type of MHCI**

Significant differences were found based on type of institution, regarding the development of a vision about how to deal with SBV ($p=0.004$), a reaction protocol ($p=0.008$) and officially reporting of SBV incidents to the FACH ($p=0.011$). Notably, the great majority of psychiatric hospitals have complied with these SBV policy requirements, but only a minority of psychiatric departments of a general hospital have done so (table 2).

**Knowledge of obligatory character**

MHCI who did know developing an SBV policy and/or officially report SBV incidents to the FACH is mandatory significantly more often complied to the SBV policy requirements than MHCI who did not know this (table 2). They more often developed a reaction protocol and more often had the policy of officially reporting these incidents if they would occur.

**Opinions on SBV policy**

Executive staff members of MHCI (MHCl) who did agree power imbalances between colleagues are a barrier to reporting less often had an internal system to register confirmed SBV incidents than MHCl who did not agree (neutral or disagree) ($p=0.039$). MHCl who did agree that FACH inspections are avoided by not reporting to the FACH less often had an internal system to register suspected ($p=0.038$) and confirmed ($p=0.010$) SBV incidents, a policy to officially report SBV incidents ($p=0.018$) or a reporting person ($p=0.010$). MHCl who did agree that it is better to organize an internal dialogue among parties involved than follow a protocol develop a vision about how to deal with SBV less often ($p=0.039$). MHCl who did agree or were neutral that a reporting person lowers the barrier to discuss SBV developed a
vision about how to deal with SBV \((p=0.046)\) and a reaction protocol \((p=0.045)\) more often (not in table).

**Presence of a reporting person**

When a reporting person was present in an MHCI, the MHCI had more often developed a vision about how to deal with SBV \((p=0.007)\) and an internal system to register suspected SBV incidents \((p=0.039)\) (table 2).

**Occurrence of SBV incidents in MHCI**

In the past three years (period 2016 till 2018), in 22 of the 56 questioned MHCI there were 53 suspected SBV incidents, and in 18 of the MHCI there were 30 confirmed SBV incidents (table 3). Most confirmed SBV incidents were in psychiatric hospitals \((n=12)\) and rehab centers for addiction \((n=12)\). When comparing these unofficially confirmed SBV incidents to the official reported incidents, as was requested by the FACH, especially the underreporting in the psychiatric hospitals is noticed \((12 \text{ reports versus } 9 \text{ reports})\).

<table>
<thead>
<tr>
<th>Type of MHCI</th>
<th>Suspected SBV incidents</th>
<th>Confirmed SBV incidents</th>
<th>Official reports as known by the FACH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N cases</td>
<td>N MHCI</td>
<td>N cases</td>
</tr>
<tr>
<td>Psychiatric hospital</td>
<td>20</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Psychiatric department of a general hospital</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatric treatment home</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Mental health outpatient service</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Sheltered living services</td>
<td>6</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Rehab center for addiction</td>
<td>19</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>53</strong></td>
<td><strong>22</strong></td>
<td><strong>30</strong></td>
</tr>
</tbody>
</table>

*Note: n/a means that at time of the study the official records for the psychiatric departments of a general hospital and rehab centers for addiction were not known or registered.*

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DISCUSSION

This study shows that the knowledge about and implementation of an SBV policy in Flemish MHCI, as required by the FACH since 2015, is unfortunately inadequate. Around 20% of the executives do not know that the development of an SBV policy is mandatory and even 36% do not realize that official reporting of SBV incidents to the FACH is obliged. About 40% of the MHCI had not developed a vision and reaction protocol; more than half of the MHCI had no internal registration system for suspected (71%) or confirmed (55%) SBV incidents as is required. In 30% of the MHCI no reporting person was assigned and finally not all SBV incidents were reported to the FACH. The type of institution, knowledge of obligations and opinions on SBV policy were related to the implementation of these requirements. Overall, psychiatric hospitals implemented specific SBV policy requirements far more often than psychiatric departments of a general hospital. Knowledge of the obligations was positively associated with the implementation of the requirements. MHCI with the opinion that an inspection could be avoided by not reporting to the FACH complied less often with the specific SBV policy requirements than those MHCI that did not share this opinion. These findings of the case in Flanders will probably also be interesting for policymakers in other countries with similar approaches towards SBV in mental healthcare.

An important finding is that the institutions insufficiently are aware and acknowledge the relevancy of such SBV policy. In Flanders, about a third of the executives do not know that the implementation of an SBV policy and reporting of SBV incidents to the FACH is mandatory. In addition, about a fifth thought that other projects demand more priority. This indicates that the communication about this SBV policy, its obligatory character and its importance is far from optimal. Possibly this request to implement an SBV policy is overlooked due to an overload of incoming information and administrative demands from the authorities. However, the lack of clear (financial) implementation incentives, as well as control and compelling negative consequences (e.g., loss of accreditation) in case of not fulfilling the requirements, will also not stimulate MHCI executives to comply to the requested measures.

Besides not sufficiently being stimulated to implement these measures, also fear of the consequences for interpersonal relations on the work floor as well as insecure reactions from authorities can play an impeding role to meet the guidelines. Some MHCI in Flanders clearly state to prefer internal protocols and solutions when confronted with SBV, over following the
authorities’ protocol, e.g., via internal dialogue between involved parties. One out of seven executives mentioned possible visits from the FACH inspection as reason for not officially reporting SBV incidents. One out of three executives found that power imbalances between colleagues increases the reluctance to report, pointing to fear of possible retaliation by the involved colleague, in line with findings of previous papers [1, 5, 7-9, 12, 13].

Installing a central function within the institution, in the form of a ‘reporting person’ that employees can contact in case of questions and problems related to SBV, is often seen as an important step in the prevention of SBV incidents [1, 9, 11]. The results of this study also point to that direction. Most respondents confirmed it stimulated discussions about SBV and MHCI with such function had also more often a registration system for suspected SBV incidents. However, it did not increase the actual registering and reporting of cases, which probably again relates to worries about possible consequences, as mentioned earlier.

Striking in our results was the underrepresentation in this survey of psychiatric departments in general hospitals, and the fact that these also had implemented SBV policy requirements less often than the other MHCI. Explanations for this are not clear. Possibly, (participating in studies about) SBV measurements specific meant for mental healthcare institutions, are regarded as even less important by the executives of these -often large- hospitals, with so many other protocols and whose core business lies in the many other medical departments.

The strength of this study is that it provides some plausible explanations for the finding that several MHCI had not complied with the requests of the government in implementing and following guidelines about SBV, therefore giving indications for improvement, probably also applicable in other countries in similar processes. A limitation of the study is the rather low response rate, so selection bias cannot be excluded. Possibly MHCI where no SBV policy was implemented or where it was not perceived as an important topic were possibly less willing to participate in this study. Another limitation is the low total number of MHCI, which is of influence on the statistical power [14]. Furthermore, it cannot be excluded that socially desirable answers were given.
CONCLUSIONS AND RECOMMENDATIONS

Only SBV policies which are adequately implemented in MHCI can contribute to preventing the occurrence of SBV incidents, but this is not self-evident. Many MHCI are not sufficiently aware of what an SBV policy should constitute or worry about the consequences when implementing such a policy. First, to stimulate compliance and implementation of an SBV policy in institutions, governments should clearly communicate about the content of the policy requests, its relevancy and mandatory character (including consequences when not followed). This encompasses also a regular monitoring of institutions. Further it is necessary to provide sufficient incentives in the form of financing and training. Departments embedded in a larger organizational structure (like a general hospital) must be given special attention. Second, to enhance reporting of SBV incidents to a central registry, concrete consequences for the institutions and the healthcare professional should be clear, and anonymity of involved people must be guaranteed. Third, when SBV incidents are reported, governments should offer support and guidance in how to address this problem (for the institution and professionals). Fourth, to enhance prevention of SBV incidents, professionals should be offered (continuously and integrated in the daily work) training and support about sexual feelings towards clients, about boundaries, identify personal risk situations and how to manage them.
REFERENCES

General discussion

1. Introduction
2. Methodological reflections
3. Main findings and discussion
4. Conclusions
5. Implications for practice and education
6. Implications for research
1. Introduction

This dissertation explored the field of intimacy and sexuality of therapists in the psychotherapeutic relationship in Flanders, Belgium. Based on three studies, the occurrence of these intimate and sexual feelings and behaviors was explored (chapter 1), as well as therapists’ attitudes in this matter (chapter 2). Furthermore, the experiences and management of such feelings were described (chapter 3), as well as the hesitance to discuss these feelings in the work field (chapter 4). Finally, the attention this topic was given in basic education and psychotherapy training was investigated (chapter 5), and the extent to which the mandatory policy on sexual boundary violation (SBV) was known and accepted by mental health executives and implemented in their mental health care institutions (MHCI) (chapter 6).

This dissertation aims to make a substantial contribution to the exploration of intimacy and sexuality of therapists in the therapy room. It has a pioneering character because it researched this topic on a large scale for the first time in Flanders (as well as in continental Europe). Previous studies on this topic were mainly conducted in the eighties and nineties in North America and Great Britain [1-10]. In addition, this dissertation combined quantitative and qualitative data, providing a broad insight into intimacy and sexuality in the psychotherapeutic relationship, leading to a richer interpretation of results. Perhaps the greatest added value of this dissertation was exploring this topic in itself, as it is still perceived as a taboo topic, which complicated research. The results provide a basis for open discussion, future research and the formulation of some recommendations for stakeholders in mental healthcare.

This discussion section starts with methodological reflections on the conducted studies, with mentioning the strengths and limitations. The main findings of our studies will be recapitulated and discussed, leading to some conclusions. Finally, some implications for practice, education and future research will be made.
2. Methodological reflections

This dissertation consists of three studies conducted in Flanders, Belgium. Firstly, a large-scale quantitative survey study was conducted among therapists (November 2016-June 2018) to determine 1) prevalence rates of intimate and sexual feelings and behaviors, 2) therapists’ attitudes in this matter, 3) the extent to which this topic was given attention in basic education and psychotherapy training, and 4) the extent sexual feelings towards clients were able to discuss in the work field. Secondly, a qualitative focus group study was conducted among therapists (February 2018-May 2019) to gain more in-depth understanding of their experiences and the managing of intimate and sexual feelings. Thirdly, a survey study gathered information of mental health care institutions MHCI (November 2018-January 2019) about the knowledge and opinions of executives about the policy on sexual boundary violation and the extent to which this mandatory policy was implemented in MHCI. Methodological considerations of these studies are described below.

Survey study among therapists
A major challenge of this survey was to spread the survey to therapists in Flanders. Therefore, a great effort was done to convince professional associations to fully participate in this study. This was necessary in a time frame of #MeToo and in the aftermath of scandals in this respect, where there is concern that such a study could lead to compromise therapists and the professional associations. This effort positively resulted in a study population consisting of all psychiatrists and all members of three of the four major psychotherapy associations in Flanders, who were in practice or in their last year of training: Flemish Association for Person-Centered Psychotherapy, Flemish Association for Behavioral Therapy, and Flemish Association for Psychoanalytic Psychotherapy. The association for systemic therapy did not participate in this study, which is a limitation, especially because they have the largest number of members.

A strength of this study is that in addition to therapists who are already practicing psychotherapy, therapists who are in their final year of training were also included, because therapists’ experiences, opinions and behavior regarding intimacy and sexuality (in the psychotherapeutic relationship) can be influenced by their (previous) work and life experiences.
Of the 1971 therapists that were contacted, 786 therapists completed and returned the questionnaire (overall response rate 40%). This achieved overall response rate is satisfactory and comparable with previous studies [1, 2, 5-9, 11, 12]. However, response rates per subgroup varied. For the three major psychotherapy associations, response rates of about 50% were accomplished, which is a good achievement [13-15]. Although the response rate for psychiatrists is rather low in comparison to the psychotherapy associations (35%), it is satisfactory compared to other surveys among medical doctors [16]. The good response rate is the result of several measurements, whereby - as much as possible - the costs for completing the survey have been reduced (e.g., reducing the length, making responding convenient), the benefits increased (e.g., asking interesting questions, telling how results will be used), and trust established (e.g., key figures that endorsed the study, anonymity ensured) [17].

Representativeness of respondents based on age and gender could not be determined, because this information was not made available by the professional associations. However, when looking at the characteristics of respondents it can be noticed that in the oldest age group (60 years and above) there were more men than women, while in the younger age groups the opposite was true, which is in line with the feminization of healthcare [51]. While age and gender selection bias are certainly possible, the results are more likely to be biased by possible under- or overrepresentation of therapists who are more or less conservative about intimacy and sexuality, respectively. Also, therapists who doubt their behavior is perceived as correct might be underrepresented. Because of the procedure for guaranteeing anonymity, it was also not possible to investigate the non-response. Besides selection bias, also information bias cannot be excluded. For example, taking into account the sensitivity of the subject, it cannot be ruled out that some respondents gave socially desirable answers, which probably leads to an underestimation of intimate and sexual occurrences, and more restrictive opinions. Therefore, the results of this study should be interpreted with caution.

An additional difficulty of this study concerns the sensitive and delicate nature of this topic, where some therapists do not feel comfortable with. Therefore, the nuanced formulation of questions in the questionnaire was extremely important, ensuring that therapists would not be offended or scared off when filling in the questionnaire. To overcome this challenge the questionnaire was multiple times discussed in the research group. Also, a pilot test among researchers and therapists in training was done.
Another challenge was how to deal in the questionnaire with the concepts of intimacy and sexuality. After a long deliberation within the research group, it was decided not to define these concepts in the questionnaire, although this could affect content validity. The overriding factor was that the aim of the study was to investigate how intimacy and sexuality is experienced and reported by therapists themselves. Furthermore, because this study is exploratory and rather descriptive in nature, not aiming to measure certain predefined constructs, such as sexual desire, it was decided not to use such validated instruments (e.g., Sexual Desire Inventory or Sexual Desire Questionnaire).

Many statistical tests have been conducted on the collected data, therefore correcting for multiple tests can be recommended, for example by using a multiple testing correction like e.g., the Bejamini-Hochberg False Discovery Rate (FDR). However, if we would use a stricter alfa-level for each test, due to the correction (leading to a more conservative Type I error rate) then the probability of rejecting an effect that does actually exists is increased (more likely to make a Type II error). There is in this study already an increasing chance of a Type II error, because many non-parametric tests were conducted, such as Chi-square analysis, which have overall less statistical power and since we often had to deal with rather small samples. However, a strong argument to use these non-parametric tests is the presence of small cells risk, complemented with a lot of variables that were not distributed normally. Therefore, instead of a correction for multiple testing, we interpreted the p-values very cautiously.

To obtain sufficient statistical power the sample size is important. However, due to the explorative nature of this study, no such power analysis was done before the start of the study, because for most outcome variables it was impossible (nor the aim) to determine in advance the anticipated incidence between groups.

Focus group study among therapists
To obtain insight in experiences and perceptions of persons, both focus groups and interviews are appropriate methods [18]. However, we chose to use focus groups instead of interviews to investigate therapists’ experiences, perceptions and behavior regarding intimate and sexual feelings. The strength of focus groups is that therapists are not by definition required to have such experiences themselves or that some therapists might feel less obliged to deeply expose themselves (which is expected in interviews and can be threatening). They might rather listen
to the other participants and play a meaningful role in the focus group by asking in-depth questions, which leads to more nuanced and detailed discussion. Furthermore, therapists might be encouraged to share their opinions and feelings in the footsteps of other therapists who express them. In addition, focus groups provide valuable additional information about interactions between participants about this topic [19, 20]. It contributes to the insight in how therapists on the work floor discuss this topic and respond to disclosures. Finally, an advantage of focus groups is that more participants can be reached compared to interviews. Nevertheless, focus group studies have its limitations. It cannot be excluded that some therapists would prefer an in-depth interview in this regard, feeling more comfortable in such context. Another possible limitation may be related to social interactions within the group. Some responses can be influenced by conformism and conflict avoidance rather than being given their own perceptions or that therapists are rather reluctant to discuss this topic openly. However, due to the voluntary participation in such focus groups, we assume this is rather unlikely. Therefore, the strengths of this method outweigh these limitations.

Concerning the inclusion criteria, both therapists who were in practice and in their last year of training were included in the focus groups. This is a strength, for the same reasons as mentioned in the survey study. Furthermore, focus groups were open to all psychiatrists and psychotherapists. Both at the end of the survey and by key figures (mainly training coordinators) an invitation was made to participate in the focus groups. Due to the more general awareness of this research in the work field, also interactional and integrative therapists as well as systemic therapists, who were not included in the survey study, wanted to participate in the focus groups. Although it can be perceived as a limitation, because findings from the focus groups are less able to be connected to the survey-findings, it can also be perceived as a strength, as now a wider range of therapists is covered.

Focus group discussions demand, based on relevant characteristics to the research topic, 1) homogeneity within groups, putting participants at ease, to enhance active participation, and 2) sufficient variety between groups, to gain an insight in differences between groups [18]. Relevant characteristics are in this matter age and experience, gender, and basic education and psychotherapy training. The strength of this study is that it succeeded in finding enough participants, distributed per characteristic to the focus groups, based on age and experience, basic education (psychiatrists versus non-psychiatrists) and psychotherapy training (systemic
therapy, interactional and integrative). In total two homogenous groups with solely psychiatrists (mixed gender and age) were conducted, three groups with solely female systemic therapists, of which one contained only relatively young therapists, two groups with only interactional or integrative psychotherapists, of which one containing female therapists only, and one rather mixed group. Ideally, more focus groups with psychiatrists could have been conducted, as well as separate male groups, and groups with person-centered, behavioral and psychoanalytic therapists. Also, focus groups with therapists trained from other theoretical orientations would have been relevant. More groups with psychiatrists might have further enriched how psychiatrists differ from non-psychiatrists, for example with regard to societal expectations, impact of type (pathologies) of clients, and being educated as a physician. Probably, separate male groups might have provided more erotically oriented experiences [55], and more insight in the (possible) implications of a double standard [56]. Extra groups with solely person-centered, behavioral, and psychoanalytic therapists might have shown more nuanced differences concerning opinions about what is constituted as good professional conduct within the different therapeutic approaches. Due to constraints of time and resources, the difficulty to find participants, and being dependent on the cooperation of others, this was not feasible.

The results of this qualitative research cannot be generalized as is the case with representative quantitative research. However, unique stories / experiences of participants can also be very ‘typically’ for the situation under study. If the experiences are recognized and confirmed by others, and they can relate this to their own practice / life, this contributes to the transferability (applicability in other contexts) of the findings [57].

A limitation of this study is that it cannot be ruled out that therapists who can speak more freely about intimacy and sexuality, were more likely to participate in the study than therapists who are more hesitant about this, influencing therefore the results.

The way in which the conversation in the focus group was started up, was creative and novel. Participants were asked to think about an intimate or sexually explicit experience with a client and which emotions and thoughts it evoked. To help participants in their reflection process each of them received a set of 26 cards in an envelope. On each card a certain emotion or thought was printed, either positively or negatively of nature. An important strength of this approach is that 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 enriches the discussion afterwards [21].

A major challenge in this focus group discussions was to build sufficient safety in the groups, leading participants to disclose their feelings and experiences about such a sensitive and delicate subject. This feeling of safety is determined by firstly, the moderator and the conditions created in which the focus group takes place, and secondly, the group interaction [18]. In order to enhance the feeling of safety, the confidentiality of the gathered data was thoroughly assured to participants, being officially noted in the informed consent that was signed by all parties. Furthermore, the moderator tried to put everyone at ease and attempted to build up safety during the focus group. With a female moderator in dominantly female groups this feeling of safety is probably further enhanced. The influence of the group interaction is hardly controllable. On some occasions the disclosure of some group members about their experiences will have enhanced the disclosure of other participants, while in other cases members’ statements or responses resulted in more unsafety, and therefore hesitance to talk about it. However, this is also the strength of this study, where group interactions were investigated, making it more detectable how in real life therapists might reinforce this taboo topic or open it up.

Survey study among mental health care institutions
All types of MHCI in Flanders, accredited by the Flemish Agency of Care and Health (FACH) and with an adult population were included in this online survey study. Executives of the accredited MHCI who were expected to have the most knowledge of or to be responsible for the implementation of the SBV policy were contacted. A strength of this study is that the names of these executives were retrieved from the FACH itself, which increased the likelihood of reaching the most suitable contact persons to fill in this survey.

A response rate of 35% was achieved, which for these kinds of studies is common but remains rather low to generalize findings [13, 22]. Besides that, due to the rather low response rate and the low total number of MHCI, there is a possibility that actual differences were not found to be significant.
Because selection bias cannot be excluded, the results of this study should also be interpreted with caution. Possibly MHCI where no SBV policy was implemented or where it was not perceived as an important topic were possibly less willing to participate to this study, therefore probably leading to an overestimation of the implementation rate of SBV policy in Flemish MHCI.

One of the challenges of this survey study was the development of the questionnaire itself, because the questions had to be asked in such a way that the researchers could deduce whether respondents were aware that implementing an SBV policy was mandatory, which was one of the aims of the study. To verify the questionnaire was clearly understood a pretest was done among three executives, working in an MHCI with a patient population of minors, only resulting in some textual adaptations. Despite these efforts and guaranteeing anonymity, it cannot be ruled out that information bias occurred due to socially desirable answers given. For instance, for those executives, being aware of the mandatory nature of the SBV policy, it might be possible that such socially desirable answers were given.

3. Main findings and discussion

The main findings are summarized and discussed, according to the aims of this dissertation. Because findings often indicated different results according to therapists’ characteristics (e.g., gender, age/experience, type of basic education and psychotherapy training) these findings will be discussed separately.

Aim 1: To estimate the occurrence of intimate and sexual feelings and behaviors of therapists, and therapists’ attitudes in this respect

The prevalence rates of intimate and sexual feelings and behavior are described in chapter 1. During their whole career, many therapists found at least once a client sexually attractive (71%), fantasized about a romantic relationship (23%), or fantasized about sexual contact (27%). Further, a large proportion of therapists reported to be emotionally quite involved with a client (96%), and felt clients were like friends (72%). The rather high prevalence rates for sexual feelings and fantasies are rather similar to previous international studies [2, 3, 6-9] and not surprising. As mentioned in the general introduction, a professional kind of intimacy is...
built up in the psychotherapeutic relationship. This intimacy can be conductive to the further development of more intimate and sexual feelings. Substantially lower rates were found for more informal, such as accepting clients they already know from their personal life (22%), confiding personal concerns to a client (16%), and starting friendships after therapy (13%). Friendships that started during therapy (4%) and sexual relationships that started during or after therapy (3%) were rather exceptional. Compared to earlier studies in North America and in British studies [1, 2, 5-9], overall lower prevalence rates of intimate and informal behaviors were found in this study. Probably, it indicates the presence of cultural differences and/or attitude changes over time due to e.g., changing legislation, polices, and events that got a lot of media attention (i.e., #MeToo).

This discrepancy between the rather high prevalence rates for sexual feelings and fantasies, and emotional involvement, compared to the lower rates for more informal and sexual behavior, can perhaps be explained by the perception of therapists concerning the potentially negative impact it respectively might have on clients. Probably feelings and emotions are seen as more permissible and less harmful to the client in contrast to actual behavior.

The rather low occurrences for actual behavior are in line with the results of the study where their opinions and attitudes about such behavior was investigated (chapter 2). Overall a restrictive attitude was found for intimate and informal behavior, indicating there is a high sense of morality among therapists. Some intimate and informal behaviors were regarded almost unanimously as unacceptable, e.g., accepting a Facebook friend request and letting the client help with a private task, whereas for other behaviors a more nuanced and varied degree of acceptability was found. A possible explanation is that a degree of intimacy is allowed as long as it occurs within the realm of the psychotherapeutic relationship, but therapists by no means want to give clients the impression they can be part of their private life.

Despite the consistency between the low acceptability rate (chapter 2) and the low occurrence rate for informal behaviors (chapter 1), for particular behavior, such as accepting a person from their personal life as a client and letting a client to come at their home to provide a service, it was still respectively twice to five times more prevalent than expected based on the acceptability rate. Probably, this finding explains the results from chapter 1 where more than a quart of therapists evaluated such own behavior rather negatively. This behavior might be
sometimes present, due to human and/or psychotherapeutic considerations, although therapists themselves are not comfortable with it.

As was to be expected, it was found that therapists categorized as being ‘rather sexually permissive’ in the attitude study more often reported having found a client sexually attractive or having fantasized about a romantic relationship, but they did not more often had sexual contact (chapter 2). As the low prevalence rate (3%) of sexual contact already suggests, the large majority of therapists that have experienced sexual feelings and fantasies, that behaved more informally and where a larger emotional involvement was noticed, never had sexual contact (chapter 1). So, it contributes to the insight that a more sexually permissive attitude nor more sexual feelings and informal behavior by default lead to sexual contact [23]. Nevertheless, most therapists who engage in sexual contact are likely to follow this path of growing transgressions, although no such process can be proven based on the data in this study. Furthermore, based on the findings of chapter 3 about the management of sexual feelings, we know that most therapists who fantasized about a romantic relationship with a client never considered starting such relationship with a client, either during or after therapy (93-95%). Reasons in the focus groups mentioned to refrain from such relationship were the power imbalance between therapists and clients (indicating it might have negative consequences for the client), and the negative consequences for the therapist self, such as job loss.

Aim 2: To gain more in-depth information about how therapists address such intimate and sexual feelings.

Chapter 3 addressed how therapists managed their intimate and sexual feelings towards clients, such as introspection, applying strict boundaries, referring the client to a colleague, and discussing these feelings with others. These will be briefly discussed below.

Results showed that introspection about intimate and sexual feelings was considered as important to do, as mentioned by participants of the focus groups, and which is also cited in earlier studies [7, 24, 25]. The survey findings indicated that the majority of therapists who fantasized about a romantic relationship with a client thought about possible consequences for themselves (65%), the client (68%), and the respective social environments.
Furthermore, it became apparent that most therapists applied strict boundaries with clients when experiencing romantic or sexual feelings for them (72%). As we know from the focus group study, ‘holding boundaries’ implicated to hold control over the therapeutic situation and their own romantic or sexual feelings in order to avoid escalation. Furthermore, these participants indicated that being emotionally less stable (e.g., having personal relational problems) affected holding (strict) boundaries. However, this was not conclusively confirmed by the survey study (chapter 3).

Another discrepancy between findings of our studies was found in referring a client to a colleague when feelings become too intense. Referring a client was considered important in the focus group study, but the survey showed that only a few therapists actually did this when feelings for their client emerged (7%). In addition, it became apparent in the focus groups that while therapists recommended this approach, it was unclear to them exactly how to manage this referral of a client (chapter 3), which confirms results of an earlier study [26].

Likewise, discussing one’s own intimate or sexual feelings with relevant other professionals, as is recommended in scientific literature [27, 28] and by therapists themselves in the focus groups, does not happen by default. The survey study showed that only just over a third of therapists discussed their fantasy to start a relationship with a client with a supervisor or in intervisio (35%), and/or in personal therapy (32%), which is rather low compared to earlier studies [3, 7, 10] with percentages roughly around 50% (chapter 3). As indicated in chapter 5, more than half of therapists indicated that experiencing sexual feelings was impossible or barely discussable in the work field (55%).

Chapter 4 showed that this hesitance to talk about intimate and sexual feelings was primarily motivated by feeling unsafe. Firstly, there is the feeling of discomfort within therapists themselves, meaning that some therapists did not feel confident enough to disclose their emotions and experiences. A similar result was found in an earlier study about this topic [29]. Overall, being somewhat unbalanced due to these feelings in itself is not so disturbing as this enhances exploration and reflection, which is desirable in this situation [30, 31]. It becomes alarming when this unbalance or lack of confidence inhibit therapists to seek guidance when necessary. This might be especially true for therapists who for instance prefer to make a clear distinction between intimacy and sexuality. Suddenly they could be confronted with the existence of a grey zone where it is possibly to struggle with certain feelings; a zone which
they never have acknowledged before. Secondly, there is the fear of the negative reaction of their environment, experienced by many therapists. The workplace in general and direct colleagues in particular were seen as unsafe and judgmental. Such findings were also reported in earlier studies [32-34]. In chapter 5, results showed that even in basic education and psychotherapy training it was perceived as a taboo topic. Also, in the focus group discussions itself there were some (negative) reactions that have led to the backing down of some group members. Friends were seen as the safest persons to turn to when in need of a conversation. Besides the own (work) environment, also the more general values, norms and events in society negatively impacted this feeling of safety. In particular the recent wave of #MeToo stories where important persons in position of power are (publicly) accused, enhanced this fear of condemnation. In general, therapist first try to sense whether it is safe to disclose their intimate or sexual feelings to others. This safeguarding also happened in another form, as was seen in the focus group discussions itself. In some cases, intimate or sexual feelings were ‘disguised’ by more acceptable issues such as emphatically describing that clients were good looking, often in a light-hearted atmosphere.

Aim 3: To explore how therapists’ basic education and psychotherapy training, and mental health care institutions deal with intimate and sexual feelings and behavior

While therapists’ personal background and their perceptions of intimacy and sexuality are likely to always affect the ability to discuss intimate and sexual feelings to some extent, also basic education and psychotherapy training hold an important key in changing the way in and extent to which such feelings can be more easily discussed. In chapter 5, a positive association was found between the presence of educational topics on this matter in basic education and psychotherapy training and finding it more easily to talk about sexual feelings in the work field. These educational topics refer to setting own boundaries when giving therapy, making it possible to discuss own emotions that arise as a result of giving therapy, dealing with a clients’ sexual feelings towards the therapist, dealing with the therapists’ feelings of friendship towards a client, and dealing with the therapists’ sexual feelings towards a client. Unfortunately, for the majority of therapists these educational topics were absent or only limited present in their basic education (ranging from 56 to 93%). Although more therapists reported the presence of these educational topics in their psychotherapy training, concerning
the last three educational topics, it was still absent or only limited present for the majority (68 to 79%). Qualitative results confirmed that intimate and sexual feelings were only limited present in the curriculum (chapter 5). It is mostly just brought up within the context of behaving ethically correct. Over the years, it seems little has changed, as we compare these results with earlier studies that indicate the same problems and concerns [6, 7, 9, 27, 33-37]. In line with this, when comparing less experienced therapists with more experienced therapists, probably graduating more recently, these educational topics were even less often present in basic education. In psychotherapy training no changes were noticed.

Suggested improvements for basic education and psychotherapy training, mentioned by therapists themselves, are essentially aimed at improving the ability to introspect and explore about these intimate and sexual feelings, often with the support of others. For instance, presenting such feelings in basic education and psychotherapy training as a normal phenomenon was emphasized, in order to diminish the hesitance of therapists to discuss this with others. They suggested the use of ‘role models’, such as renowned therapists who disclose the sometimes difficult intimate or sexual situations they encounter, and books or tv-series on this subject. Also, their recommendation to let intimate and sexual feelings be more an integrated part of the curriculum is in line with normalizing these feelings. Further, the ability to introspect was mentioned as something to be learned. Moreover, more knowledge about transference and countertransference was considered desirable, therefore enlarging the existence of the personal feelings of the therapists towards the client and the need for self-analysis about this. Finally, the focus group discussions itself were suggested as a good format to thoroughly explore intimate and sexual feelings and opinions in a rather non-judgmental way. Especially, the available time to discuss this topic more deeply and the confidentiality in the group were mentioned as essential aspects in this exploration.

In order to improve guided introspection, exploration and decrease the hesitance to talk about intimate and sexual feelings, besides education and training, it is also important to disconnect the association between sexual feelings and sexual relationships, as is explained in the general introduction. There is no evidence that sexual feelings and fantasies by default will lead to sexual contact (chapter 1), but despite this evidence the connection still exists. This connection seems to be reinforced by publicly accused therapists of sexual misconduct and the more recent #MeToo-stories, making it unsafe to talk about these sexual feelings (chapter
4). Therefore, it is very important how, in general and more specifically mental health care institutions (MHCI), deal with suspected or confirmed sexual contact of therapists with clients. All the more because it also might be relevant to the prevention of it. In chapter 6, results showed that a considerable part was unaware of the mandatory policy on sexual boundary violation (SBV). For example, 36% was not aware that officially reporting incidents of SBV to the Flemish Agency of Care and Health (FACH) was mandatory. Less than half MHCI (48%) would officially report such incident to the FACH if it would occur. MHCI worried about the consequences for the institution itself when reporting such an incident. One out of seven executives of the MHCI thought reports would not be made to avoid a visit from the FACH-inspection. It reflects the uncertainty about what consequences are to be expected. It is not that clear if the intend of the mandatory reporting is to punish offenders or to ensure the safety of patients and, where appropriate, to help care providers to return to practice.

Therapists’ characteristics regarding the above-mentioned main findings

Male therapists
The gender of therapists is an important factor that is associated with the occurrence of and attitude towards sexual feelings and behavior in the psychotherapeutic relationship. Compared to female therapists, more male therapists reported the occurrence of sexual feelings and fantasies towards their clients, they started more often a sexual relationship with current or former clients (one out of ten) (chapter 1), and they more often were categorized as having a ‘rather sexually permissive’ attitude (based on particular opinions) (chapter 2). This overall higher rates for male therapists are consistent with previous studies [2, 5-7, 9, 38]. A possible explanation is that it reflects the more general differences in intimacy and sexuality between men and women that we see in society. Men have by nature more frequent and more intense sexual desires, resulting in more sexual feelings, behavior, and more sexually permissive opinions [39-41].

Rather young and inexperienced therapists
Findings indicate that rather young and inexperienced therapists behaved somewhat differently than older therapists. Firstly, rather young and inexperienced therapists less often hold (strict) boundaries than their older colleagues (chapter 3). Secondly, as is confirmed by both the qualitative focus group study (chapter 4) and the quantitative survey study (chapter
5), the rather young and inexperienced therapists were more hesitant to talk about their sexual feelings compared to older and more experienced therapists. Thirdly, these older and more experienced therapists more often reported to start friendships with former clients and behaved more informally (chapter 1). These age differences found probably reflect the difference in the (professional) self-confidence when encountering intimate and sexual feelings between these groups. These findings seem to indicate that there is a development of more confidence and competence (in controlling situations) throughout the years, probably due to the combination of personal life experiences, working through other personal issues guided by supervision and interventions, and possible earlier experiences and management of intimate or sexual feelings in therapy [29, 42].

**Psychiatrists**

Psychiatrists emphasized more that their professional work environment in general and direct colleagues in particular are seen as unsafe and rather judgmental regarding intimate and sexual feelings than other therapists (chapter 4). Possibly the society has other expectations for psychiatrists compared to other therapists, such as being more professional, authoritative and scientific [43]. These high societal expectations might also have an impact on the evolvement of sexual feelings and behavior. Psychiatrists less often reported the experience of sexual feelings and fantasies (chapter 1), possibly indicating they block instantly such kinds of feelings, although underreporting can neither be excluded. However, it can also be related to characteristics of psychiatrists’ clients, having in general more serious pathologies and being more dependent.

Furthermore, psychiatrists mentioned the importance to complete a psychotherapy training as psychiatrist, because dealing with emerging intimate and sexual feelings, the emotions it evokes and the exploration of it, is typically attributed to something what is (to be) learned in psychotherapy training (chapter 5). Unfortunately, not (yet) all psychiatrists have followed a psychotherapy training after their basic education, although legislation about it recently changed, requiring future psychiatrists who want to practice psychotherapy to complete a psychotherapy training in Belgium [44].

**Behavioral psychotherapists**

Compared to person-centered and psychoanalytic psychotherapists, behavioral psychotherapists differ substantially on several factors related to intimacy and sexuality in the
psychotherapeutic relationship. They less often reported the occurrence of sexual feelings and fantasies, but were more often emotionally involved, and more often started friendships with former clients (chapter 1). These higher prevalence rates are in line with the reported opinions about the acceptability of particular behavior in psychotherapy. Overall, behavioral therapists were more open to accepting socially oriented behavior, such as giving a lift to a client (‘rather socially permissive attitude’) (chapter 2). Behavioral therapists indicated less often to have been educated in setting own boundaries, dealing with evoked emotions, and emerging sexual feelings or feelings of friendship (chapter 4). A possible explanation for these findings may lay in their psychotherapy orientation and training. Professional intimacy (see general introduction) is to a lesser extent present in the psychotherapeutic relationship of behavioral therapists, who focus more on the clients’ behavior and thoughts [52,53]. In addition, behavioral therapists reported more often that experiencing sexual feelings were barely or impossible to discuss in the work field (chapter 5). This possibly hampers introspection, exploration and managing these feelings well. Because, of course, behavioral therapists can also experience intimate or sexual feelings for their clients, more education and training for behavioral therapists on these topics are essential.

4. Conclusions

The ten most important conclusions that can be drawn from this dissertation about intimacy and sexuality of therapists in the psychotherapeutic relationship in Flanders, Belgium, can be summarized as following:

1. The prevalence for sexual feelings and fantasies was rather high: during their whole career, 71% of therapists found at least once a client sexually attractive, 23% fantasized about a romantic relationship with a client, and 27% fantasized about sexual contact. High prevalence figures were also found for being quite emotionally involved with clients (96%) and feeling clients were like friends (72%). In contrast, these were lower for more informal behavior, such as accepting clients they already know from their personal life (22%), confiding personal concerns to clients (16%), and starting friendships after therapy (13%). Only a small minority started a friendship during therapy (4%), and a sexual relationship during or after therapy (3%). The rather high occurrence of sexual feelings and fantasies
seems to be overall a rather universal phenomenon and not changeable over time. Likewise, sexual relationships, are and remain in Western countries rather exceptional. In contrast, occurrence of intimate and informal behavior differs more widely e.g., over time and/or culturally (as earlier international studies found overall higher prevalence rates), indicating it is more determined by opinions and attitudes.

2. Therapists’ intimate and informal behavior that might give clients the impression they may become part of their private lives, such as accepting a Facebook friend request and letting a client help with a private task, was almost unanimously defined as unacceptable. More variation in acceptability was noted for behavior that might take place in the realm of the psychotherapeutic relationship, such as giving a lift to a client.

3. Overall, more male than female therapists reported the occurrence of sexual feelings and fantasies towards clients, they started more often a sexual relationship with clients, and they more often can be categorized as having a rather sexually permissive attitude.

4. There is no clear indication that sexual feelings and fantasies, and even having a rather sexually permissive attitude inevitable and per default will lead at the end to sexual contact with a client. However, when viewed in this way, it does not contribute to considering such feelings as a normal phenomenon that might happen during the course of a career. Instead, some therapists will still react with condemning these sexual feelings and attraction towards clients, or rather reject them when colleagues (want to) talk about these feeling.

5. There is a discrepancy between the recommendations that therapists formulate and their own behavior in managing intimate and sexual feelings towards clients. For example, their recommendation to refer a client to a colleague (when feelings would become too intense) or to discuss feelings with relevant others, were generally not followed by themselves.

6. A total of 55% therapists indicated that experiencing sexual feeling for clients was impossible or barely open to talk about in the work field. Therapists with a behavioral psychotherapy training more often reported this hesitance to talk about it (63%) compared to non-behavioral psychotherapists (50%).

7. Discussing one’s own intimate and sexual feelings is hampered by two main reasons. First, there is a lack of confidence, especially among rather young and inexperienced therapists. They feel uncomfortable to show their own doubts and vulnerability, being anxious to be perceived as not behaving professionally correct. Secondly, there is a lack of a safe
environment, especially among psychiatrists. They fear condemnation by peers or supervisors, and negative societal or professional consequences.

8. In basic education and psychotherapy training the topic of intimate and sexual feelings is remarkably absent or only limited present, and often only discussed in the realm of behaving ethically correct, and rarely in the realm of the vulnerability of the therapist. We also found that little has changed over time, which is unfortunate, because training in this regard is associated with being more able to better manage these feelings. This lack of training is most obvious for behavioral psychotherapists which probably explains their higher hesitance to talk about experiencing sexual feelings (see point 6).

9. Therapists suggest improvements for basic education and psychotherapy training, mainly on three levels: improving the ability of the therapist to introspect and to explore (micro level), creating formats where such feelings can be safely discussed (meso level), and broadening the perception that intimate and sexual feelings in the psychotherapeutic relationship is human and a normal phenomenon that can occur (macro level).

10. Most of the Mental Health Care Institutions did not comply with the policy concerning sexual boundary violation, as has been mandatory since 2015, such as officially reporting these confirmed incidents to the Flemish Government. In addition to the unawareness of some requirements, there were also concerns about the negative consequences if the policy is implemented as requested.

5. Implications for practice and education

Some implications for practice and education can be proposed, based on the interpretation of the research findings. Therapists are in general aware that intimate and sexual feelings might occur during the course of a therapists’ career and know such feelings are not by default problematic. Within psychotherapy, overall, it is regarded as essential that therapists understand their feelings and how the client might influence them. A search within oneself to determine what triggered these responses, preferably with professional guidance, is highly recommended. It is seen as a valuable tool in expanding the therapists’ ability to help the client, because for a good therapeutic relationship a therapist needs to be empathic, authentic, and have an unconditional positive regard to the client, based on core-conditions of Rogers [53,54]. However, we still see much hesitance to discuss this topic with (senior)
colleagues or in supervision, and there is still (fear of) condemnation when such feelings occur, consequently leaving therapists to their own devices when encountering such feelings. Overall, it seems that their awareness and knowledge about this topic does not have its implications in practice. This thought is further strengthened, when taking into account that the first scientific knowledge and insights about this topic are described already decades ago (although mainly in North America), with little impact as result. Several factors might hamper the transition of awareness and knowledge into positive changes in practice. These factors are not limited to individual factors (e.g., denial of vulnerability) or factors related to the training and work field of therapists (e.g., vision/how this topic is brought up), but also embedded in the broader social context (e.g., dealing with SBV incidents). Therefore, changes are needed on all those levels. Essential is that therapists, and in extension professional associations, training programs, etc. as well as the society, are enabled to explore this topic deeply and have the debate on this. Only then it can become a more integrated part of therapists’ practice.

Improving introspection and exploration among therapists about their experiences and attitudes concerning intimate and sexual feelings for clients
To improve therapists’ awareness of being vulnerable to develop intimate and sexual feelings for clients, it is essential to explore this topic and introspect about this deeply, reflecting about own opinions and attitudes in this matter, and hypothesize about how it would be like and what possible consequences might be. In this regard, also the own perceptions about intimacy and sexuality in general are to be reflected on. Ideally this introspection and exploration happens with the guidance of others and is not limited to a one-time event but present as an integrated topic within e.g., the realm psychotherapy training, supervision, intervision, etc. Overall, in psychotherapy training, attention is paid to guided introspection and exploration on several issues. Unfortunately, the issue of intimacy and certainly sexuality is still often underexplored. Therefore, it is recommended that psychotherapy training expand their training on this topic, reflecting on it both more profoundly and more often. Because behavioral therapists indicated to have been educated the least in topics about intimacy and sexuality in the psychotherapeutic relationship, and most often reported hesitance to discuss this than other therapists, a greater effort is required of this specific psychotherapy training.
Due to their age, rather young and inexperienced therapists have not yet fully explored themselves and might lack some self-confidence and life-experience. Therefore, more guided introspection and exploration on this topic is also recommended especially for this group.

Finally, all therapists practicing psychotherapy should follow a psychotherapy training to enhance their ability to introspect and explore. Although this is now determined by legislation for recently graduated therapists [44], still a considerable group is not trained in practicing psychotherapy but allowed to do so (e.g., psychiatrists).

Recommendations:

- Expand all psychotherapy trainings with guided introspection and exploration on intimacy and sexuality, both more profound and more often, and both in general and specifically towards clients. The greatest effort is needed from behavioral psychotherapy training.
- More guided introspection and exploration for rather young and inexperienced therapists on this topic.
- Motivate therapists practicing psychotherapy without a psychotherapy training, to follow such training.

Enabling this introspection and exploration

*By improvements in the training and work field of psychotherapy*

Introspection and exploration on intimacy and sexuality, both in general and specifically towards clients is only possible when a number of requirements are met: Time to fully introspect and explore on this topic, in a safe atmosphere, with trustworthy persons where confidentiality and discretion is assured.

It is recommended to have a good supervisor to be adequately guided during introspection and exploration. Ideally, the supervisor itself brings up this subject of intimacy and sexuality on a regular base, making it less difficult for the supervisee to talk about it when needed. Furthermore, the supervisor should, when the supervisee discloses intimate or sexual feelings for a client, display an accepting attitude, reassuring the supervisee that experiencing such feeling is normal in this kind of profession and only human, and so providing a safe opportunity to talk about the evoked emotions (and not respond with distrust and anxiety to behave unethically). In this regard, the right of supervisors to report inappropriate behavior in certain
conditions, is not that favorable, although we certainly acknowledge the importance of such right.

Furthermore, the supervisor should be able to ‘unmask’ disguised feelings of more profound intimate or sexual feelings of the supervisee and detect opinions that might hamper introspection and exploration on this subject.

It might also be helpful, depending on the context, if supervisors, training directors, or other important persons from the direct work and/or training environment disclose their own experiences from the past regarding intimate and sexual feelings towards clients. Additionally, group discussions where such topics can be further explored, e.g., during intervision meetings with peers, might be very helpful. When both less and more experienced therapists are together in one group, the less experienced therapists might learn from the more experienced therapists what these feelings can evoke and how to manage it. The disclosure of significant therapists from the direct environment about their past intimate and sexual experiences might enhance the own introspection and exploration of therapists. It makes the idea that therapists experience intimate or sexual feelings for a client less abstract and more personal, therefore enhancing also their own vulnerability in this matter.

Finally, also within the work field of psychotherapy the debate should start about this topic. Professional associations, psychotherapy training programs, MHCI, even small group practices, etc. should question and broaden their perceptions and approach on intimacy and sexuality in the psychotherapeutic relationship. They need to evaluate how they currently deal with this topic in order to evolve further.

Recommendations:

- Create safe conditions, with sufficient time and trustworthy persons when introspecting and exploring this topic.
- Prepare supervisors better to enhance adequate guidance during introspection and exploration of supervisees on this topic: making intimate and sexual feelings towards clients a topic being regularly discussed, giving reassurance it is human (instead of responding with distrust), unmask disguised feelings, detect opinions that hamper introspection and exploration on this subject.
Create role models from the direct environment who disclose, when appropriate, their past intimate and sexual experiences for clients, especially for rather young and inexperienced therapists, e.g., through revealments of educators and in group discussions with (senior) colleagues.

- Start debates on this topic with authorities, stakeholders, key figures, etc. in the work field.

By improvements in society

Besides a safe direct environment, required to introspect, explore and talk about intimate and sexual feelings towards clients with others, also the broader societal environment has an influence on this, because it affects the conditions needed to introspect, explore and discuss this topic more freely.

First, there can be a negative influence when events occur, such as role models that have (appear to) behaved incorrectly (based on professional guidelines and/or legislation) and are heavily condemned for doing so, often through a sensational public debate (e.g., #MeToo). It affects the feeling of safety negatively, due to the negative consequences and the overall presumption (that still exists) that sexual feelings are the precursor of sexual behavior. Therefore, it is desirable for the general public, therapists themselves, stakeholders, policymakers etc. to adjust their societal expectations towards therapists. They should become aware that therapists are only human, are vulnerable to develop intimate and sexual feelings for clients, that each situation with a client is unique, and appropriateness of behavior highly depends on the context [45]. Despite certain feelings, the vast majority of therapists continue to behave according to professional guidelines and legislation. Hopefully this increased awareness helps to not simplify reality and condemn therapists too quickly. Especially psychiatrists will benefit from this increased awareness, when also applied on them. Nowadays they still feel more heavily condemned to have these intimate or sexual feelings than other therapists, due to the higher societal expectations. Raising this awareness can be accomplished by several means, for instance: 1) disseminating (scientific) information about this topic, 2) fictional therapists in books, films or tv-series that describe their feelings and the context in which these feelings occur in a nuanced way, and 3) important role models that disclose their past intimate and sexual feelings towards clients. Certainly, these latter revealments make such feelings more human, indicating also good and renowned therapists encounter this.
Second, it might be helpful if people in general would feel less discomfortable with the topic of intimacy and sexuality. Nowadays, many people still have difficulties to talk about this topic, as something that is an integrated and important aspect of their humanity, which occurs in a natural way in divers life situations. This is certainly not conducting to the understanding also therapists as human being may experience intimate and sexual feelings towards clients. Therefore, ideally, from an early age, it should be learned that intimacy and sexuality are natural parts of life, that can be talked about [46].

Third, policy and legislation should not hamper the introspection and exploration of this topic and the extent to which it can be discussed, but ideally improve it. However, in the context of the prevention of sexual boundary violations in mental health care, a rather repressive policy can be pursued. Such a repressive policy might make mental health care institutions (MHCI) and therapists more anxious and hinder further introspection, exploration and discussion about it [47]. This is unfortunate, because introspection, exploration and discussions are important elements in the prevention of sexual boundary violations [48]. Therefore, it is recommended that policy measures, in general and in MHCI, are focused on ensuring the safety of patients, and where appropriate, help care providers to return to practice. Furthermore, these consequences of an SBV-policy should be clearly communicated to the MHCI and therapists. Additionally, defining sexual relationships with a client as a crime, as is the case in North America, Germany and the Netherlands [49, 50], is from this perspective less justified. In contrast, it is very important to approach these incidents in a nuanced way, therefore enabling that therapists who have made wrong choices are helped and therapists who abused their clients are held accountable. Nevertheless, the harm of all clients in these cases should be recognized and addressed as much as possible.

Finally, change and revolution, coming from within, started by a few engaged therapists, is essential. Only when more and more therapists are able to publicly acknowledge to other therapists, they experience intimate and sexual feelings towards clients, the less it will be treated as a precursor of sexual misconduct, and the more other therapists will open up about their feelings. This sets in motion a positive movement, ultimately leading to more safety in the direct environment, more introspection, more exploration, better psychotherapy practice, and improved wellbeing of therapists.
Recommendations:

- Create awareness among the general public, therapists, stakeholders, policymakers etc. that therapists might experience intimate and sexual feelings for clients, which is only human, and they overall remain to practice psychotherapy very professionally. This can be done by revealing such feelings from (fictional) role models from the broader environment and through the dissemination of (scientific) information.
- Learn for an early age that intimacy and sexuality are natural parts of life.
- Aiming policy and legislation to have a nuanced approach on SBV, enabling appropriate help and/or hold therapists accountable when they behaved incorrectly.
- Communicate clearly to MHCI about consequences when they implement an SBV-policy.
- Create change in society from within, setting in motion a positive movement, where more and more therapists are able to speak freely to other therapists about their intimate and sexual feelings towards clients.

6. Implications for research

Comparative research

The study population of the survey study consists of, in addition to psychiatrists, therapists with a person-centered, psychoanalytic or behavioral psychotherapy training. It is also interesting to conduct this survey study among other therapists in Flanders, Belgium, to get a broader more complete overview of the occurrences and attitudes regarding intimate and sexual feelings and behavior in Flanders. Besides systemic therapists, being a large group in the Flemish landscape of therapists, also smaller psychotherapy trainings, such as integrative psychotherapy, interactional psychotherapy, gestalt psychotherapy, hypnotherapy, etc. could be included.

Furthermore, it is unfortunate that comparative data of most European countries as well as Wallonia (French-speaking part of Belgium) is still currently missing, because it could further shed light on e.g., how occurrences of intimate and sexual feelings, behavior and attitudes are possibly influenced by societal and cultural contexts. Additionally, it is recommended to do follow-up studies in the upcoming years in Flanders, to investigate if the next generation of therapists, experience and manage these intimate and sexual feelings differently.
Finally, experiencing intimate and sexual feelings and behaviors towards clients are not limited to mental health care services, and within mental health care services, it is not limited to therapists. Therefore, it is interesting to study these feelings and behaviors for several groups of healthcare providers. It will lead to more insight in how job duties and societal expectations of these jobs, are associated with experiences and management of these feelings and behaviors.

Additional research
Although this dissertation intended to provide a broad insight into intimate and sexual feelings in the psychotherapeutic relationship, it cannot, of course, be considered as comprehensive. First, more studies are needed on basic education and specific psychotherapy training from a more neutral point of view. More insight is needed in what is actually addressed in the several curricula and how it changes over time. Besides that, the crucial role and actual approach of supervisors when confronted with supervisees encountering intimate and sexual feelings, should be investigated thoroughly.

Second, implementation and evaluation studies should be conducted concerning the formulated recommendations for practice and education. More insight is needed if an approach, focusing more on the introspection and exploration of this topic by both therapists and in extension the work field of therapists, is indeed more beneficial for therapists. Furthermore, the impact of policy and legislation on the extent to which intimate and sexual feelings can be openly talked about and explored, should be further investigated.

Third, a more in-depth study of Flemish therapists who have actually started sexual relationships with clients might also be important to gain a clearer insight from within. It provides a more nuanced context in which such relationships can develop, therefore enhancing the insight if wrong choices were made and/or if it happened from an abusive perspective. Above all, it will be helpful in supporting therapists more appropriately when their psychotherapeutic relationships develop into more personal relationships.

Forth, in future comparative survey studies, such surveys might be extended with other factors related to how therapists experience, perceive and deal with intimate and sexual feelings. Important factors can be self-care, perceived safety in basic education and
psychotherapy training, perceived (conservative) attitude of the supervisor, characteristics of clients, own attitude on intimacy and sexuality, informal or sexual relationship in the past (e.g., with own supervisor), etc.

Finally, more research is also desirable on the impact on clients when their therapists have intimate and sexual feelings for them, behave more informally or amicable, or when (wanted/unwanted) sexual behavior takes place. Such studies can take place by, for example, asking therapists about their clients who have experienced such feelings and behavior with their previous therapist.
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English summary

**Background**: This dissertation explored the field of intimacy and sexuality of therapists in the psychotherapeutic relationship, in Flanders, Belgium. More specifically, the feelings, behaviors and attitudes of psychotherapists were investigated. The main focus is on sexuality, but intimacy is also addressed, as they are interwoven to one another.

Scientific studies have indicated that sexual attraction of therapists towards clients is rather common (60 to 90%). When such feelings are experienced, it often elicits a gamut of other emotions, mostly negative, such as feeling guilty, discomfort, anxious, and confused. One of the most important recommendations to manage such feelings well, is discussing these feelings with relevant others. However, many therapists are hesitant to talk about these intimate and sexual feelings. An important factor that hampers to speak more freely about these feelings, is due to the easily made association with engaging in a (not allowed) sexual relationship. Although only a small minority of therapists ever engage in a sexual relationship with clients (1 to 7%), experiencing intimate and sexual feelings for a client is still often perceived as a precursor of sexual contact.

**Problem definition and aims**: Until now, in Belgium this topic was never thoroughly investigated on a large scale. Most scientific studies on this topic were conducted in North America, mainly in the eighties and nineties, without follow-up in the following decades. Due to this lack of recent (and European) empirical data, the debate about intimate and sexual feelings in the psychotherapeutic relationship is rather absent in Flanders, Belgium. However, such a debate is desirable to evaluate and improve the way intimate and sexual feelings are currently dealt with.

Furthermore, little was known about how therapists in Flanders experience and manage such feelings when encountered in the therapy room. The hesitance to discuss this topic was never been investigated properly. However, it is important to make these issues more transparent and thus stimulate more openness about it, in order to improve wellbeing of therapists and ultimately the psychotherapeutic relationship.

Finally, information about how basic education and psychotherapy training deal with this topic was absent. Though, this is relevant to know as therapists are a product of their education and training. Furthermore, it was important to know to what extent a policy on sexual boundary
violation is implemented in mental health care institutions (as is required since 2015) and which possible factors were related to non-compliance. These results and insights can eventually function as a basis for the formulation of recommendations for education and other stakeholders in the field.

In sum, this dissertation aimed 1) to estimate the occurrence of intimate and sexual feelings and behaviors of therapists, and therapists’ attitudes in this respect, 2) to gain more in-depth information about how therapists address such intimate and sexual feelings, and 3) to explore how therapists’ basic education and psychotherapy training, and mental health care institutions deal with intimate and sexual feelings and behavior.

Method: Three different studies were conducted. First, a large-scale quantitative survey was conducted among therapists to determine prevalence rates of intimate and sexual feelings and behaviors, therapists’ attitude in this matter, the extent to which this topic was given attention in basic education and psychotherapy training, and the extent to which sexual feelings towards clients were able to discuss in the work field. Second, a qualitative focus group study was conducted among therapists to gain more in-depth understanding of their experiences and the managing of intimate and sexual feelings. Third, a survey study gathered information of mental health care institutions about the knowledge and opinions of executives about the policy on sexual boundary violations and the extent to which this mandatory policy was implemented in these mental health care institutions.

Results: Results showed that prevalence for intimate and sexual feelings was rather high. During their whole career, 71% of therapists found at least once a client sexually attractive, 96% were quite emotionally involved with a client, 72% felt clients were like friends, 23% fantasized about a romantic relationship with a client, and 27% fantasized about sexual contact. Prevalence was lower for informal behavior, such as confiding personal concerns to clients (16%) and starting friendships after therapy (13%). Only a small minority started a sexual relationship during or after therapy (3%). Overall, more male than female therapists reported the occurrence of sexual feelings and fantasies toward clients, and they more often started a sexual relationship with them.

The rather restrictive attitude found for intimate and informal behavior seems to indicate there is a high sense of morality among therapists. Behavior that might give clients the impression they may become part of the private life of therapists was almost unanimously
defined as unacceptable. More variation in acceptability was noted for behavior that might take place in the realm of the psychotherapeutic relationship.

To manage intimate and sexual feelings well, therapists recommend introspecting and discussing these feelings with (senior) colleagues or in supervision. However, there is still much hesitation to discuss this topic with relevant others. Besides feeling rather uncomfortable to discuss such sensitive issues, there is still fear of condemnation when such feelings would be disclosed.

In basic education and even in specific psychotherapy training the topic of intimate and sexual feelings is remarkably absent or only limited present, and often only discussed in the realm of behaving ethically correct, and rarely in the realm of the vulnerability of the therapist. An association was found between the presence of this topic in psychotherapy training and perceiving less difficulties to discuss this topic in the work field, indicating psychotherapy training hold an important key to initiate change.

Overall, many mental health care institutions did not comply with the policy concerning sexual boundary violation, as has been mandatory since 2015. In addition to the unawareness of some requirements, there were also concerns about the negative consequences if the policy is implemented as requested.

**Conclusion:** In Flanders, many therapists experience intimate and sexual feelings for clients. Although therapists perceive such feelings as something natural that can occur during the course of career, and they are in general in favor of discussing such feelings with relevant others to manage these feelings well, in practice there is still much hesitance to discuss this. There is still discomfort and fear of condemnation to disclose this, consequently leaving therapists to their own devices when encountering such feelings. Overall, it seems that their awareness and knowledge about this topic does not have its implications in practice. Several factors might hamper the transition of awareness and knowledge into positive changes in practice. These factors are not limited to individual factors or factors related to the training and work field of therapists, but also embedded in the broader societal context. Therefore, changes are needed on all those levels, where the debate on this topic should get started. Only then this topic can become a more integrated part of therapists’ practice.
Nederlandstalige samenvatting

Achtergrond: Dit proefschrift handelt over intimiteit en seksualiteit van therapeuten in de psychotherapeutische relatie in Vlaanderen, België. Meer bepaald worden de gevoelens, het gedrag en de attitudes van psychotherapeuten bestudeerd. Het onderzoek richt zich hoofdzakelijk op seksualiteit, maar omdat intimiteit en seksualiteit vaak met elkaar verbonden zijn, wordt ook het aspect intimiteit mee onderzocht.

Wetenschappelijke studies hebben aangetoond dat redelijk veel therapeuten zich seksueel aangetrokken voelen tot een cliënt (60 tot 90%). Wanneer zo’n gevoelens worden ervaren, brengt dit vaak andere negatieve gevoelens met zich mee, zoals schuld, schaamte, bezorgdheid en verwarring. Eén van de belangrijkste aanbevelingen om goed om te gaan met deze gevoelens, is het bespreken van deze gevoelens met anderen. Toch is het zo dat veel therapeuten het nog moeilijk vinden om over deze intieme en seksuele gevoelens te praten. Een belangrijk element dat het openlijk hierover praten bemoeilijkt, is de associatie die soms te gemakkelijk gemaakt wordt met het aangaan van een (niet toegestane) seksuele relatie. Hoewel slechts een kleine minderheid van de therapeuten ooit een seksuele relatie start met een cliënt (1 tot 7%), wordt het ervaren van intieme en seksuele gevoelens nog te vaak gezien als een voorbode van seksueel contact.

Probleemstelling en doelstelling: In België is dit onderwerp, tot hiertoe, nooit op grote schaal uitvoerig bestudeerd. De meeste wetenschappelijk studies over dit onderwerp zijn uitgevoerd in Noord-Amerika, dateren van de jaren tachtig en negentig, en zijn in de daaropvolgende decennia niet herhaald. Mede door het gebrek aan recente (en Europese) empirische data, is er geen debat over intieme en seksuele gevoelens in de psychotherapeutische relatie, in Vlaanderen, België. Zo’n debat is nochtans nodig om de manier waarop men momenteel omgaat met deze intieme en seksuele gevoelens te evalueren en te verbeteren.

Momenteel is ook onbekend hoe therapeuten zelf deze intieme en seksuele gevoelens ervaren en hoe ze hier mee om gaan. De aarzeling om dit te bespreken is nooit terdege onderzocht. Vanuit de doelstelling om het welzijn van de therapeut te verbeteren en uiteindelijk ook de psychotherapeutische relatie met de cliënt, is het belangrijk om dit onderwerp meer transparant te maken, om hier zo meer openheid over te stimuleren.
Voorts is niet geweten hoe men in de basisopleiding en psychotherapietraining van therapeuten dit onderwerp benadert. Deze informatie is wel relevant, aangezien therapeuten een product zijn van hun opleiding en training. Verder is het belangrijk om te weten in welke mate de geestelijke gezondheidszorgorganisaties een beleid inzake de preventie en het omgaan met seksueel grensoverschrijdend gedrag hebben geïmplementeerd (dat verplicht is sinds 2015) en welke mogelijke factoren deze implementatie verhinderen. Deze resultaten en inzichten kunnen eventueel gebruikt worden als basis voor het formuleren van aanbevelingen voor de opleidingen en andere stakeholders.

Samengevat beoogt dit proefschrift 1) een inschatting te maken van hoe vaak intieme en seksuele gevoelens en gedrag bij therapeuten voorkomen, en hun attitude hierover, 2) meer diepgaand inzicht te verkrijgen in hoe therapeuten om gaan met deze gevoelens, en 3) te exploreren hoe men in de opleiding en training van therapeuten omgaat met dit onderwerp, alsook in de geestelijke gezondheidszorgorganisaties.

**Methoden:** Er zijn drie verschillende studies uitgevoerd. Ten eerste is er een grootschalige kwantitatieve vragenlijst-studie bij therapeuten afgenomen om de prevalentie te bepalen van intieme en seksuele gevoelens en gedrag, de attitude van therapeuten hierover, de mate waarin dit onderwerp behandeld werd in de basisopleiding en psychotherapietraining, en de mate waarin seksuele gevoelens voor cliënten bespreekbaar is in het werkveld. Ten tweede is er een kwalitatieve focusgroep studie uitgevoerd bij therapeuten om meer diepgaand inzicht te verkrijgen in hoe zij deze gevoelens ervaren en hoe zij hier mee om gaan. In de derde studie is een vragenlijst afgenomen bij leidinggevenden van geestelijke gezondheidszorgorganisaties om informatie te verzamelen over hun kennis en opinies inzake het beleid aangaande de preventie en het omgaan met seksueel grensoverschrijdend gedrag en de mate waarin dit verplicht beleid werd geïmplementeerd in hun organisatie.

**Resultaten:** De resultaten laten zien dat prevalentiecijfers voor intieme en seksuele gevoelens redelijk hoog is. Van de bevraagde therapeuten geeft 71% aan zich doorheen de loopbaan ten minste één keer seksueel aangetrokken te hebben gevoeld tot een cliënt, 96% was emotioneel erg betrokken bij een cliënt, 72% had het gevoel dat cliënten vrienden waren, 23% fantasieerde over een romantische relatie met een cliënt, en 27% fantasieerde over seksueel contact. De prevalentiecijfers zijn lager voor informeel gedrag, zoals het in vertrouwen nemen van een cliënt over persoonlijke zorgen (16%), en het starten van een vriendschap na de
therapie (13%). Enkel een kleine minderheid begon een seksuele relatie met een cliënt tijdens of na de therapie (3%). In het algemeen zijn het vaker mannelijke therapeuten die aangeven seksuele gevoelens en fantasieën te ervaren, en ook een seksuele relatie beginnen met een cliënt in vergelijking met vrouwelijke therapeuten.

De eerder restrictieve houding ten aanzien van intiem en informeel gedrag lijkt te betekenen dat er een hoog moreel besef is bij de therapeuten. Gedrag van therapeuten, waardoor cliënten mogelijk de indruk zouden kunnen krijgen dat ze deel kunnen uitmaken van het privéleven van de therapeut, wordt bijna unaniem onacceptabel geacht. Er is minder eensgezindheid als het gaat over gedrag dat mogelijks plaatsvindt in het kader van de psychotherapeutische relatie.

Volgens therapeuten is introspectie en het bespreken van intieme en seksuele gevoelens met andere (senior) collega’s of met een supervisor een goede manier om met deze gevoelens om te gaan. Toch aarzelt men nog vaak om dit met anderen te bespreken. Naast een bepaalde schroom om dit soort sensitieve onderwerpen ter sprake te brengen, is men ook bang voor veroordeling wanneer men dit soort gevoelens zou onthullen.

In de basisopleiding en zelfs de specifieke psychotherapietraining van therapeuten wordt dit onderwerp van intieme en seksuele gevoelens niet uitvoerig behandeld. Als het aan bod komt dan is het vaak vanuit een ethische invalshoek en veel minder vanuit de kwetsbaarheid van de therapeut. Therapeuten die rapporteerden dat dit onderwerp wel redelijk uitvoerig behandeld was in hun psychotherapietraining, hadden minder het gevoel hadden dat dit onderwerp onbespreekbaar was in het werkveld. Dit betekent dat de psychotherapietrainingen een belangrijke sleutel in handen hebben om deze bespreekbaarheid te verbeteren.

In het algemeen zijn er relatief veel geestelijke gezondheidszorgorganisaties die geen beleid inzake de preventie en het omgaan met seksueel grensoverschrijdend gedrag geïmplementeerd hebben in hun organisatie, zoals dit verplicht is sinds 2015. Naast het feit dat men zich niet altijd bewust is van een aantal van de vereisten, wordt het beleid soms niet geïmplementeerd omdat men bezorgd is over de mogelijke negatieve gevolgen wanneer men het beleid wel zou implementeren.
Conclusie: In Vlaanderen ervaren veel therapeuten intieme en seksuele gevoelens voor cliënten. In het algemeen beschouwt men zo’n gevoelens als iets natuurlijks dat men kan ervaren in de loop van een carrière en is men voorstander om deze gevoelens te bespreken met relevante anderen, om zo op een goede manier met deze gevoelens om te gaan. Ondanks dit, aarzelt men in de praktijk nog vaak om dit toch te bespreken. Naast de schroom die men ervaart, is er ook angst voor veroordeling wanneer men dit zou onthullen, waardoor therapeuten bijgevolg nog steeds aan hun lot worden overgelaten wanneer zij zo’n gevoelens ervaren. In het algemeen lijkt het erop dat de visie en de kennis over dit onderwerp zijn weerslag niet kent in de praktijk. Er zijn verschillende factoren die dit mogelijk verhinderen. Deze factoren bevinden zich niet enkel op individueel vlak of zijn enkel gerelateerd aan de opleiding of de werkomgeving van de therapeut, maar deze zijn ook gerelateerd aan een bredere maatschappelijke context. Daarom zijn veranderingen nodig op al deze vlakken, samen met een debat hierover. Enkel dan kan dit onderwerp over intieme en seksuele gevoelens, op meer geïntegreerde wijze, zijn plaats krijgen in de praktijk van therapeuten.
Dankwoord

Iedereen die mij een beetje kent, wist dat als ik ooit een doctoraat zou maken, dat het over seksualiteit zou gaan. Zelfs mijn lieve kinderen klagen dat het bij mij altijd over seks moet gaan. Maar seksualiteit, intimité, liefde, verbondenheid, relaties… Wat is er boeiender dan dat? Maar bovenal, is er iets belangrijkers dan dat?

Een doctoraat maken is afzien, dat is met de moed der wanhoop blijven doorgaan. Ik zou trots kunnen zijn op het feit dat ik dit doctoraat tot een goed einde heb gebracht, maar ik ben vooral trots op en dankbaar voor de mensen om mij heen die mij geholpen hebben toen ik viel en mijn enthousiasme deelde als het goed ging.

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En zo kom ik tot de conclusie dat het uiteindelijk toch altijd om liefde en relaties gaat.

Lara
Mechelen, 2021
Curriculum Vitae

Biography
Lara Vesentini (°1976) completed in 2000 her study ‘Health Sciences’ at the Maastricht University in the Netherlands. She started her career as a manager in the Reinaert Kliniek in Maastricht (Aug 2000 – Jan 2002) and proceeded to work ever since in the academic field. First at the Hogeschool PXL doing research about traffic safety and sexuality of elderly (Feb 2002 – Dec 2009), afterwards at the Katholieke Universiteit Leuven about elderly care (Jan 2010 – Dec 2011). In 2013, she started as assistant of Professor Johan Bilsen, with her PhD project on ‘Intimacy and sexuality in the psychotherapeutic relationship’ at the Mental Health and Wellbeing Research Group of the Vrije Universiteit Brussel (VUB). Besides her PHD, Lara had a teaching assignment at the Faculty of Medicine and Pharmacy, mainly consisting of guiding a group of students in doing a scientific quantitative research (Epistat), guidance of master-theses, exercises in epidemiology, and an introduction in qualitative research. Furthermore, she was for the VUB the administrative coordinator for the interuniversity Manama-educations regarding Public Health. During her PhD she was member of the steering committee for the Manama-education Occupational Medicine and the Manama-education Youth Health and Adolescent Medicine, member of the education council of Medicine and the Manama-education Global Health, member of the Faculty Council of Medicine and Pharmacy, and member and secretary of the department of Public Health.
Articles published in international peer-reviewed journals


Presentations at international conferences


- Psychotherapists’ attitudes to intimate and informal behavior towards clients (oral presentation). *9<sup>th</sup> World Congress for Psychotherapy*. Moscow, Russia, June 2021*.

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Naast de liefde voor het leven is de seksualiteit van alle drijfveren het krachtigste en meest overheersende werkzame motief: zij legt onophoudelijk beslag op de helft van de vermogens en gedachten van het jongere deel van de mensheid. Zij is het ultieme doel van bijna alle menselijke inspanningen. Zij oefent een ongewenste invloed uit op de meest belangrijke zaken, verstoort van uur tot uur de meest serieuze bezigheden en verwart zelfs de grootste menselijke geesten... . Seks vormt zonder twijfel het centrum van 's mensen handel en wandel en ondanks alle sluiers waarmee zij wordt toegedekt, duikt zij overal op. Zij veroorzaakt oorlogen en leidt tot vrede, zij is de onuitputtelijke bron van wijsheid en vernuft, de sleutel tot alle toespelingen en de kern van alle geheimzinnige wenken, van alle onuitgesproken aanzoeken en alle gestolen blikken; zij is geen ogenblik uit de gedachten van wie jong zijn en dikwijls evenmin van wie op leeftijd zijn. Zij speelt voortdurend door het hoofd van wie in onkuisheid leven en zij prikkelt evenzeer en onverflauwd de fantasie van wie in kuisheid leven.

Arthur Schopenhauer