A 'FORBIDDEN ZONE':
SEXUAL ATTRACTION
IN
PSYCHOTHERAPY

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DECLARATION

Unless specifically indicated to the contrary in the text, this thesis is the result of my own work.

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ABSTRACT

Therapist-client sexual involvement has been shown to have damaging effects on clients, therapists and the mental health professions. As sexual attraction necessarily precedes sexual involvement, the incidence, experience and management of sexual attraction to clients was investigated in a sample of 485 South African clinical psychologists (return rate 23%). Evaluation of training and attitudes to sexual involvement with current and former clients and to other forms of touch in therapy were also investigated. Survey data from 111 psychologists reveal that 63.1% (79.1% of men and 52.9% of women) have been sexually attracted to clients, at least on occasion, while 97.1% have never become sexually involved with a client. Most (61.4%) do not feel anxious, guilty or uncomfortable about the attraction, although more women (50%) than men (26.5%) do. More than half (58.2%) felt that their sexual attraction had benefited the therapy process, while 76.1% believed that it had never been harmful. Men reported significantly more frequent benefit than women. In managing their sexual attraction, 60.8% sought support from supervisors, peers and their own therapists, while 31.9% worked through the feelings on their own. Ethical practice and welfare of clients were more important reasons for refraining from acting on sexual attraction than fear of legal or professional censure. Ethics codes consulted reflect the lack of nationally endorsed guidelines. Almost half (45.7%) had received no education about therapists' sexual attraction to clients, while only 10.6% had received adequate education. Education about the ethics of therapist-client sexual involvement was rated as significantly more adequate than training about therapists' sexual attraction to clients. Most (74.2%) said that their training was useful in helping them to make informed decisions about sexual involvement with clients. The majority (92.5%) felt that education on these issues should be a required part of training for clinical psychologists. Sexual involvement with former clients was considered less unethical than with current clients (65.2% vs 98.9%). 55.9% believe that there are circumstances in which sexual involvement with former clients might not be unethical, particularly depending on time since termination. Appropriate time between termination of therapy and sexual involvement ranged from immediately (1.8%) to never (44.1%). Certain forms of touch are considered ethical, although attitudes varied depending on context and form. A handshake was rated to be always ethical by 66.3%, while 83.2% believe kissing is never ethical. There was lack of consensus about hugging and holding hands. Implications of findings and directions for future research are discussed.

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1 CHAPTER ONE: INTRODUCTION

A large body of research-based information is currently available on the incidence and consequences of sexual involvement between therapist and client (Section 2.6). However, given that sexual attraction necessarily precedes actual involvement, it is surprising that this topic has received relatively little research attention (Pope, Keith-Spiegel & Tabachnick, 1986). In addition, studies have shown that training institutions and clinical internships provide little or no education about this topic (Bernsen, Tabachnick & Pope, 1994; Pope et al., 1986; Rodolfa, Kitzrow, Vohra, & Wilson, 1990; Rodolfa et al., 1994).

In line with the current focus on prevention of sexual transgressions in therapy, the present study explores the incidence of clinical psychologists' sexual attraction to their clients, how they experience and manage the attraction, and their rationales for doing so. The study includes an investigation of their rating of the academic training they received about therapists' sexual attraction to clients and about the ethics of therapist-client sexual involvement. It also investigates psychologists' attitudes to sexual involvement with current and former clients and to other forms of touch in therapy.

The topic of therapist[1]-client sexual involvement is reviewed, including codes of conduct and ethics guidelines aimed at protecting the welfare of clients and guiding the behaviour of therapists in this regard (Sections 2.1-2.4). Debates, controversies and ethics guidelines in the 'grey' areas of therapists' sexual involvement with former clients (Sections 2.7 and 2.8) and touch in therapy (Section 2.9) are explored. Education and training initiatives aimed at reducing the risk of and preventing sexual transgressions are highlighted (Section 2.11). Rationales for investigating the topic of therapists' sexual attraction are then discussed, including the reasons why this is a 'forbidden zone' (Section 2.12). The review is concluded with an examination of empirical research on therapists' sexual attraction to clients (Section 2.13).

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[1] The generic term 'therapist' is used in this review, given that studies have investigated, not only psychologists, but also physicians, psychiatrists and social workers. As far as possible, it has been specified which health professional was surveyed.

2 CHAPTER TWO: LITERATURE REVIEW

To contextualise the aims of the present study it is necessary to review the research on sexual involvement between therapists and clients within the field of professional ethics in the mental health field, and psychology in particular. Despite the proscription of such relationships in almost every ethics code in the mental health field, in the late 1960s it began to be speculated that transgressions were widely occurring. Initially these suspicions were met with denial followed by shocked silence. Concerned members of the profession then began to lift this 'veil of silence' with copious research aimed at empirically investigating the incidence of such behaviour. Evaluating the consequences of such relationships for clients, identifying demographics and characteristics of 'at risk' therapists and clients, and exploring rehabilitation of transgressing therapists followed. Numerous and vociferous ethical debates were raised by research findings. These prompted an exploration of the 'grey areas' of post-termination sexual involvement between therapists and clients and the role played by touch in sexual transgressions, including research on the incidence of such behaviour and therapists' attitudes towards them. The contemporary focus appears to be on risk management and prevention of sexual transgressions. This includes a focus on the role that inadequate academic training in ethics may play in sexual transgressions, and assessing the efficacy and limitations of ethics codes and guidelines developed to protect the welfare of clients and guide therapists' behaviour in this regard. More recently, in an attempt to understand the complexity of the dynamics underlying therapist-client sexual involvement, some researchers have directed research attention to therapists' sexual attraction to their clients, the primary focus of the present study. The following literature review will outline in detail these developments.

2.1 ON 'BEING ALL THINGS TO ALL CLIENTS'- DUAL/MULTIPLE RELATIONSHIPS

All therapeutic interventions are made for the benefit of clients and their treatment (Simon, 1991). With this aim in mind, the American Psychological Association (APA), in its first ethics code in 1953 stated that a cardinal obligation of psychologists is to respect the integrity

and protect the welfare of those with whom they work (cited in Sonne, 1994). Most human service ethics codes reflect and are based on five fundamental principles: respect autonomy, do no harm, benefit others, be fair, and be faithful (Kitchener, 1984, 1985; in Vasquez & Strohm-Kitchener, 1988). In this regard psychologists are urged to avoid dual or multiple relationships as these carry the risk of harm to and/or exploitation of the clients with whom they work (Anderson & Kitchener, 1998; Sonne, 1994; Strohm-Kitchener, 1988).

A dual, or multiple relationship can be defined as one in which a psychologist functions in more than one professional relationship, as well as those in which s/he functions in a professional role and another definitive and intended non-professional role (Sonne, 1994).

Avoiding dual relationships in practice, however, is unrealistic given that psychologists, consistent with their training, can and do function in any number of professional roles (Canadian Psychological Association [CPA], 1991; Lyn, 1995). These include therapist, educator, supervisor, researcher or expert witness, as well other roles which do not directly reflect their profession, such as socially, in business, or in families. The perhaps more pertinent question, then, has become: 'Which dual relationships, and under what circumstances, are unethical or harmful to clients?' Those that are deemed to carry a high risk of adverse consequences for clients are, consequently, explicitly prohibited by most ethical codes of the mental health professions (Strohm Kitchener, 1988). Other important criteria for evaluating the ethicality of dual relationships is the extent to which they impair the therapists' objectivity and judgement or result in conflicts of interest and roles (Pope, Levenson & Schrover, 1979; Sonne, 1994; Strohm Kitchener, 1988).

Strohm Kitchener (1988) asserts that 'the ethics of dual role relationships are clearly one of the most troublesome issues in professional ethics today' (p.220). This truism is reflected in the numerous studies over the last several years that that have examined the beliefs and behaviours of therapists with regard to dual relationships (Anderson & Kitchener, 1996; Borys & Pope, 1989, 1995; Bouhoutsos, Holroyd, Lerman, Forer, & Greenberg, 1983; Gartrell, Herman, Olarte, Feldstein, & Localio, 1986; Herman, Gartrell, Olarte, Feldstein, & Localio, 1987; Holroyd & Brodsky, 1977; Pope, Tabachnick & Keith-Spiegel, 1987; Stake & Oliver, 1991; Thoreson, Shaughnessy & Frazier, 1995; Thoreson, Shaughnessy, Heppner, & Cook, 1993; Trent & Collings, 1997; Wincze, Richards, Parsons, & Bailey, 1996).

2.2 SEXUAL DUAL RELATIONSHIPS

Of the potential dual relationships, those of a sexual nature have received the most scrutiny and have been most consistently condemned as the most disruptive and potentially damaging (Smith & Fitzpatrick, 1995). Since the time of Hippocrates sexual relationships between healer and patient have been considered unethical (Pope et al., 1986). However, it was only in the late 1970s that the APA explicitly prohibited therapist-client sexual intimacies. Today most ethical codes of the mental health professions prohibit such relationships (e.g. APA, 1992; Association of State and Provincial Psychology Boards, 1991; CPA, 1992).

2.3 RATIONALES FOR PROSCRIBING SEXUAL DUAL RELATIONSHIPS[2]

According to Vasquez (1988) the principle prohibiting sexual involvement between therapist and client is the clearest, most explicit, and most concrete of the ethical rules. In addition, 13 USA states have criminalized therapist-client sexual relationships, while others have bills pending or task forces studying the problem (Schoener, 1995).

The prohibition against sexual involvement between therapist and client is informed by the recognition that such relationships carry a high risk for harm to, or exploitation of, clients (Jehu, 1994; Pope, 1994), i.e. they are seen to violate the principle of nonmaleficence (Steere, 1984). In addition, the therapeutic relationship is a fiduciary one in which a client places special confidence in the therapist who is responsible for acting in good faith and with due regard for the client's best interests and welfare (Felman-Summers, 1989; White, 1995). The client places her trust in the therapist as a professional helper who will hold her well being and safety as paramount. Sexual involvement is seen as violating this critical element of trust (Appelbaum & Jorgenson, 1991; Cummings & Sobel, 1985; Edelwich & Brodsky, 1982; Vasquez & Strohm Kitchener, 1988).

In addition, a client enters the therapeutic relationship because she/he needs help and care. In

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[2] A wide range of terms are used in the literature to describe sexual relationships between therapist and client i.e. 'sexual abuse', 'sexual exploitation', 'sexual misconduct' 'sexual intimacies', 'sexual dual relationships', 'sexual contact' etc. Hereafter, in this paper, the term 'sexual involvement' will be used for the sake of consistency. In addition, while

this way an unequal power relationship is established between a client in need and a therapist with (supposedly) superior knowledge, skills and power to meet these needs (e.g. Blanchard & Lichtenberg, 1998). The promise to abstain from abusing this power for personal gratification is, therefore, central to the therapeutic contract (Herman et al., 1987; Jehu, 1994). If sexual involvement occurs in the relationship, this is considered an abuse of power by the therapist who is seen as exploiting the client's vulnerability (Edelwich & Brodsky, 1982; Sonne, 1994; White, 1995). Therapists' sexual involvement with clients is also seen as a violation of the principle of abstinence, which states that therapists must abstain from using patients for their own personal gratification (Simon, 1991).

Others argue that because of the power differential between therapist and client, clients can never give true consent to any dual relationship with their therapists, including those of a sexual nature (e.g. Slimp & Burian, 1994). Bartell and Rubin (1990) argue, therefore, that the onus must be on the more powerful partner (i.e. the therapist) to remain accountable for such relationships.

2.4 ETHICS CODES AND GUIDELINES IN SOUTH AFRICA

At present in South Africa there is a lack of a nationally endorsed set of ethics guidelines for psychologists to consult (Wassenaar, 1998). This appears to be largely attributable to the chequered and complex history of psychological associations and organisations in South Africa which mirrors the country's political history (Louw, 1997a; Wassenaar, 1998). This status quo might have serious implications for psychologists in relation to the topic of the present study. It might leave psychologists confused about what resources to consult when faced with ethical dilemmas generally, and sexual attraction to their clients specifically, and result in lack of knowledge about ethical principles and guidelines on the issue of sexual involvement with clients and former clients.

While it is beyond the scope of the present study to explore in depth the history of the development of ethics codes in South African psychology, a synopsis relevant to the present study is presented. It was ten years after the statutory inception of the profession of

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recognizing that no language is value-free, this term is considered more neutral than some others used.

psychology (1974) before the first ethical guidelines for clinical psychologists were published (Steere & Wassenaar, 1985). Prior to this, regulation of the profession was primarily statutory, based on Act 56 of 1974[3] and its provisions which 'in content focused on fairly course legal violations and not on the more subtle ethical dilemmas encountered by psychologists in daily practice' (Wassenaar, 1998, p.137). In 1992 the Psychological Association of South Africa (PASA) Ethics Committee, in consultation with the Professional Board for Psychology (PBP) and practitioners, drafted a revised version of the statutory regulations for psychologists. This document was based on the Steere and Wassenaar (1985) principles, Act 56, and on elements and experience of preceding ethics committees (South African Medical and Dental Council [SAMDC], 1992). The Psychological Society of South Africa (PsySSA) which was formed in 1994 after PASA was disbanded, has been developing a new code of conduct for psychologists which is to be published soon (Psy Talk, 1999). It is to be based on the APA, CPA and British Psychological Society (BPS) codes (ibid.). In the interim PsySSA was advised to use the 1991 CPA code. Meanwhile the PBP publishes revised statutory regulations (Wassenaar, 1998).

The situation is further complicated by the apparent confusion, among psychologists and clients, between ethics codes of voluntary psychological associations and statutory regulations of the PBP (ibid.). Ethics codes of voluntary associations primarily offer support and ethical advice to members and mediate in complaints referred to it by the public and other sources. They have no statutory powers and can at the most cancel a psychologist's membership of the association. The PBP, on the other hand, is a statutory organisation and is the highest authority over South African psychologists, whose primary function is to protect consumers of psychological services. It is worth noting that the SAMDC includes no mention of sexual involvement between clients and former clients in the rules specifying the acts or omissions in respect of which disciplinary steps may be taken by a Professional Board and the council (SAMDC, 1994).

However, despite the confusing status with regards ethics codes in this country, proposed guidelines about sexual relationships between psychologist and client are similar to those in

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[3] This act provides for disciplinary inquiries to be held if complaints against psychologists are received by the Health Professions Council of South Africa (HPCSA), formerly the SAMDC.

the USA and the United Kingdom. Principle 6.1 of the above mentioned draft document states that: 'Psychologists [should] make every effort to avoid dual relationships that could impair their professional judgement or increase the risk of exploitation ...sexual intimacies between psychologists and clients and/or ex-clients are unethical' (SAMDC, 1992).

In the light of the above discussion, an investigation of which ethics codes and guidelines clinical psychologists' consult forms part of this study.

The review now returns to the topic of therapist-client sexual involvement.

2.5 THE 'RUMPELSTILTSKIN EFFECT' – NAMING THE PROBLEM

It was first speculated as far back as three decades ago that, despite the proscription against therapist-client sexual involvement, this behaviour widely occurred. Initially, these suggestions were greeted with scepticism, denial, and silence (Pope, 1988, 1993)[4], and it is only since the 1970s that the mental health professions have begun to openly acknowledge and research the topic (Pope et al., 1997).

The first survey based on self-reports of physicians which provided evidence of sexual involvement with clients was published in 1973 by Kardener, Fuller and Mensch, while it was only in 1983 and 1984 that studies on sexually exploited clients, and evidence of harm to them, were published (Bouhoutsos et al., 1983; Feldman-Summers & Jones, 1984).

The first survey of psychologists was conducted in 1977, when Holroyd and Brodsky investigated attitudes and practices regarding erotic and nonerotic physical contact with patients. Since then a large amount of research has been undertaken on the incidence of therapist-client sexual involvement, the effects of such contact on clients and therapists attitudes to such involvement (e.g. Akamatsu, 1988; Borys & Pope, 1989; Gartrell et al., 1986; Glaser & Thorpe, 1986; Lamb & Catanzaro, 1998; Pope, et al., 1979; Pope et al., 1987; Pope et al., 1986; Stake & Oliver, 1991; Thoreson et al., 1993; Thoreson et al., 1995; Wincze et al., 1996).

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[4] See these articles for detailed accounts of reasons.

2.6 RESEARCH FINDINGS

2.6.1 Consequences to Clients of Sexual Involvement with Therapists

Survey research and clinical case studies indicate that therapist-client sexual involvement has negative consequences for clients (Bouhoutsos et al., 1983; Feldman-Summers, 1989; Garrett & Davis, 1994; Jehu, 1994; Pope, 1988, 1994; Stake & Oliver, 1991). For example, approximately 90% of clients who had sex with their therapists were judged by subsequent therapists to have been hurt by the experience (Bouhoutsos et al., 1983; Gartrell et al., 1987).

The effects on clients have been likened to rape response syndrome, post-traumatic stress disorder, reaction to incest and reaction to spouse or child battering. (Pope, 1988, 1994; Pope & Bouhoutsos, 1986). Common reactions include loss of trust in self and others, sexual and identity confusion, feelings of guilt and emptiness, reluctance to seek help from caregivers, rage, depression, isolation, suicidal risk, self-damaging behaviour and psychosomatic complaints (e.g. Garrett & Davis, 1994; Jehu, 1994; Pope & Bouhoutsos, 1986; Pope, 1988, 1994).

An investigation of the research revealed that those who argue that sexual contact is therapeutic were writing primarily in the 1960's and 70s (e.g. Mc Cartney, 1966; Romeo, 1978; Shepard, 1976; all cited in Zelen, 1985). In reviewing the literature, the present author was unable to locate impartial advocates of therapist-client sexual contact in the last decade or so. For example, Holroyd and Bouhoutsos (1985) found that those psychologists who had been sexually intimate with patients were less likely to report adverse effects of such intimacy either for patients or for the treatment process.

A critique of this research is included in Section 2.8.

2.6.2 Consequences to the Profession of Psychology of Therapist-Client Sexual Involvement

In the USA, where most research on this topic has been undertaken, therapist-client sexual involvement is one of the major causes of malpractice suits and ethical and licensing complaints (Pope et al., 1986; Pope, 1993). Sexual misconduct has accounted for more than 50% of all cases of membership termination by the APA in the last seven years, while in

1998 the largest single category of unethical behaviour that ended in loss of membership was sexual misconduct (APA Ethics Committee, 1999). In addition, the most frequently filed ethics complaints are related to sexual misconduct on the part of therapists (ibid.). Therapist-client sexual misconduct is also seen as impairing the therapeutic process and bringing the profession of psychology into disrepute (Garrett & Davis, 1994; Jehu, 1994).

2.6.3 Consequences to Therapists of Therapist-Client Sexual Involvement

In addition, many therapists who become sexually involved with their clients experience negative effects, including guilt, loss of self-esteem and disruption of their professional and personal lives (Herman et al., 1987). They may lose certification and licensure, be dropped from membership of professional organisations, lose or be restricted in insurance liabilities, be sued in criminal or civil court, and in some American states be convicted of a felony (Edelwich & Brodsky, 1982; Vasquez & Strohm Kitchener, 1988). In extreme cases suicide may result (Celenza, 1991).

In South Africa, there is a dearth of survey research on the ethical beliefs and behaviours of psychologists, and few reports and statistics regarding complaints received by the PBP have been published. An exception is a paper by Louw (1997b), which reports relatively few complaints by clients of sexual misconduct by their psychologists. These have, however, been increasing (i.e. none between 1974-1980, five from 1981-85 and six from 1986-90). Of all the complaints received by the Board, those of sexual misconduct ranked 4 out of 11. According to a recent paper by Wassenaar and Slack (1999), 6% of complaints to the PBP and PsySSA relate to sexual misconduct.

These figures are significantly lower than international findings. For example, in the USA in 1998, 44% of complaints to the APA Ethics committee were of sexual misconduct (APA Ethics Committee, 1999). This raises an interesting question of whether the incidence of therapist-client sexual misconduct in South Africa is lower than in the USA, or whether such behaviour is complained about less frequently.

It is also worth noting an interesting discrepancy between ethical complaints against psychologists, and what psychologists themselves experience to be troubling ethical dilemmas. In a recent study comparing data from seven countries, including South Africa,

dilemmas related to confidentiality were ranked highest in all countries, while sexual issues were not highly ranked in any country (Slack & Wassenaar, 1999). Of the South African respondents included in the study, only 8% reported ethically troubling incidents related to sexual dual relationships in psychotherapy.

2.6.4 Incidence of Therapist-client Sexual Involvement

Despite increasing awareness and sensitivity about sexual relationships between therapists and clients (Borys & Pope, 1989; Bouhuotsos et al., 1983), research findings indicate that transgressions continue to occur. Depending on which survey or estimate is cited, research has reported that between 1% and 12% of male therapists, and 0.5% and 3% of female therapists have at some time been sexually intimate with a client (Akamatsu, 1988; Borys & Pope, 1989; Gartrell, et al., 1986; Gartrell, Milliken, Goodson, Thieman, & Lo, 1995; Haspel, Jorgenson, Wincze, & Parsons, 1997; Lamb & Catanzaro, 1998; Pope, 1994; Pope et al., 1986; Stake & Oliver, 1991). While few of these studies have investigated different health professionals in the same study, incidence of therapist-client sexual involvement appears relatively consistent across the helping disciplines. Most studies have been published in the USA, and similar surveys have yet to be published in other countries, however, case reports, position papers and theoretical discussions published in European countries indicate that such relationships exist in all Western countries (e.g. Bolten, 1987; Soudjin, 1987; Van-Marle, 1988; all cited in Wincze et al., 1996). A recent comparative study between an Australian and an American state suggest similar rates of sexual involvement in the two countries (ibid.).

2.6.5 Variables Associated with Therapist-Client Sexual Involvement

Various theoretical discussions and research efforts have attempted to identify demographic and other variables associated with therapists who become sexually involved with their clients. However, the causes of therapist-patient sexual involvement are complex and multi-dimensional, and it is worth cautioning at the onset that many efforts to understand this phenomenon are hampered by a tendency to reductionism and over-simplification (Gabbard, 1994b; White, 1995), as well as by methodological limitations. In addition, much of the research focussing on characteristics of 'offending' therapists is based on clinical observation rather than systematic research, with little quantitative data currently available on their prevalence among transgressing therapists (Jehu, 1994). The following discussion is presented in the light of this cautionary note. It does not claim to be exhaustive, but to

highlight the most important variables associated with therapist-client sexual involvement.

2.6.5.1 Therapist Variables

Gender differences

A consistent finding across research is that therapists who report sexual involvement with clients are predominantly male, while clients involved in sexual contact with therapists are more likely to be women (Borys & Pope, 1989; Bouhoutsos et al., 1983; Garrett & Davis, 1994; Gartrell et al., 1995; Haspel, et al., 1997; Jehu, 1994; Lamb & Catanzaro, 1998; Pope, 1993, 1994). In addition, most males who become sexually involved do so with more than one client (Holroyd & Brodsky, 1977; Rutter, 1989). This gender bias among psychologists, specifically, appears to continue, at least in the USA. Of complaints to the APA related to sexual misconduct in 1998, 76% of these involved a male psychologist and a female client (APA Ethics Committee, 1999). According to Pope (1990b) in his review of the literature, the incidence for male therapists ranges from 1% to 12% compared to 2% to 3% for females. More male than female therapists are also likely to view sexual involvement with clients as therapeutic and/or ethical, and are more likely to consider having sex with a client than are female therapists (Borys & Pope, 1989; Lyn, 1995; Pope et al., 1986).

However, these results may not be as unambiguous as at first appears. For example, in some more recent studies these differences have narrowed (e.g. Rodolfa et al., 1994; Garrett & Davis, 1994), while other studies have found no significant gender differences (e.g. Akamatsu, 1988; Stake & Oliver, 1991). The incidence of male clients who have been sexually involved with their therapists may also be underreported. Gonsiorek (1989), for example, suggests that the socialization of men excludes a perception of themselves as powerless victims. Therefore self-blame, and consequent silence, results when males have been sexually involved with their therapists (cited in Jehu, 1994).

Age differences

It has been reported that 'offending' therapists are more likely to be older than 40 years of age, to have a strong propensity to control and a need for power (Garrett & Davis, 1994; Jehu, 1994, Kardener, 1974; Lamb & Catanzaro, 1998), and to be 10 - 25 years older than their clients (Garrett & Davis, 1994).

Loneliness, distress and problematic relationships

Therapists' loneliness and problems with personal relationships, including marital discord, have been cited numerous times as contributing factors in the development of sexual relationships with clients (Marmor, 1976, in Epstein, 1994; Glaser & Thorpe, 1986; Jehu, 1994). Other sources of distress include low self-esteem, depression, mid-life crises and professional burnout (Jehu, 1994). Twemlow and Gabbard (1989) state, therefore, that the best prophylactic against sexual involvement with clients is a satisfying personal life.

Narcissistic vulnerability

Several authors, particularly those who are psychoanalytically orientated, believe that narcissistic vulnerability/pathology plays a major role in therapist-client sexual involvement. They argue that sexual involvement with clients is a defense against feelings of shame, humiliation or other circumstances which may threaten the therapists' self-esteem, sense of cohesive self and identity (Book, 1995; Epstein, 1994; Gabbard, 1994b; Kernberg, 1994).

Cognitive distortions

Cognitive distortions have also been implicated in cases of sexual misconduct. Abel, Osborn and Warberg (1995) suggest that the most pernicious belief that therapists who become sexually involved with clients hold is that such behaviour is beneficial for a client (cited in Hamilton & Spruil, 1999). Therapists who hold this belief have been shown to be more likely to have sex with their clients than therapists who do not. (e.g. Gartrell et al., 1987, in ibid.).

2.6.5.2 Mismanagement of the Erotic Transference[5] and Confusing Countertransference with Love

Many recent psychoanalytically oriented writers have pointed out that the mismanagement of the erotic transference is a key feature in therapist-patient sexual involvement (e.g. Book, 1995, Kernberg, 1994; Strasburger, et al., 1992). Psychoanalytically orientated authors also argue that therapists who act on their feelings of sexual attraction tend to confuse countertransference feelings with 'real love.' (e.g. Gabbard, 1994d, 1995; Book, 1995;

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[5] Defined as "all the ways in which the patient's experience of the analytic relationship is shaped by his or her own psychological structures – by the distinctive, archaically rooted configurations of self and object that unconsciously organise

Celenza, 1991, 1995). Section 2.12.1.5 includes a definition and more detailed discussion of sexual attraction as countertransference.

2.6.5.3 Recency of Training

The suggestion has been made that more recently trained therapists are better informed about and sensitive to the issues surrounding exploitative dual relationships with clients (Stake & Oliver, 1991), and, arguably, less likely to become sexually involved with clients. A scrutiny of the research reveals a definite decline in the rates of therapist-client sexual involvement over the past two decades, at least as reported by therapists themselves in survey research. Whether, however, this reflects an actual decline in incidence of such behaviour promoted by improved academic training programmes and increased awareness of the negative consequences of such behaviour for clients, is debatable. Given that clients' complaints to their professional associations of therapist sexual misconduct has not declined, as discussed previously, suggests that therapists are simply more reluctant to disclose such contact for fear of censure, legal action and/or loss of reputation. The latter argument is supported by many authors (e.g. Samuel & Gorton, 1998; Williams, 1992).

2.6.5.4 Homosexual Contact

Homosexual contact has also received some attention in the literature. It appears that a small percentage of therapist-client sexual involvement involves same sex clients (Gartrell et al., 1986), although Gabbard (1994b) believes same-gender sexual involvement is underreported. With regard to female-therapist, female-client sexual contact, findings suggest that therapists who are not at ease with their feelings of same sex attraction may be at higher risk for engaging in sexual involvement with clients (Benowitz, 1994). Despite a small sample size, Trent and Collings (1997) found that 5 of the 6 respondents in their study who had sexual contact were women who had sexual contact with women. This result is consistent with findings of a study by Mogul (1992) that a greater number of the complaints made against women psychiatrists tend to be for homosexual contact (cited in Jehu, 1994). These findings seem to support the theoretical argument that it may be primarily 'power needs' that motivate psychotherapists to become sexually involved with clients, rather than gender differences (e.g. Garrett & Davis, 1994). It seems important, therefore, to view therapist-client sexual

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his or her subjective universe' (Stolorow & Lachmann, 1984, cited in Stolorow, 1992).

contact in the larger context of gender and, therefore power, issues in psychotherapy.

2.6.5.5 Therapists' Status

Sonne and Pope (1991) found that psychologists who had attained high levels of professional achievement reported a higher rate of sexual involvement with patients. Pope (1993), in noting that many therapists who have become sexually involved with clients are highly educated, prominent, respected professionals, argues that this status may not only help these therapists avoid detection but also contribute to their belief that they are beyond restraints, the law and accountability.

2.6.5.6 Theoretical Orientation

According to Pope's (1990b) review of the literature in the field, no article has reported a relationship between theoretical orientation and sexual involvement. This is despite the findings that psychodynamically orientated therapists more strongly affirm the unethical nature of such relationships (Borys & Pope, 1989; Conte, Plutchik, Picard, & Toksoz, 1989, in Folman, 1991; Holroyd & Brodsky, 1977). Gutheil and Gabbard (1993) have noted a historical discrepancy between espoused beliefs about sexual involvement with clients and behaviours in many psychoanalytic 'giants' such as Jung, Klein and Winnicott.

2.6.5.7 Work Setting

A number of authors and studies support the contention that therapists in private practice are more at risk to engage in sexual contact with clients than are their colleagues in other settings. (Epstein, 1994; Garrett & Davis, 1994; Kardener, 1974). Presumably this is because private practice is a more isolated work setting with less access to peer consultation processes and other support networks which might mitigate against, and protect the therapist from becoming sexually involved with their clients.

2.6.5.8 Sexual Involvement with Educators

A number of studies have reported on the incidence of educators engaging in sexual relationships with students (Glaser and Thorpe, 1986; Thoreson et al., 1993; Thoreson et al., 1995). Studies have shown that students who have sexual relationships with their educators and supervisors are more likely to become sexually involved with their clients once they are qualified (Pope, Levenson & Schover, 1979; Glaser & Thorpe, 1986; Pope, 1989; Pope & Bouhoutsos, 1986). However, more recently, Lamb and Cantanzaro (1998), found no support

for this finding. The argument has been made that educators may be acting as role models of inappropriate social and sexual behaviour. This modelling effect has led many authors to highlight the importance of proscribing sexual relationships between educators and trainee therapists (e.g. Folman, 1991; Housman & Stake, 1999; Pope & Bouhoutsos, 1986; Vasquez, 1988). Many ethics codes include such proscriptions.

2.6.5.9 Client Variables

Although it is beyond the scope of the present study to investigate, it does need to be mentioned that attempts have been made to identify clients who are at risk for becoming sexually involved with their therapists (e.g. Pope & Bouhoutsos, 1986).

2.6.6 Therapists' Attitudes[6] to Sexual Involvement with Current Clients

In line with findings from self-reports of therapists that the incidence of therapist-client sexual involvement is on the decline, is the change in attitudes to this behaviour. An appraisal of the research reveals that that over time fewer therapists report that they perceive any benefits of such relationships and more report perceiving harm. Presumably this is a result of increased awareness of the deleterious consequences to clients of such involvement. However, as mentioned previously, therapists may simply be more aware of the legal, ethical and professional consequences of such behaviour and thus report what they think they should (i.e. the now 'politically correct' view that such behaviour is harmful and unethical rather than what they actually believe). This trend in change in attitudes is evident if one compares early studies (1970s) with those in the 1980s and 1990s. For example in the Kardener et al. study (1973), 19% of physicians believed that erotic contact with a patient might be beneficial to clients, while in the Pope et al., (1987) study engaging in erotic activity with a client was considered unquestionably unethical by 95% of respondents. Most recent studies which have investigated therapists attitudes to therapist-patient sexual involvement have shown that the majority believe it to be both unethical and harmful to clients (Borys & Pope, 1989; Herman et al., 1987; Holroyd & Bouhoutsos, 1985; Pope et al., 1986; Pope et al., 1987; Stake & Oliver, 1991; Thoreson et al., 1993; Thoreson et al., 1995).

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[6] It needs to be noted that the topic of 'attitudes' is a wide and complex one which is beyond the scope of the present study to explore in any depth. However, for the purposes of this study an attitude is defined as 'a relatively stable tendency to

2.7 THE 'GREY ZONE' – POST-TERMINATION SEXUAL INVOLVEMENT BETWEEN THERAPIST AND CLIENT

Although there is reasonable consensus that therapist-client sexual involvement while psychotherapy is in progress is unethical, mental health professionals and ethics committees have grappled with the acceptability of sexual contact in other situations, especially between therapists and their former clients (e.g. Holroyd & Brodsky, 1977; Thoreson et al., 1993; Thoreson et al., 1995) and to a less extent between educators and students/supervisees (e.g. Lamb & Cantanzaro, 1998).

The ethicality of the 'grey' area of post-termination sexual involvement between therapists and clients remains highly controversial, as reflected in surveys of therapists' attitudes, beliefs and behaviours and in the ethics codes of various professional organisations (Appelbaum & Jorgenson, 1991; Garrett & Davis, 1994). Existing data suggests that the incidence of sexual contact between therapists and former clients tends to be higher than between therapists and current clients (Akamatsu, 1988; Borys & Pope, 1989; Lyn, 1995; Thoreson et al., 1993).

2.7.1 Rationales for Proscribing Post-Termination Sexual Involvement between Therapist and Client

Some researchers argue that the dangers, cited previously, inherent in sexual involvement while psychotherapy is in progress, apply to post-termination sexual contact, albeit to a lesser extent (e.g. Jehu, 1994). The primary reason for proscribing such contact, remains the potential harm to, or exploitation of, the client which has been shown to occur even after termination of psychotherapy (Gabbard & Pope, 1989; Pope, 1993; Pope & Vetter, 1991). The argument is 'once a client, always a client', even when psychotherapy has been terminated (e.g. Sell, Gottlieb & Schoenfeld, 1986). Gabbard and Pope (1989) cite a number of premises for this argument. Firstly, they argue that residues of the transference continue even after psychotherapy officially ends. Secondly, the 'internalized image' of the therapist appears to continue after termination and to play a significant role in the effectiveness of psychotherapy. Thirdly, the unequal power relationship is deemed to continue, even after

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interpret and respond in a certain way towards persons, objects, institutions or issues' (Chaplin, 1970).

psychotherapy ends (Martin, 1999). In addition, other professional responsibilities continue even after termination, including the need to maintain confidentiality and records. The therapist might also be subpoenaed to give evidence and need to be available to the client for further treatment which may occur far into the future (Jehu, 1994).

In counter-argument some claim that post-termination sexual contact may be ethical or permissible under certain circumstances. Justifications of such behaviour have included: if 'real love' is involved, if marriage follows, that it is unrealistic to expect to completely eliminate sex with former patients, that famous therapists have done it, that harm does not always occur or that it violates the clients constitutional right to freedom of choice.[7] From the perspective of some feminist writers, who have as a primary goal of psychotherapy the creation of an egalitarian relationship with greater symmetry of roles, placing all former clients sexually 'off-limits' is seen as infantilizing of the client and dehumanising of the therapeutic encounter (e.g. Machover, 1986, cited in Brown, 1988).

2.7.2 Ethics Codes on Post-Termination Sexual Involvement between Therapist and Client

Disagreements about the ethicality of post-termination sexual involvement between therapists and clients are also reflected in ethics codes, and reactions to these. An example is the contrast between the APA's decision to limit the ban on sexual relationships with former clients to 2 years after termination of psychotherapy versus the American Psychiatric Association's absolute ban on such relationships (Smith & Fitzpatrick, 1995). It is worth noting the APA's caveat that subsequent to this time period, a psychologist does not engage in a sexual relationship with a client except in the most unusual circumstances. In addition it is the psychologist's responsibility to prove that there has been no exploitation of the former client. (APA, 1992). Psychologists are also required to examine all relevant factors, including time since termination and circumstances of termination, nature and length of therapy, the client's personal history and mental status and whether there will be adverse effects on the client (ibid.). However, more recently, the APA's Ethics Code Task Force has suggested a 'perpetuity rule' that would prohibit relationships irrespective of how much time has elapsed since termination of therapy (Martin, 1999). Fisher (1999), asserts that: 'The task

[7] See Gabbard (1994c) for objections.

force decided that an absolute ban on post-termination sexual relationships more clearly addresses the inherent power imbalance which is not erased with termination' (cited in Martin, 1999, p.44). She argues that a time-limited ban can contribute to both therapist and client believing that feelings of sexual attraction may eventually be consummated and may even be condoned by professional ethics, and thus interferes with an ongoing therapeutic relationship or resumption of therapy following termination (ibid.).

This development appears to be largely attributable to strong opposition to the existing code by authors who have argued that any time limit is necessarily arbitrary and that sexual involvement with former clients should be proscribed (Gabbard, 1994c; Herman et al., 1987; Lazarus, 1992; Sell et al., 1986). Others argue that a blanket proscription is not essential. For example, Appelbaum and Jorgenson (1991), advocate a one year waiting period before therapists engage in sexual contact with former clients.

It needs to be noted that ethics codes are not internationally, or even regionally uniform. Some codes are more liberal, particularly in Europe, and in addition stress different guiding principles from time since termination. The Netherlands Institute for Psychology (NIP), for example, stresses the importance of 'due care' in making decisions about sexual relationships with former clients. It states: 'If it concerns a sexual relationship the psychologist has the responsibility to show, if he is asked to do so, that he observed all carefulness which could be required from him, being a professional psychologist' (NIP, 1998, Principle III.1.3.9)[8]. The CPA (1991) code of ethics emphasises the power relationship between client and therapist stating that the psychologist does not engage in sexual relationships with former clients '...for that period of time following therapy during which the power relationship reasonably could be expected to influence the client's personal decision making' (Principle II.26, p. 11).

The differences in codes raises an interesting question 'Is the defining criterion whether sexual involvement occurred, or whether it violates underlying ethical principles and values?' Perhaps this draws attention to a need for codes based on principled ethical arguments rather than prohibitions and utilitarian ethics. For as Pope (1993) has noted, often economic and other forms of self-interest have been more motivating factors than the profession's concern

[8] Unfortunately this is a poor translation.

for clients' welfare. It is, perhaps, also worth asking if blanket proscriptions of post-termination sexual contact might not be contradictory to espoused aims of psychotherapy, such as the facilitation of a client's maturity, autonomy and the ability to form and sustain healthy relationships.

As noted previously (Section 2.4) in South Africa the proposed version of the code of conduct for psychologists states that sexual intimacies with current and former clients are unethical. However, it remains problematic for psychologists in this country that an ethics code for psychologists has yet to be finalised.

This may also account for the finding of a recent South African study of the ethical beliefs and behaviours of a sample of psychologists, in which on average respondents felt that 11 months was an appropriate post termination period before sexual contact with former clients was acceptable (Trent & Collings, 1997). It must, however, be cautioned that this study was based on a very small sample.

Also, in the legal setting, court cases with regard to therapist-client sexual misconduct have held that termination does not legitimate therapists' later sexual involvement with clients (e.g. Gabbard & Pope, 1989). In the State of Florida, USA, for example, the law states that for the purposes of determining the existence of sexual misconduct the psychologist-client relationship is deemed to continue in perpetuity (Jehu, 1994).

2.7.3 Therapists' Attitudes to Post-Termination Sexual Involvement with Clients

In addition, while there is variability in attitudes about the appropriateness of post-termination sexual involvement between therapist and client, it is generally considered to be less unethical than sexual contact with current clients (Akamatsu, 1988, Borys & Pope, 1989; Gartrell et al., 1986; Lyn, 1995; Herman, et al., 1987; Pope et al., 1987; Thoreson et al., 1993, Thoreson et al., 1995). For example, in the Akamatsu study (1988), 55.2% of psychotherapists felt that there were some circumstances, especially depending on time since termination in which sexual relationships with former clients might not be unethical. In the Pope et al. (1987) study engaging in erotic activity with a current client was considered unquestionably unethical by 95% of the 465 respondents, while only half believed that sexual contact with a former client fell into this category. In the Herman et al. (1987) national survey

of psychiatrists, sexual contact with clients was considered to be always inappropriate by 98%, while 30% believed it to be sometimes appropriate after termination of therapy.

Given that the issue of post-termination sexual involvement between therapists and client remains a controversial area, and that there is a dearth of South African data on therapists' attitudes and beliefs about these relationships argues for further and ongoing research of this topic.

2.8 CRITIQUE OF THE RESEARCH ON SEXUAL DUAL RELATIONSHIPS

A number of cautions in interpreting research findings in the area of sexual involvement between clients and former clients are warranted. According to post-modern and other thinkers, research can never be value-free or uninfluenced by the ideology/perspectives of the observer/researcher (Slife & Williams, 1995). As these authors note, there are often hidden assumptions in research in the behavioural sciences. Benezra (1988) suggests that conceptions of therapist sexual involvement with current and former clients may be biased by entrenched values and convictions which make it all but impossible to accept any views other than the existing zeitgeist (in Pope, 1990b). It has been argued that cultural myths, beliefs and biases about such involvement prevent objective, research-based assessment of the consequences. Gross (1977), for example, argues that 'conventional morality' prevents fair consideration of the uses of erotic contact as an important aspect of psychotherapy (cited in ibid, p. 480). While this is an extreme viewpoint, it does appear that the prevailing ethos in this field, at least in the United States of America where most research has been conducted, is that therapist-patient sexual contact is a priori damaging, unethical and to be avoided. This is born out by the use of language such as 'abuser', 'sexual exploitation' and 'perpetrator' in many studies. It could be argued, then, that those who advocate opposing viewpoints may find it as difficult to be heard today, as did earlier authors who first opened up debate and research in the field three decades ago.

Pope (1990b) identified an interesting bias in the literature in this field. He found that, without exception, all journal articles reporting studies of the occurrence or effects of therapist-client sexual involvement included at least one female investigator. In contrast

individual male therapists authored all journal articles and public presentations which contend that such involvement is not harmful. It appears important, therefore, to be aware that 'implicit agendas' may be involved, with male researchers de-emphasising, and females emphasising, the harmfulness of such relationships.[9]

Another critique that has been made of research on the negative effects of therapist-client sexual involvement is that it is dependent on those who volunteer or agree to participate. Only those, therefore, who have been hurt by such involvement or who believe themselves to be negatively affected are likely to be motivated to participate (Pope, 1990b; Williams, 1992). Thus findings are likely to confirm the harmfulness and/or negative effects of such relationships. It remains unclear, however, how 'silent' clients have been affected by sexual involvement with their therapists. In addition, as Williams (1992) points out, an underlying assumption is that harm was caused to the client because his/her sexual partner was a therapist. However, without a matched control group of clients who suffered distress and harm due to a broken relationship with a non-therapist, it remains unknown whether harm was caused because the sexual partner was a therapist or because the relationship ended.

Also, the data-gathering methods and situations do not allow extrapolation to a larger population concerning the conditions in which harm does or does not occur, nor what other factors in the client's life may have caused the observed damage (Williams, 1992). According to Pope & Bouhoutsos (1986) empirical research to either prove or disprove benefit or harm has been very difficult to undertake because of the inaccessibility of both therapist and client populations.

Particularly where there are contradictory findings, it is also important to bear in mind methodological limitations. Pope (1990b) cites the primary of these being selective memory in retrospective studies, reporting bias, unrepresentative samples, and distortions in data obtained from secondary sources. For example, different selection criteria for sample selection make it difficult to compare results (Pope, 1988), as does the use of different measurement instruments. In other instances the sample populations have also been different, for example social workers and psychologists. Stake and Oliver (1991) point out that incidence of sexual involvement can also vary considerably depending on how this behaviour is defined.

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[9] It also needs to be mentioned that the present researcher is female.

In addition, most of the formal demographic studies of psychologists who become sexually involved with clients are drawn from survey research, either in the form of self-report surveys or surveys in which therapists provide information about clients who reported sexual involvement with a previous therapist to them (Pope, 1993).

Cognisance needs to be taken of these methodological limitations, potential biases and hidden assumptions in research in the field.

Another area of controversy is the role played by physical touch in cases of therapist-client sexual involvement. The review will now focus on an exploration of this topic.

2.9 TOUCH IN PSYCHOTHERAPY

2.9.1 Controversies Surrounding the Use of Touch in Psychotherapy

The role played by non-sexual touch in psychotherapy generally, and in therapist-client sexual involvement in particular, is also an issue fraught with dissenting viewpoints and controversy. There is generally a lack of consensus about touch in psychotherapy as well as the complex ethical and clinical issues surrounding its use (Durana, 1998). In addition, as Jayaratne , Croxton and Mattison (1997) point out, few guidelines exist about the use of touch in psychotherapy (cited in Sehl, 1998). Psychoanalytically orientated therapists since Freud have eschewed the use of touch in psychotherapy. Their argument is that its use interferes with the ability to work through transference issues, and is a breach of the therapeutic frame. Other researchers argue that touching is closely related to status and power issues (Henley, 1973, 1977, in Pope et al., 1997), that gender and status determine the politics of who touches when, where and how (Jourard, 1976, cited in Durana, 1998) and that women are touched more than men. Alyn (1988) argues that touch, while not necessarily unethical, can reinforce the culturally prescribed unequal power relationship between genders and reproduce routine violation of women's boundaries (in ibid.). Durana also asserts that therapists need to be sensitive to issues of power, boundaries and gender when using touch in psychotherapy. In addition, clinicians practising such behaviour run the risk of having it interpreted as a sexual advance (Smith & Fitzpatrick, 1995).

2.9.2 The 'Slippery Slope' Hypothesis

Perhaps the most ubiquitous argument for abstaining from using any form of touch in psychotherapy, including non-sexual forms, and that most relevant to the present study, is that it can and does lead to sexual involvement (e.g. Brodsky 1989; Folman, 1991; Gutheil & Gabbard, 1993; Rutter, 1989). Many authors argue that the erosion or breach of therapeutic boundaries, such as non-sexual touching, sexual humour, the therapists' self-disclosure and social contact with clients, may be transitional steps to sexual involvement (Simon, 1991; Strasburger et al., 1994). This is the so-called 'slippery slope' hypothesis in which seemingly innocuous and harmless behaviours lead inevitably to ones that are more serious and harmful to the client. The line between innocent, non-sexual touching and sexually infused touching may be a fine one. As Holroyd and Brodsky (1980) point out: "It is difficult to determine where 'nonerotic hugging, kissing and affectionate touching' leave off and 'erotic contact' begins" (cited in Pope et al., 1997, p.995)

There has been some empirical research to investigate the relationship between non-sexual touch and sexual involvement. A survey of social workers reported that respondents who became sexually involved with clients reported significantly more non-sexual touch with clients than did their colleagues who did not become sexually involved (Gechtman, 1989). Borys and Pope (1989) in their survey of psychologists, psychiatrists and social workers found that therapists involved in nonsexual boundary violations are at an increased risk of becoming sexually involved with their clients.

2.9.3 The Benefits of Touch in Psychotherapy

Although widely eschewed by most schools of psychotherapy, studies show that therapists do use non-sexual touch in their work with clients (Holroyd & Brodsky, 1977; Lamb & Catanzaro, 1998; Stake & Oliver, 1991). In a recent survey of social work psychotherapists, 44% of males and 34% of females indicated that they occasionally or frequently hugged their client in a way they considered to be non-sexual (Sehl, 1998). In a survey of social workers by Jayaratne, Croxton and Mattison (1997), 83.7% of subjects reported that they hugged or embraced their clients (cited in ibid.). In addition many therapists advocate the therapeutic benefits of touch. According to Simon (1992) a gentle, reassuring touch or hug can be the most appropriate response at certain times or with certain clients (cited in Smith & Fitzpatrick, 1995). Therapeutic purposes and benefits include the expression of care and

warmth (Holroyd & Brodsky, 1977), congratulation, reassurance, support, comfort, consolation, solace, concern and caring, the facilitation of self-disclosure, self-exploration and catharsis (Edwards, 1981; Goodman & Teicher; 1988; both cited in Garrett & Davis, 1994). Touch is widely held to be permissible in working with children (Mitchum, in Pope, et al., 1997) and the elderly (Weisberg & Haberman, 1989, in ibid.). However, as Pope et al. (1997) suggest, this may be because, for a variety of social, religious and other factors, sexual feelings in, and towards, the former two populations may be overlooked, denied or ignored.

In a study by Horton, Clance, Sterk-Elifson and Emshoff (1995) clients reported that touch fostered trust and greater openness with the therapist, enhanced their self-esteem and communicated the therapist's acceptance of them. A phenomenological study by Gelb (1982) identified four factors associated with clients' positive evaluation of touch in psychotherapy: clarity regarding touch and boundaries; perception of having control in initiating and maintaining contact, congruency of touch with the degree of intimacy and issues discussed, and a belief that touch was for their benefit and not that of the therapist (cited in Durana, 1998).

2.9.4 Therapists' Attitudes to Touch in Psychotherapy

Studies which have investigated therapists' attitudes to a variety of forms of physical contact/touch indicate that therapists believe that touch may be ethical in psychotherapy, depending on the nature of touch and circumstances in which it is used (Holroyd & Brodsky, 1977; Pope et al., 1987; Stake & Oliver, 1991). While there is variability in attitudes, these studies indicate that a handshake is generally considered to be ethical, while kissing is not, and that there is less consensus about holding hands and hugging. Historically and currently, marked differences in beliefs about physical touch have been evident between therapists of different theoretical orientations. For example, in the Holroyd and Brodsky (1977) study, 30% of humanistic therapists, but only 6% of psychodynamic therapists believed that touching could be beneficial to clients. It is also interesting to note that while 25-30% of humanistic therapists engaged in non-erotic hugging, kissing and touching versus 5% for psychodynamic and cognitive behavioural therapists, the number of sexual incidents does not differ according to therapeutic orientation. This finding raises questions about the 'slippery slope' hypothesis, discussed previously.

Although empirical research has shown that physical contact is crucial to human development, research investigating the effects of touching on therapeutic outcome is both scant and inconclusive (Holub & Lee, 1990; cited in Smith & Fitzpatrick, 1995). In addition, ethical guidelines about touch are not standardised (Durana, 1998). The issue is further complicated by the fact ethical behaviour can be used for unethical reasons (e.g. Dyck, 1993). For example, hugging a client whose child has been killed may actually be more ethical than a handshake infused with sexual connotations. Dyck (1993) also asserts that it is possible for a psychologist to be morally undeveloped yet behaviourally ethical.

It is also worth noting that these studies are all conducted in and from the viewpoint of western cultures. In non-western cultures, including Black South African culture, touch is not only accepted but also expected, and its absence in a therapeutic setting might in fact be non-therapeutic. The importance of training therapists to be sensitive to ethnic and cultural differences among clients in determining ethical behaviour has been highlighted by Vasquez and Eldridge (1994), and can be argued to be applicable to the issue of touch in psychotherapy. Feminist authors have also disputed the idea of a fixed, universal set of boundaries that can never be crossed. Brown (1994), arguing from this perspective, believes that the delimitation of appropriate boundaries in psychotherapy is highly variable and depends on factors such as race, class, culture, setting and the specific relationship between therapist and client. Again, this shows the need for ethics guidelines to be based on principles rather than on simple proscriptive rules.

As is evident from the above discussion, the need for ongoing research to investigate therapists' attitudes to these controversial issues in psychotherapy is both justified and necessary. The present study, therefore is interested in investigating South African clinical psychologists' attitudes to sexual involvement with current and former clients and towards other forms of touch in psychotherapy. Do psychologists believe that there might be circumstances in which these relationships are ethical? Do they consider sexual involvement with former clients to be less unethical than with current clients? What factors, if any, might influence the ethicality of such involvement? Finally, the controversy surrounding the use of touch in psychotherapy and the dearth of empirical research on therapists' attitudes in this regard argues for further investigation in this area.

2.10 THE NEED FOR CHANGE: FOCUS ON PREVENTION AND RISK MANAGEMENT

As is evident from the previous discussions, awareness has been raised about the incidence and effects of therapist-client sexual involvement, and the factors and variables that might influence such involvement. Cummings (1985) termed sexual involvement between psychologists and clients in America a 'national disgrace' and called for firm and unequivocal measures to deal with this problem (cited in Pope & Bouhoutsos, 1986). The numerous research surveys, case study reports and theoretical and ethical debates on the topic have led most researchers to agree that changes are necessary in those systems responsible for educating, controlling, disciplining, and licensing therapists, in an attempt to prevent therapist-client sexual involvement. While there are no simple answers, there has clearly been a need for changes on a public policy and operational level. Given that sexual attraction necessarily precedes sexual involvement and that training in ethics has been argued to reduce the risk of this consequence, the remainder of this review addresses these two topics which are central to the present study:

2.11 ETHICS TRAINING ABOUT THERAPIST-CLIENT SEXUAL INVOLVEMENT AND THERAPISTS' SEXUAL ATTRACTION TO CLIENTS

2.11.1 Ethics Training and Therapist-Client Sexual Involvement

In an effort to understand what factors contribute to therapists becoming sexually involved with their clients, and to find ways to reduce or prevent the occurrence of this ethical transgression, many researchers and authors have turned their attention to the issue of training in ethics. Most of the studies reviewed which investigate therapist-patient sexual involvement suggest in their conclusions that inadequacies in the quality and amount of ethics education and training may play a role in sexual transgressions and /or call for improved training on this topic (e.g. Bernsen, et al., 1994; Borys & Pope, 1989; Celenza, 1991; Folman, 1991; Stake & Oliver, 1991; Wincze et al., 1996). Given the suggested association between a lack of training and sexual transgressions, a number of researchers have investigated this topic specifically. These studies are discussed below.

2.11.2 Inadequacy of Training about Sexual Issues in the Field of Ethics

Many studies have reported results which indicate that training in sexual issues and dilemmas in

the field of ethics in psychotherapy is non-existent, limited or inadequate (e.g. Gartrell, Milliken, Goodson, Thieman, & Bernard, 1995; Gechtman, 1989; Rodolfa et al., 1990; Pope & Tabachnick, 1993). This appears to hold true for all the healing professionals who have been surveyed, including psychologists, social workers, physicians and psychiatrists.

According to Folman (1991), in addition to increasing the risk for therapist-client sexual involvement, the lack of training on issues of therapists' sexual attraction to clients, therapist-client sexual involvement and ethical guidelines of practice in these areas has had three major consequences. The first is that therapists perceive their feelings of sexual attraction to clients as taboo and are therefore unwilling to risk discussion with peers and supervisors when there is a problem. Secondly, they are left isolated and alone, and thirdly that they have failed to develop the coping strategies and supportive resources that can be utilised in managing these feelings before they lead to destructive behaviour.

Studies have shown that between 33% and 55% of professionals have reported that they received no training in sexual ethics in their graduate programmes (Glaser & Thorpe, 1986; Pope et al., 1986, Rodolfa, et al., 1994) and between 51% and 91% have rated their graduate training in sexual ethics as inadequate (Pope & Feldman-Summers, 1992, cited in Housman & Stake, 1999; Pope et al., 1986; Pope et al., 1997).

2.11.3 Training about Therapists' Sexual Attraction to Clients

Training about therapists' sexual attraction to clients, specifically, appears to receive even less attention than the topic of therapist-client sexual involvement. In analysing eight national studies (with data from 5 148 therapists), Bernsen et al. (1994) found that most subjects reported no graduate training concerning this topic, while only 10% reported adequate training. Rodolfa et al. (1990) found that the majority of the 70 trainee and qualified psychologists that they surveyed reported limited training with respect to sexual attraction to clients and reported that, in general, sexual dilemmas were seldom addressed in their respective academic training programmes. Rodolfa et al. (1994) reported that 40% of the psychologists working in university counselling centres whom they surveyed had received no education about sexual attraction, while 51% had not received training during their internship. In the Pope et al. (1986) survey only 9% of psychologists reported adequate training or supervision about sexual attraction to clients, while Pope and Tabachnick (1993)

found that only 14.7% of the psychologists surveyed believed that their training to manage sexual arousal was good. Blanchard and Lichtenberg (1998) report that more than a third of the counselling psychologists they surveyed had received no training on this topic.

2.11.4 Recent Improvements in Training

However, it is clear that awareness is growing about the importance of ethics training and more recently some studies have indicated improved training about therapist-client sexual involvement and about therapists' sexual attraction to clients. In the Samuel and Gorton (1998) national survey of directors of psychology internships accredited by the APA, 99% of respondents reported that their training included at least one session on education related to psychologist-patient sexual involvement. In addition they also felt that education on issues related to management of sexual feelings and maintenance of boundaries should be a mandatory requirement in psychology internship programmes. Housman and Stake (1999) compared directors of clinical psychology doctoral programmes and their students in their reporting of sexual ethics training. All directors and 94% of students reported sexual ethics training in their programmes. A disturbing finding of this study, however, is that students evaluated their training as only 'fair' and in addition showed significant deficits in knowledge of sexual ethics principles. This result raises questions about the effectiveness of ethics training. Blanchard and Lichtenberg (1998) reported another interesting finding. In their survey 95% of directors of graduate training programmes for counselling psychologists reported that the topic of therapists' sexual feelings towards clients is formally addressed in their doctoral programmes, however only 56.7% of graduates from these programmes reported that they had received such training. This result suggests that educators might be overestimating the amount of training they offer.

2.11.5 Addressing the Need for Improved Training

In line with the importance attributed to ethics training on sexual issues in psychotherapy, a strong movement has begun towards establishing more formally structured training in sexual ethics and dilemmas, including the experience of sexual attraction and sexual involvement with current and former clients (e.g. Bates & Brodsky, In Rodolfa et al., 1990; Folman, 1991; Housman & Stake, 1999). A number of authors call for such training to be a mandatory part of training and a requirement for accreditation (Gartrell et al., 1987; Housman & Stake, 1999; Samuel & Gorton, 1998; Vasquez, 1988). In this regard, a number of important factors have been identified:

2.11.5.1 Creating a Climate Conducive to Learning

The importance of creating a climate conducive to learning about, and examining, therapists' sexual attraction to clients and other sexual issues is emphasised by a number of authors (e.g. Housman & Stake, 1999; Vasquez, 1988). Celenza (1995) argues for a less punitive atmosphere in the psychology profession, generally, towards therapists who are anxious that they might become sexually involved with a client so that they will feel free to seek consultation if and when they feel the need. She also contends that supervisors can help potentially vulnerable therapists and trainees in clarifying, differentiating and tolerating the intensity of sexual and other feelings. The Rodolfa et al. (1994) study found that professionals who had a positive supervisory or collegial relationship were more likely to seek consultation when they experienced feelings of sexual attraction to clients. Housman and Stake (1999) also found that clinical psychology students were more likely to consult a supervisor about their sexual attraction if they rated their programme atmosphere more positively. In addition, students who had discussed these feelings with a supervisor showed the best understanding of sexual ethics. In an earlier survey of psychologists by Haas, Malouf and Mayerson (1986) respondents identified the most frequent and useful source of ethics knowledge as discussions with colleagues (cited in Hall, 1987). This points to the importance of supervision/consultation in acquiring and understanding ethical principles.

2.11.5.2 Addressing Therapists' Direct, Personal Experience of Sexual Attraction

Rodolfa et al. (1990) and Pope et al. (1997) stress that training programmes need to address the professional, ethical and legal issues involved in therapists' sexual attraction to and sexual involvement with clients. In addition, however, they highlight the importance of acknowledging and exploring the therapist's direct, personal experience of sexual attraction. By focussing exclusively on admonitions to the therapist to respond with sensitivity and respect, within appropriate limits and boundaries, and with acceptance of sexual attraction, Pope et al. (1986) contend that therapists are likely to find it difficult to share with their colleagues and peers situations which are confusing, frightening or anxiety provoking.

2.11.5.3 Importance of Differentiating between Sexual Attraction and Sexual Involvement

Edelwich and Brodsky (1982) point out that training programmes sometimes misrepresent the injunction not to act on feelings of sexual attraction to a client as meaning that one must not admit to having such feelings. A number of authors assert that it is imperative to differentiate

between being sexual attracted to clients and acting on this attraction (Hamilton & Spruil, 1999; Housman & Stake, 1999; Pope et al., 1986; Rodolfa et al., 1990). Without such a distinction being made an honest and open discussion of sexual feelings is impossible.

2.11.5.4 Developing Skills for Managing Sexual Attraction

As we know from the wide body of research in health psychology, information and knowledge are often insufficient to change behaviour (e.g. Taylor, 1990). Most proponents of ethics training also argue that exposure to professional standards is not enough to make ethical decisions (Vasquez, 1988). Most models of ethics, therefore, emphasise a learning process of ethical reasoning and decision-making. Hamilton and Spruil (1999), in their paper aimed at identifying and reducing risk factors related to trainee-client sexual involvement, argue that while many training programmes for psychologists provide the necessary knowledge and information on how to respond to sexual ethical dilemmas, often they do not ensure that students have the requisite skills to respond effectively to such dilemmas, including the experience of sexual attraction to clients. These authors offer useful and practical suggestions about what such training needs to encompass. These include case studies and other 'real-life' examples, training in maintenance of therapeutic boundaries, educators' self-disclosure of their own experiences of sexual attraction, the role of clear case conceptualisation and practical suggestions for monitoring therapeutic boundaries.[10] As Folman (1991) puts it '... we need to include in these programs not merely theories, but effective strategies for containing and managing sexual impulses and feelings of love which may arise in therapy' (p.172).

Vasquez (1988) argues for the development of self-awareness regarding personal sexuality, power, and ego needs for trainee therapists, including experiential activities such as role-plays. Rodolfa et al. (1990) advocate the usefulness of small group discussions which allow trainee therapists to examine their feelings and behaviours when they experience sexual attraction. Bridges (1994) also emphasises experiential training to increase therapists' comfort with sexual material and to facilitate development of a repertoire of coping, containing and conceptualising skills, while Strasburger et al. (1992) stress the importance of experiential problem-solving training.

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[10] See this article for a detailed discussion of these factors.

Despite the value of these recent educational efforts around therapist-client sexual involvement and unethical behaviour, Bridges (1994) argues that they may have paradoxically and unintentionally exacerbated pre-existing anxiety that therapists' experience about their sexual attraction to clients. In addition, no research has investigated whether in fact improved training does reduce the incidence of therapist-client sexual involvement (Samuel & Gorton, 1999).

2.11.6 Ethics Training in South Africa

Wassenaar (1998) states that: '... professional ethics receives inadequate attention in psychological training and research in South Africa' (p.140). In addition, he believes that in this country, unlike in the USA, an emphasis on ethics has not increased more recently and is currently undertaking research to verify this impression (ibid.). He further asserts that continuing education in ethics must become a priority of the PBP.

2.11.7 Summary

In summary, firstly it is clear that many universities in the USA, provide little or inadequate training about sexual issues and dilemmas in psychotherapy, including therapists experience of sexual attraction to their clients, although more recent studies report improvements in training. According to Wassenaar (1998) there is also a dearth of such ethics training in South Africa. Secondly, where training is offered, it is often based on providing information on legal and ethical guidelines, to the neglect of experiential learning and self-awareness development. Finally, if the training atmosphere and supervisors' attitudes are perceived as positive and open, therapists and trainee therapists are more likely to discuss their feelings of sexual attraction with supervisors. This might then reduce the risk of sexual involvement.

The review will now focus more specifically on the phenomenon of therapists' sexual attraction to clients, including the rationales for investigating this topic, and the taboos which make an open exploration difficult. It includes a summary of recent empirical research, with particular emphasis on those studies which form the basis for the research questions and hypotheses of the present study.

2.12 THERAPISTS' SEXUAL ATTRACTION TO CLIENTS

The rationales for investigating therapists' sexual attraction to clients are outlined below.

2.12.1 Rationales for Investigating Therapists' Sexual Attraction to their Clients

2.12.1.1 Ubiquitous, Normal Nature of Sexual Attraction

Psychotherapy is, by its very nature, a deeply intimate relational experience. Therapists often experience a natural sense of emotional satisfaction from their role in the therapeutic experience (Vasquez & Strohm Kitchener, 1988). This natural caring, warmth and regard for clients can, at times, evolve into more sexual/erotic feelings. Since the early writings of Freud, therapists' sexual feelings for clients were acknowledged, and more recent authors agree that sexual feelings and longings on the part of the therapist are a normal, inevitable, predictable and natural part of psychotherapy (Bridges, 1994; Folman, 1991; Gabbard, 1994b, 1995; Pope & Tabachnick, 1993; Pope et al., 1986; Samuel & Gorton, 1998; Sehl, 1998; Strean, 1993; Tansey, 1994).

The APA similarly asserts that:

> 'The necessary intensity of the therapeutic relationship may tend to activate sexual and other needs and fantasies on the part of both patient and therapist, while weakening the objectivity necessary for control' (cited in Strasburger, Jorgenson & Sutherland, 1992, p. 545).

Therapists sometimes have to face overwhelming and intense sexual feelings towards their clients, while at the same time maintaining their professional boundaries and ensuring that the mental health needs of the client remain primary (Vasquez & Strohm Kitchener, 1988).

As Strean (1993) states, clinicians are:

> 'obligated to monitor their sexual desires, experience them fully without acting on them, and control them without pressuring themselves or their patients to deny, suppress, or repress sexual feelings and fantasies' (p.ix).

There is, therefore, fair consensus that it is not unusual for therapists to experience sexual attraction for their clients and that these feelings can be intense and compelling enough to threaten the therapist's objectivity and ability to maintain clients' welfare as paramount.

2.12.1.2 Mismanaged Sexual Attraction can Lead to Unintended and Non-therapeutic Outcomes

Apart from actual sexual involvement, which has been discussed extensively in previous sections, unrecognised, misunderstood, or inappropriately handled sexual feelings can lead to a variety of other unintended and non-therapeutic outcomes. These include therapeutic impasses, shame and isolation, and therapists' withdrawal from, or overinvestment in, the treatment process (Bridges, 1994; Folman, 1991; Housman & Stake, 1999; Tansey, 1994).

2.12.1.3 Therapist Guilt, Shame and Anxiety

Sexual attraction to their clients may also cause therapists feelings of discomfort, shame, anxiety or guilt (Pope et al., 1997). Benjamin (1994) contends that this is because therapists experience their sexual feelings as an 'internal transgression' and fear that 'reparation can turn to destruction, that love can injure as well as heal' (p. 201). Such feelings may result in a stilted, unnatural manner in therapy, the suppression of ordinary friendliness and interest, harmful misdiagnoses of patients or bias in choice of clients, such as female therapists avoiding treating attractive male clients (Pope et al., 1986). In addition, Sehl (1998) contends that anxiety, guilt and shame about sexual feelings can make it difficult for therapists to comprehend their contributions to stalemates in psychotherapy and might impede their ability to assist clients who may themselves have similar reactions to their own sexual feelings. He argues that anxiety may also lead therapists to minimise clients' need for love, lead to premature interpretations, seductive behaviour, or aggressive confrontation of the client's sexual material, while remaining unaware of their own sexual feelings. Lehrman (1960) maintains that guilt-ridden erotic feelings are a major problem of young male therapists treating attractive female clients (in Pope et al., 1986). It could be argued that if therapists are unable to celebrate their own and their clients' sexuality, they put the lid on its natural and healthy expression. They also deny themselves a deeper understanding of their clients' problems and difficulties in the area of sexuality, as well as the opportunity to heal these.

The above mentioned outcomes have received less priority/discussion in the literature. By their nature less tangible, obvious or 'measurable', they could be argued to be equally damaging to the client and the psychotherapy process.

2.12.1.4 The Myth of Invulnerability

It is undoubtedly true that some therapists who cross the boundaries into sexual encounters with clients have personality pathology and/or are disturbed. However, the belief that 'only such therapists become sexually involved with clients' or 'it can never happen to me', obscures the real possibility that perhaps every therapist is more or less at risk depending on life stressors and other situational variables which may increase his/her vulnerability to sexual transgressions. A number of theorists dispute the politically correct stance that disavows the universal vulnerability to sexual transgressions (Celenza 1995; Gabbard, 1994a, 1994b; Tansey, 1994). Rutter (1990) describes how he came perilously close to sexual involvement with a client:

> 'From this experience I discovered at first hand just how passionate the erotic atmosphere can become in relationships in which a man holds the power and the woman places trust and hope in him. Any illusion I had that I was exempt from this seductive intensity was left far behind' (p.6).

Freud, too, in a letter to Jung who had transgressed sexual boundaries with a client, wrote: 'I have come very close to it a number of times and had a narrow escape' (McGuire, 1974, letter 145F, cited in Gabbard, 1994d, p. 230).

Celenza (1995) argues that it is the therapist who insists he or she is invulnerable to becoming sexually involved with clients who is most at risk. Pope and Bouhoutsos (1986) and Garrett and Davis (1994) also contend that if therapists deny the normal process of sexual attraction to clients they may tend to act on these feelings. Conversely, Gorkin (1985) states: 'By accepting my feelings and fantasies, I find the danger of acting out or evading them is thereby diminished' (cited in Sehl, 1998, p. 40). As discussed previously (Section 2.6.5.1), the temptation to succumb to feelings of sexual attraction may be particularly hard to resist when the therapist him/herself is experiencing periods of personal stress, crises, neediness or vulnerability. Recognising therapists' vulnerabilities is an important factor, given that psychotherapy is by its nature a demanding and difficult profession. Sullivan (1954) stated that psychotherapy was the most

difficult of all professions because the therapist's own needs are excluded from the relationship (cited in Twemlow & Gabbard, 1989). Often therapists bring to their work their own need for healing, or seek to relieve a sense of isolation and aloneness (Buie, 1983, cited in ibid.). In addition Guy and Liaboe (1985) have demonstrated that therapists commit suicide at a rate that far exceeds the general population (cited in Strean, 1993).

2.12.1.5 Sexual Attraction as an Aid to the Therapeutic Process – Psychodynamic Contributions

It is the psychodynamic literature which has most contributed to the understanding that the therapist's sexual attraction to clients can benefit the therapeutic process[11]. In addition, it provides theoretically based constructs and frameworks for understanding and managing such feelings. While this literature is beyond the scope of the present study to address in depth, a brief review will shed some light on key contributions to understanding the phenomenon of therapists' sexual attraction to clients.

Psychodynamically orientated clinicians view the therapist's sexual feelings as a form of countertransference. For the purposes of this study countertransference is broadly defined as 'all those reactions of the analyst to the patient that may help or hinder treatment' (Slakter, 1987, cited in Abend, 1989, p.374). When these responses are sexual and/or loving in nature, this is termed 'erotic countertransference'.

In his 1915 paper *'Observations on Transference-Love'*, Freud clearly stated that the therapist's erotic countertransference was not to be confused with 'real love', but had to be viewed as a response to the client's transference (in Celenza, 1991). This transference in turn was induced by the analytic treatment and not by the attributes or 'charms' of the therapist. This traditional conceptualisation of countertransference was that it resided exclusively in the therapist, was essentially a destructive or disrupting force in treatment and had, therefore, to be overcome (Abend, 1989; Freedman & Lavender, 1997).

Early psychodynamic writers since Freud (e.g. Lehrman, 1960; Tower 1956, both in Bridges

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[11] For the purposes of the present study, 'psychodynamic' is used as a generic term to broadly include psychoanalytic, object-relations, psychodynamic and self psychological theorists, while maintaining an awareness that these theoretical schools themselves differ widely on many issues.

1994) emphasised the ubiquitous nature of therapists' sexual feelings in an aim to normalise such reactions and combat guilt, shame and/or embarrassment. Later theorists (e.g. May, 1986, in ibid.) expanded and deepened clinician's understanding of how to work with sexual feelings in psychotherapy, seeing the therapist's role as containing sexual tension and bearing the resulting anxiety without acting or withdrawing in disgust and alarm. This conceptual frame for managing sexual feelings is now standard practice (e.g. Langs, 1982, in ibid.).

Over the years psychodynamically orientated writers have developed and deepened the understanding that countertransference can be a potentially valuable therapeutic resource, a view that is now widely accepted in psychodynamic circles (Abend, 1989). Conversely, others have highlighted the dangers if countertransference is mismanaged (e.g. Gabbard, 1994d).

However, despite the importance ascribed to the understanding of countertransference, there remains a dearth of psychoanalytic writing on erotic countertransference, relative to other forms of countertransference. It is only recently that authors writing from this perspective have renewed open exploration and debate on the topic (e.g. Celenza, 1991, 1995; Gabbard, 1995; Kernberg, 1994; Russ, 1993; Sehl, 1998; Tansey, 1994). Gabbard (1994d) argues that the opening up of this once forbidden area,[12] parallels a contemporary (psychodynamic) shift in understanding the therapist's role from one of a detached, remote and objective 'blank slate', to one who brings his/her own needs, wishes, history, conflicts and dynamics to the therapeutic encounter. Hirsch (1994) highlights a second contemporary shift away from seeing the therapeutic relationship as one between an ill client and a well therapist. A contemporary view of countertransference is offered by Ogden (1994) as constituting a 'dialect between the analyst as a separate entity and the analyst as a joint creation of the intersubjectivity of the analytic process' (cited in Gabbard, 1995, p.481).

Today many psychodynamically orientated therapists agree that if competently handled, the therapist's sexual feelings can provide valuable information about the client's functioning, psychic conflicts and interpersonal relationships, as well as about important aspects of the therapeutic process (Bridges, 1994; Celenza, 1991, 1995; Freedman & Lavender, 1997;

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[12] Initiated with a panel held in 1992 at a meeting of the APA entitled 'Love in the Analytic Setting'.

Gabbard, 1994d; Hirsch, 1994; Kernberg, 1994; Tansey, 1994). Russ (1993) describes this intersubjective matrix between therapist and client in which: 'Both people weave in and out of the erotic relational configuration...plumbing the extent of aggression, hate, seduction, and love, moving toward ultimate resolution of the patient's core difficulties' (p.405).

In addition, therapists' sexual feelings for their clients can provide valuable information to therapists about themselves, enhancing their professional development and growth, as well as promoting insight into their motivations, intentions and behaviour. For example, understanding the meaning of sexual feelings may help therapists see when these defend against a range of feelings in themselves which may be intolerable, such as rage, disappointment, grief, hate or even love (Bridges, 1994; Celenza, 1991; Gabbard, 1994d, 1995). It has also been argued that the therapist's sexual countertransference shows his/her ability to engage with the client (Goldberger & Evans, 1985; Welles & Wrye, 1991; both cited in Russ, 1993).

It must be noted that the implication of these psychodynamic writings is that the therapist's sexual attraction and sexual feelings are only countertransference, and not as Pope et al. (1997) and others have highlighted, genuine emotional, cognitive and bodily experiences in the therapist.

However, despite this caveat, Pope et al. (1986) contend that:

> 'Taken as a whole, the literature indicates that the failure to acknowledge and examine countertransference blocks its therapeutic potential and unleashes destructive effects' (p. 149).

In summarising the rationales for investigating therapists' sexual attraction to their clients, it can be argued that a.) therapists' sexual feelings towards their clients are ubiquitous, normal and inevitable, b.) these sexual feelings can and do, at times, lead to sexual involvement c.) perhaps every therapist is potentially at risk for acting on his/her sexual feelings by becoming sexually involved with clients d.) there are other, often less tangible, negative consequences to denying or mismanaging such feelings e.) such feelings can inform the therapeutic process and be used to benefit the well being and growth of the client and f.) sexual feelings can be a source of growth for the therapist.

However, despite these compelling arguments for a deep and open exploration of therapists' sexual attraction to clients, this has not occurred. Disturbing in the face of the above discussion, is the argument advanced by many authors that 'our profession has neglected to prepare psychologists for the intimate nature of the therapy process, and the sexual feelings and attraction that are normally experienced at some time in a therapist's career' (Folman, 1991, p.171).

Surprisingly little research has focussed on understanding the phenomenon of sexual attraction, and its relationship to sexual involvement. Until recently, there has been a strong tendency in the psychology profession to avoid or deny dealing with this issue. Tansey (1994) says that the profession of psychology has failed 'openly to acknowledge, examine, and understand erotic countertransference as it exists prior to its blatant enactment in the form of sexual transgression' (p. 141). The following section elucidates the reasons for a pervading 'veil of silence' that has, until recently, been drawn over the topic of therapists' sexual attraction to their clients.

2.12.2 A 'Forbidden Zone' – Why Therapists' Sexual Attraction to Client has been Taboo

Pope et al. (1986) postulate that sexual attraction is seen as a 'taboo', something to hide and be ashamed of rather than a natural phenomenon in human interactions, including psychotherapy. They argue that is partly attributable to the traditional psychoanalytic view of countertransference, still held by many today, that it is an impediment to psychotherapy which has to be overcome. Resistance to discuss the topic may also be attributed to erotophobia – the reluctance to discuss sexuality in general (Vasquez, 1988).

2.12.2.1 The Incest Taboo

The ability to openly debate and investigate the meaning of a therapist's sexual arousal, or attraction to his/her clients, may also be hampered by its link to the incest taboo. Many psychodynamically oriented authors argue that psychotherapy is analogous to the parent-child relationship and that sexual involvement is, therefore, tantamount to an incestual relationship (Feldman-Summers, 1989; Folman, 1991; Gabbard, 1994a; Hirsch, 1994; Tansey, 1994). From this perspective, therapists are likely to regard their sexual attraction to clients with fear and discomfort, if not horror, and be reluctant in the extreme to acknowledging it to themselves, let

alone to other professionals. This argument is persuasive, given that some authors have identified strong similarities between the effects on clients who have been sexually involved with therapists and victims of sexual abuse and incest (e.g. Pope, 1988; Pope & Bouhoutsos, 1986).

2.12.2.2 Confusing Sexual Attraction with Sexual Involvement

Pope et al. (1997) argue that the profession of psychology may be reluctant to broach the topic because therapists' sexual attraction to clients may have become associated with therapist-client sexual involvement, a topic which as discussed previously (Sections 2.2, 2.3 and 2.6) has received widespread condemnation and strong professional and legal censure. This situation could be exacerbated by the fact that virtually every article read for the present study discussed sexual attraction together with reports and descriptions of therapist-client sexual involvement.

2.12.2.3 Stereotypes: 'The Psychopathic Predator' and the 'Lovesick Therapist'

A further obstacle to open discussion of sexual feelings is the belief that therapists who become sexually involved with clients have severe psychopathology (Wolf, 1992, in Tansey, 1994), are predatory, sociopathic men who use their power to exploit vulnerable female clients; or are lonely, divorced, 'lovesick' males experiencing a mid-life crisis (Abel et al., 1995; Gabbard, 1994b; Strasburger et al., 1992). These stereotypes have a number of consequences. Firstly, they make it difficult for therapists striving to be 'good enough' to acknowledge sexual feelings when they arise, for fear of receiving pathological labels. Secondly, they can lead to a belief of 'it could never happen to me.' Both experienced and trainee psychologists may then conclude that sexual feelings will not lead to 'acting out' unless the therapist/trainee is male and has severe personality disturbances, and therefore do not warrant attention or thought. This further reinforces neglect of the topic. Closely linked to this factor, is the myth of invulnerability discussed previously (Section 2.12.1.4).

2.12.2.4 Other Factors Contributing to the 'Veil of Silence'

The following factors, highlighted by Pope et al. (1997), also contribute to the 'veil of silence'. Sexual attraction is a topic closer to therapists' direct experience (i.e. has more personal immediacy) than therapist-client sexual involvement. The majority of therapists do not become sexually involved with their clients, however, most have at some time been sexually attracted to clients (e.g. Pope et al., 1986; Rodolfa et al., 1994; Sehl, 1998). The

topic of sexual attraction may also highlight aspects of therapists which appear contradictory to their persona as an altruistic providers of help to those in need. Therapists may also be apprehensive that public research on sexual attraction may invite clients to ask direct questions about their feelings, which may evoke anxiety in the therapist. Therapists may also feel that openly acknowledging, and publishing works on, sexual attraction to clients may increase the likelihood that therapists will engage in sex with clients (i.e. the misconception that 'talking about it will make it happen'). Therapists may also be concerned that material on therapists' sexual feelings may be misinterpreted, misconstrued, or used without sensitive contextualisation. Openly addressing sexual attraction in training programmes may also be difficult for trainee therapists, as this requires a self-disclosure and openness that might elicit discomfort, fear of criticism or perception of personal inadequacy.

2.12.2.5 Ideological and Contextual Factors

Pope et al. (1997) argue that it is important for therapists to be cognisant of contextual factors such as age, gender and race which may influence how and whether they will feel sexually attracted to a client. In addition, society's perceptions and attitudes towards these factors are likely to play a role in how the individual therapist thinks about, interprets, and responds to his/her sexual feelings towards the client. For example, Bridges (1994) contends that sexual feelings may be difficult for therapists to acknowledge if they cross age or sexual orientation boundaries (e.g. an older female therapist being attracted to a much younger male client; or a heterosexual male therapist who feels sexually attracted to a male client).

2.12.2.6 Resistance by Educators/Supervisors to Address Sexual Issues

As discussed previously (Section 2.11.5.1) it is also argued by many authors that the attitude of supervisors/educators is an important factor in whether therapists discuss their sexual feelings toward clients (e.g. Folman, 1991). However, studies have show that supervisors are perceived to be uncomfortable with, and resistant to, discussing sexual issues in psychotherapy, including trainee therapists' sexual feelings towards clients (Folman, 1991; Hamilton & Spruil, 1999). Hamilton and Spruil (1999) further assert that supervisors may hold the misconception that competent, well-adjusted therapists can avoid, control or contain sexual feelings without the need for supervision. Supervisors holding such a belief are likely to be unwilling to make self-disclosures about their own experiences of sexual feelings. Without such 'normalising' information, trainees will continue to regard sexual feelings as rare and ominous

signs of a troubled relationship. In a recent survey of Canadian psychiatry residents, Blackshaw and Patterson (1992) found that while 85% of respondents thought that it was normal to experience sexual feelings towards clients, and 80% of these agreed it was important to discuss these feelings in supervision, 45% percent did not do so (cited in Hamilton & Spruil, 1999). This is an important finding, given that many codes of ethics and guidelines state that psychologists need to obtain assistance for problems which might reduce their ability to benefit and not harm others, including such measures as obtaining professional consultation (e.g. APA, 1992; CPA, 1991). Canter, Bennett, Jones and Nagy (1994) have also recommended that psychologists seek consultation if they are considering a sexual relationship with a former client. As discussed, intense sexual attraction does lead, in some cases, to sexual involvement and failure to seek consultation and/or supervision may therefore be contributing to sexual transgressions. However, Pope (1993) points out that supervision does not necessarily prevent therapist-client sexual involvement. He cites cases where therapists have become sexually involved with clients while receiving close and direct supervision conducted by experienced and skilled supervisors.

2.12.2.7 Unrealistic Expectations of a Therapist

In addition, training programmes specifically, and the profession of psychology generally, may implicitly or explicitly convey to students and qualified therapists the impression that they must be 'paragons of mental wellness'. Such unrealistic expectations may create a climate in which therapists and therapists in training are afraid to talk to colleagues and supervisors about their sexual feelings towards clients.

2.12.2.8 Theoretical Orientation

According to Hamilton and Spruil (1999), the psychodynamic school is the only theoretical orientation to provide a set of constructs for understanding therapists' sexual feelings for their clients as a normal and predictable part of the psychotherapy process. However, the recent trends towards briefer and more problem-focussed approaches to psychotherapy have led to a decline in discussions of transference and countertransference (e.g. Gutheil, 1989; Rao et al., 1997, both cited in Hamilton & Spruil, 1999). Furthermore, there are many therapists for whom these constructs are incompatible with their theoretical orientation. This situation leaves a significant number of therapists, supervisors, educators and trainees with no theoretical basis for discussing sexual feelings in psychotherapy.

2.12.2.9 Ambiguous, Complex Nature of Sexual Attraction

In addition, the topic of the therapist's sexual attraction to clients is not as clear-cut as therapist-client sexual involvement (Pope et al., 1997). In the latter case, ethical guidelines are unambiguous – sexual involvement with clients is considered to be taboo. The phenomenon of sexual attraction, however, is complex, variable, unpredictable and ambiguous, and may be much less likely to lead to a sense of closure, conclusion or confidence about what will follow.

2.12.2.10 Lack of Concrete Guidelines for Managing Sexual Attraction

Outside the psychodynamic literature, there are few concrete guidelines by which therapists can understand the meaning and implications of the experience of their sexual attraction to clients. Bridges (1994) argues that while therapists *know* that sexual contact between therapist and client is prohibited by ethical standards, there are very few guidelines for helping them decide when to deal with their sexual feelings by interpreting them, ignoring them, normalising them or using them. As a result professionals and educators are in the process of developing such guidelines (e.g. Edelwich & Brodsky, 1991; Gorkin, 1987; Steres, 1992; all cited in Bridges, 1994; Folman, 1991). As far as the present author is aware, the only published book to date which specifically explores the issue of therapists' sexual feelings towards clients is the recently published work by Pope et al. (1997). Such guidelines seem overdue and imperative, given that therapists' sexual attraction to clients requires that they construct anew with each experience the meaning and causes of their attraction. They have to evaluate a wide range of possible meanings. For example, 'Do my sexual feelings suggest something is amiss in psychotherapy? Do I have unresolved sexual problems? Do my sexual feelings signal a sign of a more healthy integration in my client? Are they communicating vital information about my client's internal world? Are they suggesting I am at risk for becoming sexually involved?' The possibilities are infinite and seem to require of the therapist a depth of understanding, personal awareness and discernment in deciphering the often complex and variable meanings. For in the final analysis, the meaning of the therapist's sexual feelings can never be adequately understood apart from the individual therapist and client, the unique dynamics of their therapeutic relationship and the history and context in which it is embedded.

As the above discussion highlights, there is a real need to better understand the phenomenon

of therapists' sexual attraction to clients. Some researchers have begun to empirically investigate the incidence, experience and management of therapists' sexual attraction to clients. The review now focuses on these recent developments.

2.13 ENTERING THE 'FORBIDDEN ZONE' – RESEARCH ON THERAPISTS' SEXUAL ATTRACTION TO CLIENTS

The professional research silence about therapists' sexual feelings for their clients continued until 1986 when Pope and his colleagues conducted the first anonymous survey to investigate psychologists' sexual attraction to clients.

2.13.1 Incidence of Sexual Attraction to Clients

In the Pope et al. (1986) study, 95% of male psychologists and 76% of female psychologists reported that they had been sexually attracted to their clients, at least on occasion. The last decade has seen a renewed, albeit limited, interest in this topic. All of the few subsequent surveys that have investigated therapists' sexual attraction to clients report that the vast majority of subjects have been sexually attracted to clients, at least occasionally. Percentages of respondents who reported sexual attraction range from 80% to 88% (Bernsen et al., 1994; Blanchard & Lichtenberg; 1999; Pope et al., 1987; Pope & Tabachnick; 1993; Rodolfa et al., 1994; Sehl, 1998; Stake & Oliver, 1991). Two of these studies surveyed social workers indicating that the experience of sexual attraction to clients is not confined to psychologists. However, it is interesting and noteworthy that the only South African study to include a question about psychologists' sexual attraction to clients reported a much lower rate of attraction (59%) (Trent & Collings, 1997). In all studies only a minority of subjects reported that they had acted on their sexual attraction by becoming sexually involved with clients, although more males than females do (9.4% of males and 2.5% of females in the Pope et al. (1986) study; 3.6% of males and 0.5% of female subjects in the Bernsen et al. (1994) study and 5.5% of males and 2.16% of females in the Rodolfa et al. (1994) study). These results confirm the gender bias discussed in the review of literature (more males than females act on their attraction) and the trend towards lower reported incidence of therapist client sexual involvement.

2.13.2 Gender Differences in Sexual Attraction to Clients

As discussed previously (Section 2.6.5.1) more males than females report sexual involvement

with their clients. This same gender bias is evident in research on therapist's sexual attraction to clients. These studies all show that more males than females report sexual attraction to clients (Housman & Stake, 1999; Pope et al., 1986; Rodolfa et al., 1994; Sehl, 1998; Stake & Oliver, 1991; Trent & Collings, 1997).

2.13.3 Emotional Response to Sexual Attraction

An interesting finding, and one that bears out the argument in literature review (Section 2.12.1.3), is that many subjects report feeling concerned about their sexual attraction to clients. In the Pope et al. (1986) study, 63% reported feeling guilty, anxious or confused about the attraction, while 55% of respondents in the Rodolfa et al. (1994) study reported these feelings. Rodolfa, Kraft and Reilley (1987) also reported that therapists experienced their sexual attraction to clients to be stressful (cited in Rodolfa et al., 1990). Therapists' concern and anxiety about their sexual attraction to clients may be partly attributable to the taboos surrounding the topic discussed previously (Section 2.12.2). Also as noted, therapists' anxiety about their sexual attraction has potentially serious implications for the psychotherapeutic process. Whether males and females differ in their emotional response to their sexual attraction was investigated in four of these studies (Blanchard & Lichtenberg, 1999; Pope et al., 1986; Rodolfa et al., 1994; Trent & Collings, 1997). Findings are contradictory. While the Pope et al. and Rodolfa et al. studies found no significant differences between males and females in their feelings of discomfort, guilt or anxiety, Blanchard & Lichtenberg (1999) found that males felt more self-assured and less discomfort and general negativity about their sexual attraction than did females. In the Trent and Collings study, 21.4% of males said they were concerned about the attraction while only 7.4% of females reported concern. This result needs to be interpreted with caution, however, given the different wording of the question. However, it does suggest that more research is required to investigate whether male and female therapists differ in their emotional response to their sexual attraction to clients.

2.13.4 Assessment of the Impact of Sexual Attraction on the Psychotherapy Process

Pope et al. (1986) and Rodolfa et al. (1994) investigated how therapists perceive their sexual attraction to have impacted on the psychotherapy process. In the former study 69% of subjects said that their sexual attraction had been beneficial in at least some instances, while 48% of subjects in the Rodolfa et al. study reported this to be the case. Again a gender bias is evident,

with males reporting more frequent perceived benefits than females. Sehl (1998), in his survey of clinical social work therapists, also reported that males were more likely than females to state that they had used their sexual feelings in the treatment process. Only one study asked respondents to indicate what they believed the perceived benefits to be (Rodolfa et al., 1994). These included greater empathy and greater awareness of transferential and countertransferential aspects of the therapeutic process. Subjects also reported that on occasion their sexual attraction to clients had been harmful or an impediment to the psychotherapy process (49.3% in the Pope et al. study and 43% in the Rodolfa et al. study). Harmful effects reported by Rodolfa et al. included feeling distracted from client issues, difficulty confronting clients, early referral or termination, or feeling overly involved with clients. Interestingly, in the South African study both males (76.2%) and females (70.4%) said that their sexual attraction had little or no effect on the psychotherapy process (Trent & Collings, 1997).

2.13.5 Management of Sexual Attraction

In those surveys which investigated how therapists managed their feelings of sexual attraction to clients, approximately half of respondents sought supervision and/or peer consultation (Blanchard & Lichtenberg, 1999; Housman & Stake, 1999; Pope et al., 1986; Rodolfa et al., 1994; Stake & Oliver, 1991). Few studies have investigated other ways of managing sexual attraction, apart from supervision and consultation (Blanchard & Lichtenberg, 1999; Pope et al., 1987; Stake & Oliver, 1991). The former authors reported that 75.4% of a sample of counselling psychologists registered with the APA introspected about their sexual attraction to clients, while in the Stake and Oliver (1991) study of a sample of psychologists from Missouri, USA, 69.5% said they worked through these feelings on their own. Whether these two constructs are comparable is questionable, however these findings suggest that a primary way of managing sexual feelings might be to keep them to oneself. Stake and Oliver (1991) and Pope et al. (1987) both reported that males are significantly more likely to disclose or discuss their feelings of sexual attraction with their clients than are females. Where subjects were asked their reasons for refraining from sexual involvement with clients, the most important cited were 'unethical' and 'countertherapeutic/exploitative' (Pope et al., 1986; Rodolfa et al., 1994).

In addition, as discussed previously (Section 2.11.3), those studies which investigated training about therapists' sexual attraction to clients, report that subjects have received either no or

inadequate graduate training on the topic (Bernsen et al., 1994; Blanchard & Lichtenberg, 1999; Pope & Tabachnick, 1993; Pope et al., 1986; Rodolfa et al., 1990; Rodolfa et al., 1994). There is some evidence to suggest that better training may facilitate an acknowledgement of and increased comfort with feelings of sexual attraction to clients. In the Blanchard and Lichtenberg (1999) study, of those who reported sexual feelings to clients, 62% felt that more training would have helped them cope better with their sexual feelings for clients. In addition, those who received adequate training on the topic felt more self-assured and confident when encountering sexual feelings for a client than did those who reported inadequate training. However, those who had received adequate training did not feel less discomfort or general negativity than those reporting inadequate training.

Interestingly, some studies have found that sexual attraction is perceived by some to be unethical. For example, Housman and Stake (1999) reported that 68% of trainee psychologists did not know that sexual feelings for clients were normal and not unethical. Interestingly, this was the only USA study with a lower reported incidence of sexual attraction (50%), suggesting that if a therapist or trainee therapist thinks sexual attraction is unethical they may be more unlikely to acknowledge or report it. In the Pope et al. (1987) study, 1 out of every 10 psychologists believed that being sexually attracted to a client was unethical.

A few cautionary notes need to be made about the interpretation of and inferences that can be drawn from these findings. Firstly methodological differences (e.g. different wording of questions and different rating scales) makes comparisons somewhat questionable. Secondly the sample populations vary markedly between studies. Also the South African study, as has been noted previously, employed a very small sample.

2.13.5.1 The Pope et al. (1986) Survey of Psychologists' Sexual Attraction to Clients

Given that the present study is based on that of Pope et al. (1986), additional findings of that study are discussed. These authors found that more younger than older therapists reported sexual attraction to clients. Those subjects who felt uncomfortable, guilty or anxious about their sexual attraction were more likely to seek supervision, as were those who had received at least some graduate training about sexual attraction to clients. These authors also report that the majority of subjects who had been sexually attracted to clients had never seriously considered sexual involvement with the clients. Most subjects did not have sexual fantasies about their clients,

although more males than females did. Most respondents believed that their clients were not aware of their sexual attraction to them, while most believe the attraction to be mutual.

As can be seen from the above discussion a number of questions remain unanswered, and will be addressed in the present study. Do males and females differ significantly in their emotional response to their sexual attraction to clients? Do South African psychologists experience (or report) less attraction than American ones? Do they perceive the attraction to have less impact on the psychotherapy process than do therapists in America? How do they manage their attraction?

2.13.6 Summary

Despite the increased research interest in sexual involvement between therapists and clients, very little empirical research has investigated therapists' sexual attraction to clients, which is argued to necessarily precede sexual involvement. This includes the extent to which therapists are sexually attracted to clients, how they respond to and manage such feelings, their rationales for doing so, how they evaluate the impact of their sexual attraction on the psychotherapy process and whether and how often they act on these feelings. In addition, research has shown that while sexual attraction is a widespread experience for therapists, graduate training programmes and clinical internships leave them almost entirely unprepared to deal with these feelings (Bernsen, et al., 1994; Pope et al., 1986; Rodolfa et al., 1990, Rodolfa et al., 1994). Also as discussed, there is a lack of a nationally endorsed set of ethical guidelines for South African psychologists to consult when faced with challenging ethical situations such as therapists' sexual attraction to clients.

In South Africa, only one study that the present researcher is aware of has addressed sexual involvement between psychologist and client (Trent & Collings, 1997), while none has looked specifically at therapists' sexual attraction to clients and the training they receive on this topic and other sexual issues and dilemmas in psychotherapy. Given that the above study employed a small sample, in addition to reporting a much lower incidence of therapists' sexual attraction than in studies in the USA, argues for further empirical research of South African psychologists' experience of this phenomenon.

2.14 AIMS OF THE STUDY

The present study aims to gather initial data about clinical psychologists' experience of sexual attraction to clients and whether local training programmes are perceived to be providing adequate education about this topic and about therapist-client sexual involvement. Given the controversy that rages around post-termination sexual involvement and other forms of touch in psychotherapy, the study includes an investigation of clinical psychologists' attitudes to these behaviours. As these topics are all related to issues of power, boundaries and ethics in psychotherapy, it was decided to combine them in the present study.

Such studies could contribute to a clarification and understanding of these topics and help inform theory, practice and teaching in this regard. It is hoped that the study will stimulate and inform open discourse and debate on the ethics of sex in psychotherapy, and more specifically, on the phenomena of psychologists' sexual attraction to clients. It may contribute to 'normalising' the experience of sexual attraction to clients, given the taboo, anxieties, and misunderstandings argued to surround the topic. Such research may be useful in informing the development of post-graduate curricula which address these issues constructively and effectively, and to develop strategies and programmes to reduce the risk of therapists acting on their feelings of sexual attraction by becoming involved with clients. It appears particularly relevant at a time of developing a new code of ethics for South African psychologists (Psy Talk, 1999; Wassenaar, 1998), and may contribute to the development of a code which in addition to protecting clients takes cognisance of the values and beliefs of psychologists.

This study, therefore aims to specifically investigate:

i. The incidence of South African clinical psychologists' sexual attraction to clients, including how they response to, manage and evaluate the impact of the attraction on the psychotherapy process.
ii. Clinical psychologists' evaluation of graduate training and internships in addressing the ethics of therapist-client sexual involvement and therapists' sexual attraction to clients.
iii. Clinical psychologists' attitudes to sexual involvement with current and former clients

and to other forms of touch in psychotherapy.

Of particular interest, based on the review of literature, is whether there are differences in responses based on the following variables: sex and age of the psychologist, recency of training, training in ethical issues, theoretical orientation, years in practice, and whether the psychologist attends personal therapy, supervision or both.

2.15 HYPOTHESES AND RESEARCH QUESTIONS

The following hypotheses derived from the literature reviewed were formulated to empirically address the above aims. Given that the present study is largely exploratory, additional research questions are also included.

2.15.1 Psychologists' Sexual Attraction to Clients

Hypothesis 1: Significantly more clinical psychologists than not will report sexual attraction to clients.

Hypothesis 2: Significantly more males than females will report sexual attraction to clients.

2.15.2 Psychologists' Emotional Response to their Sexual Attraction

Hypothesis 3: A significant percentage of clinical psychologists will report that their sexual attraction tends to make them feel uncomfortable, guilty or confused.

Hypothesis 4: Significantly more females than males will report that their sexual attraction to clients tends to make them feel uncomfortable, guilty or anxious.

Hypothesis 5: Significantly more clinical psychologists who report that their sexual attraction tends to make them feel uncomfortable, guilty or anxious will seek consultation/supervision, than those who report that their attraction does not tend to make them feel uncomfortable, guilty or anxious.

Hypothesis 6: Significantly more clinical psychologists who report adequate training will report that their sexual attraction does not tend to make them feel uncomfortable, guilty or anxious than those who report inadequate training.

2.15.3 Psychologists' Assessment of the Impact of Sexual Attraction on the Psychotherapy Process

Hypothesis 7: A significant percentage of clinical psychologists will report that their experience of sexual attraction benefited the psychotherapy process, at least on occasion.

Hypothesis 8: Males will report significantly more frequent benefits than females.

Hypothesis 9: A significant percentage of clinical psychologists will report that their sexual attraction to clients was harmful or an impediment to the psychotherapy process, at least on occasion.

2.15.4 Training about Therapist-Client Sexual Involvement and Therapists' Sexual Attraction to Clients

Hypothesis 10: The majority of clinical psychologists will report inadequate training about therapists' sexual attraction to clients and about the ethics of sexual involvement between therapist and client, or former client.

2.15.5 Additional Research Questions

In assessing subjects' experience of sexual attraction to clients, the study will investigate the incidence of clinical psychologists' sexual fantasies about current or former clients, whether subjects believe their sexual attraction to clients to be mutual, whether they believe the client is aware of the attraction, as well as their contemplation of sexual involvement with clients and actual sexual involvement.

In addition to the primary aim of the study - to investigate the incidence and experience of sexual attraction to clients and rating of training - the study is also interested in gathering additional data related to the primary hypotheses:

i. How clinical psychologists manage their feelings of sexual attraction to clients, i.e. what they do when attracted.

ii. The reasons clinical psychologists' give for refraining from sexual involvement when sexually attracted to clients.

iii. What ethics codes and guidelines clinical psychologists consult.

iv. Attitudes to sexual involvement with current and former clients and towards other forms of touch in psychotherapy.

v. Whether there are any circumstances in which clinical psychologists believe sexual involvement between therapist and client might be ethical.

vi. What factors clinical psychologists consider important in determining the ethicality of post-termination sexual involvement between therapist and client.

vii. What clinical psychologists consider an appropriate time interval, if any, after termination of psychotherapy before sexual involvement may begin. Based on the review of literature, it is expected that there will be divergence of attitudes.

3 CHAPTER 3: METHOD

3.1 RESEARCH DESIGN

Given the sensitive nature of the subject matter of the present study, it was decided to use an anonymous self-report survey research format. It is recognised that this method has many potential limitations such as low response rate, response and sample bias, untruthful respondents, the inability to check responses, and the fact that data gathered reflects reported and not actual behaviour (Kerlinger, 1986; Parten, 1950). However, the primary advantage of this method for the topic under investigation is that it is possibly the most effective way of gathering data of an ethically sensitive nature. It is also the standard method used for all previous research in this area (e.g. Pope et al., 1986; Pope & Tabachnick, 1993; Rodolfa, et al., 1994). It is also well suited to gathering exploratory data from a wide population which is not directly observable. The self-report questionnaire developed for this study is based on those used in previous studies to facilitate comparison of results. As the present study is exploratory and aimed at gathering initial data, it was decided to sample only registered clinical psychologists.

3.2 SUBJECTS

A random sample of 500 names and addresses of the 1614 clinical psychologists currently registered with the Health Professions Council of South Africa (HPCSA) was generated using the Statistical Package for the Social Sciences (SPSS). The original list excluded interns and students. 15 of the original sample were no longer residents in South Africa, and due to cost constraints and logistical considerations these names were removed from the list. A total of 485 questionnaires were, therefore, mailed. An envelope with a 'free-post' label was included to facilitate a higher response rate, as was a covering letter outlining the purpose of the study and requesting participation in the study. (A copy of the covering letter is included in Appendix A). Given the sensitive nature of the topic, potential participants were ensured that all information obtained in the study would be treated as totally confidential and remain anonymous. They were advised that no identifying details were required on the questionnaire.

3.3 SURVEY QUESTIONNAIRE

A structured 3 page self-report questionnaire comprising four sections with 39 questions was sent to subjects. The questionnaire is based on those studies reviewed in Section 2.12.3, and in particular the Pope et al. (1986) study. It employed a tick-response format with brief open-ended questions. A copy of the questionnaire is included in Appendix B.

Section 1. Demographic Details: Items in this section were drawn from a range of studies (e.g. Garrett & Davis, 1994; Pope et al., 1986) to elicit relevant information on subjects' personal and professional circumstances. Included are: sex, age, marital status, sexual orientation, years of professional experience, practice setting, types of clients, proportion of long and short term clients, theoretical orientation, and whether or not the therapist is undergoing his/her own personal therapy, supervision or both. It includes items related to training e.g., year of first registration, highest qualification, and university of origin at which post-graduate training was undertaken.

Section 2. Sexual Attraction: This section is based on the Pope et al. (1986) study to investigate subjects' experience of and response to their sexual attraction to clients. Subjects were asked if they had ever been sexually attracted to a client. Those who had were asked how often they have felt sexually attracted to female and male clients on a three-point Likert scale: rarely, (once or twice), occasionally, (3-10 times) or frequently (more than 10 times). An additional question asked subjects how they managed the sexual attraction (i.e. 'In those instances in which you have felt sexually attracted to a client, what have you done?' (Section 2, Question 12). The options presented to subjects were those used in the study by Stake and Oliver (1991), with the addition of 'sought peer consultation' and 'other'. Why, if relevant, subjects' chose to refrain from acting on their attraction by becoming sexually involved with clients was also investigated. It was decided to present respondents with a list of choices based on the reasons volunteered in the Pope et al. (1986) study. The rationale was to keep the questionnaire as short as possible to encourage a higher response rate, and to facilitate comparison with results of that study. The disadvantage of this is that the study was not able to assess whether these responses would have been volunteered by subjects without a forced choice.

Also included were how subjects experienced the attraction (i.e. whether it tended to make them feel uncomfortable, guilty, anxious or not) whether the client was aware of the psychologist's sexual attraction and whether they perceived it as mutual; the perceived impact of the attraction on the psychotherapy process; the incidence of sexual fantasies about clients; whether therapists had ever seriously considered sexual involvement with a client; and incidence of actual sexual involvement with clients. For the purposes of the present study, sexual involvement was defined as 'contact which was intended to arouse or satisfy sexual desire in the patient, therapist or both' (Gartrell et al., 1986). This definition was chosen over others as it encompasses a broader range of behaviours than intercourse or direct genital stimulation, and in addition includes the factor of intent.

Section 3. Training: This additional section was included to investigate, in more detail, subjects' evaluation of their training in sexual issues in the field of ethics. Subjects were asked to indicate on a 4–point Likert scale the amount of training they received in their post-graduate training and internship on therapists' sexual attraction to clients and on the ethics of sexual involvement between therapist and client or former client (1= 'no such education' and 4= 'adequate education'). They were asked whether they felt their training was useful in helping them to make informed decisions about sexual involvement with clients. If subjects perceived their training to be inadequate, they were asked to indicate, in a brief open-ended question, what they believe would constitute adequate training. They were also asked whether they believe education about therapists' attraction to, and sexual involvement with, clients and former clients should be a required part of the training curriculum for clinical psychologists, as well as to state what ethical codes or guidelines they consult.

Section 4. Attitudes to sexual involvement with current and former client and to others forms of touch: This section, an addition to the Pope et al. (1986), assessed subjects' attitudes to touch in psychotherapy, and to sexual involvement with both current and former clients. It includes questions based on the work of Akamatsu (1988), Glaser and Thorpe (1986), Stake and Oliver (1991) and Thoreson et al. (1993, 1995). Separate ratings were employed to explore whether there are differences in therapists' attitudes regarding the variables of ethicality and harmfulness. Respondents were asked to indicate on a 5-point Likert scale:

a.) How ethical they deem a variety of forms of physical touch and sexual involvement, where 1

= 'never ethical' and 5= 'always ethical' and

b.) The perceived harmfulness of these same behaviours, where 1 = 'always harmful' and 5 = 'never harmful').

Respondents were also asked if there were any circumstances in which sexual involvement with clients may be appropriate and what factors, if any, they perceive as being important in determining the ethicality of sexual involvement between therapists and former clients. The latter items were based on those used in the Akamatsu (1988) study. Finally, subjects were asked how long after termination of psychotherapy sexual contact might be appropriate, if at all.

Section 5. This section gave subjects the opportunity to volunteer further information or comments.

3.4 STATISTICAL ANALYSES

Results in the following chapter were computed using Microsoft Excel spreadsheet and SPSS (version 97 for Windows). Non-parametric statistical tests (Chi-Square and Mann Whitney) were conducted as the primary test of significance as these are almost as powerful as parametric tests and do not call for as restrictive a set of assumptions as do parametric statistics (Kerlinger, 1986). Particularly relevant for the present study is the assumption of normal distribution. They are also recommended in cases where N>30 (Runyon, 1977). Pearson product moment correlation's were performed to test whether there were significant associations between ethicality and harm ratings of sexual involvement with current and former clients and other forms of touch in psychotherapy. A Mann Whitney test was performed to investigate whether males and females differ in their attitudes to the former behaviours.

4 CHAPTER 4: RESULTS

This chapter will summarise demographic data and the results of data analysis as detailed in Section 3.4. The discussion of these results is presented in chapter five.

4.1 DEMOGRAPHIC CHARACTERISTICS

Questionnaires were returned by 112 subjects, a 23.09% return rate. One male returned an uncompleted protocol, reporting that he was retired and had not practised as a psychologist for many years. There were, therefore, 111 useable protocols. Although many protocols had incomplete sections and missing data, all were used given the few respondents.

Of the subjects who responded, 43 (38.7%) were male and 68 (61.3%) were female. As the median age was 39 (Range 25-85; SD = 9.6), for the sake of descriptive convenience it was decided to designate subjects 38 years of age and under as 'younger psychologists' and those 39 years and older as 'older psychologists'. 33.3% (n=37) of the sample were younger females, 28% (n=31) were older females, 15.3% (n=17) were younger males and 23.4% (n=26) were older males.

Most were married (64%, n= 71), while 12.6% were single (n= 14), 13.5% were in a stable relationship (n=15), 9% were separated or divorced (n= 10) and 0.9% were widowed (n= 1).

The majority of subjects described their sexual orientation as heterosexual (n=98, 88.3%), while 7.2% (n=8) stated they were homosexual and 4.5% said they were bisexual (n=5). A Masters degree was completed by 84.6% of subjects (n=94), while 14.4% (n=16) had also completed a doctoral degree. One subject omitted this question. More than half of the subjects (n= 58, 52.3%) currently attend supervision, while 82 (73.9%) had in the past attended, or currently attend, personal therapy.

Subjects were asked to indicate the three theoretical orientations that most influence their practice. The results for this question are given in Table 1 as percentages of subjects acknowledging influence of each theoretical orientation.

Table 1

Theoretical Orientation: Percentages Acknowledging Influence of Given Orientation (n=111)

Theoretical Orientation	First Influence	Second Influence	Third Influence
Psychodynamic/Analytic	37.8	11.7	12.6
Systemic	18	14.4	7.2
Eclectic	18	10	13.5
Cognitive	11.7	18	9
Humanistic	8.1	8.1	10.8
Other	6.3	3.6	1.8
Behavioural	2.7	9	14.4

Most subjects indicated that they spent the majority of their time working with adults (78.4%, n=87), followed by children (12.6%, n=14), other (6.3%, n=7) and neuropsychology (2.7%, n=3). Other areas indicated were substance dependency (n=2), lecturing (n=1), spiritual (n=1), medical psychology (n=1), consultation (n=1) and assessment of gay clients (n=1).

Subjects were asked to specify their main work setting. If more than one, they were asked to rank order these where 1= 'most time spent', 2= 'next most time spent', etc. These results are presented in Table 2 as percentages of subjects indicating each work setting.

Table 2

Main Work Setting (n=111)

	Percentage of Respondents				
Setting	**1**	**2**	**3**	**4**	**5**
Private Practice	64.9	20.7	1.8	0.9	
Health Services	18.9	7.2	0.9	0.9	
Other	7.2	3.6			
University	5.4	5.4	3.6		
Social Services	0	2.7	1.8		
Voluntary Agency	0	2.7	0.9		1.8

(Note: 1= most time spent; 5 = least time spent)

Most time is spent in private practice (64.9%, n=72), followed by health services (18.9%, n=21), other (7.2%, n=8) and university (5.4%, n=6). Cited as 'other' were education (n=3), public sector (n=2), corporate (n=2) and correctional services (n=1). No subjects cited voluntary agencies or social services as their main work setting.

The earliest year of first registration, was 1970, while the most recent was 1999 (mean 1992). The median number of years in practice since qualifying was 8 (Range 0-27, SD=6.64). Eighteen universities were represented and almost half the subjects were trained at the following four universities: Rand Afrikaans University (14), Unisa (13), Pretoria (12), and University of Natal, Pietermaritzburg (11).

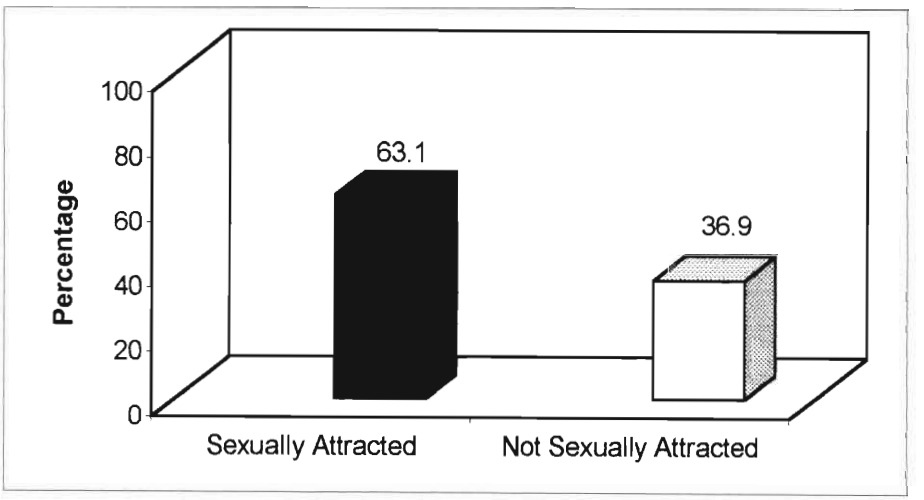
4.2 CLINICAL PSYCHOLOGISTS' SEXUAL ATTRACTION TO CLIENTS

4.2.1 Incidence of Sexual Attraction to Clients[13]

Hypothesis 1: As expected, significantly more subjects than not (63.1%, n=70) reported that they had been sexually attracted to clients, at least on occasion (Chi-Square = 1, 7.577, p= .006). Only 41 respondents (36.9%) reported never having been sexually attracted to any client. Figure 1 presents percentages of all subjects who were and were not sexually attracted to clients.

Figure 1

Sexual Attraction to Clients –All Subjects (n=111)



[13] Following the lead of Pope et al. (1986) in all one-variable cases with two, or multiple categories, the expected frequencies for categories were treated as equal, which may not have been realistic.

4.2.1.1 Client Awareness of and Mutuality of Attraction

Subjects who had been sexually attracted to clients were asked: 'In instances when you were attracted to a client, was the client aware of it?' (Section 2, Question 5). More than half of the 69 subjects who responded (1 male did not answer) believed that the client was not aware of their attraction (n=38, 55.1%). Only 13% (n=9) thought clients were aware of the attraction, while 22 (31.9%) were unsure. The majority of subjects were not sure whether the client was also attracted to them (n= 41, 60.3%). Almost a third thought that the attraction was mutual (n= 21, 30.9%), while only 6 (8.8%) felt that their client was not also attracted to them. One male and one female did not respond. There were no significant differences between males and females on these variables as tested by Chi-Square analyses.

4.2.1.2 Sexual Fantasies about Clients

Subjects were asked: 'While engaging in sexual activity with someone other than a client, have you ever had sexual fantasies about someone who is or was a client?' (Section 2, Question 10). The significant majority of subjects (75.7%, n=53) reported that they had never had such fantasies (Chi-Square = 2, 59.171, p< .0005). Fantasies were reported rarely (once or twice) by 20% (n=14) and occasionally (3-10 times) by 4.3% (n=3) of subjects. No subjects reported that they had frequently (more than 10 times) had such fantasies. There were no significant differences between males and females on this variable (Chi-Square = 2, .581, p = .748), nor between younger and older subjects on this variable as tested by univariate analysis of variance, F (1) = .132, p = .717.

4.2.1.3 Contemplation of Sexual Involvement with Clients and Actual Sexual Involvement

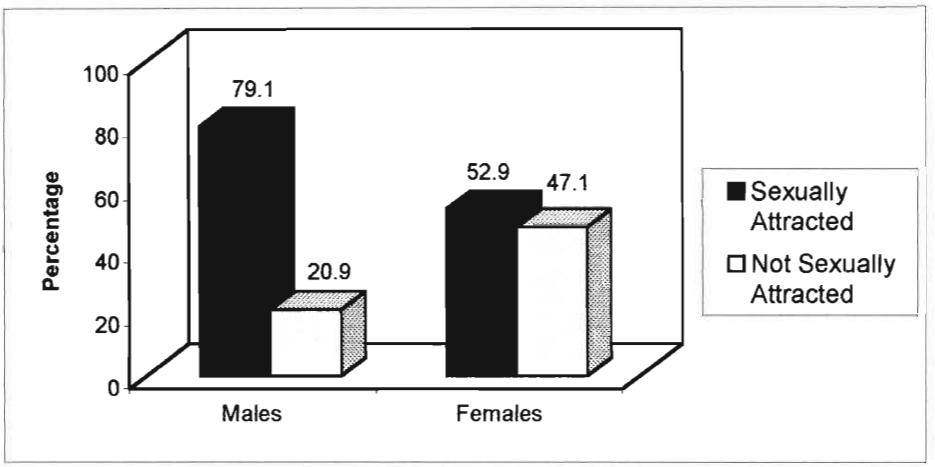
Of those subjects who reported sexual attraction to clients a significant majority (89.9%, n=62) had never seriously considered sexual involvement with a client (Chi-Square = 2, 99.739, p< .0005). Of those who had, 6 (8.7%) had rarely considered this, while only 1 (1.4%) respondent had considered this occasionally. There were no significant differences between males and females on this variable (Chi-Square = 2, 2.121, p = .346). One male omitted to respond. The vast majority of subjects (97.1%) reported that they had never become sexually involved with clients (Chi-Square = 1, 61.232, p< .0005). Sexual involvement with clients occurred rarely for 2.9% of the sample. Both subjects were males.

4.2.1.4 Gender Differences in Sexual Attraction to Clients

Hypothesis 2: As expected, significantly more males than females reported sexual attraction to clients (Chi-Square = 1, 7.721, p = .005). Figure 2 shows the percentages of male and female subjects who were and were not sexually attracted to clients.

Figure 2

Male and Female Subjects' Sexual Attraction to Clients (n=111)

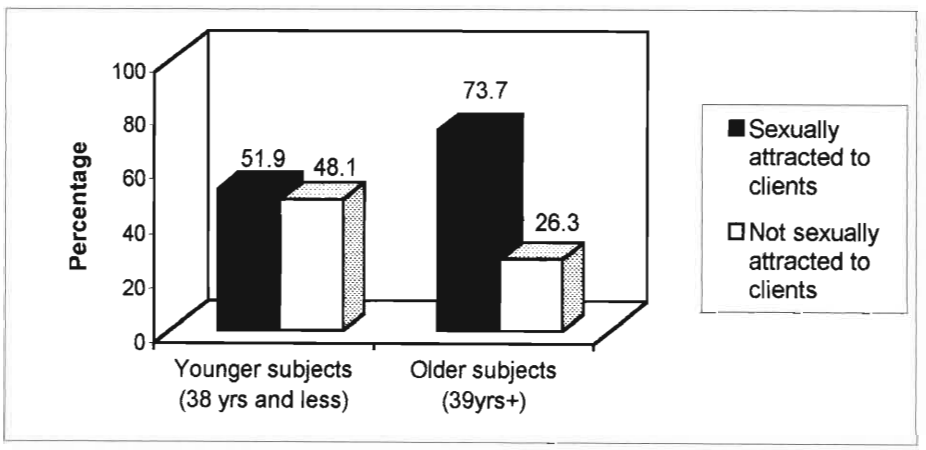


4.2.1.5 Age Differences in Sexual Attraction to Clients

Significantly more *older* than younger subjects reported sexual attraction to clients (Chi-Square = 1, 5.674, p = .017). Figure 3 shows the percentages of older and younger subjects who were and were not sexually attracted to clients.

Figure 3

Younger and Older Subjects' Sexual Attraction to Clients (n=111)



4.2.1.6 Sexual Attraction and Experience

It could be argued that younger and older subjects differ in amount of experience they have had in managing feelings of sexual attraction and that this might influence their reporting of sexual attraction. In order to investigate this possibility, for the sake of statistical convenience and based on frequencies of reported numbers of years in practice, subjects with 7 years or less in practice were defined as 'less experienced' and those with 8 years and more experience as 'more experienced'. A Chi-Square test revealed no significant differences in reported rate of sexual attraction between these two groups (Chi-Square = 1, 1.444, p = .229). This indicates that age is an independent variable from experience.

4.2.1.7 Sexual Attraction to Male and Female Clients

Table 3 presents frequencies of males and females sexually attracted to male and female clients.

Table 3

Subjects' Frequency of Attraction to Male and Female Clients (n=70)

	Attracted to Male Clients								Total	
	Never		Rarely		Occasionally		Frequently			
	N	%	N	%	N	%	N	%	N	%
Males	13	38.2	19	55.9	2	5.9	0	0	34	100
Females	1	2.7	29	80.6	6	16.7	0	0	36	100
	Attracted to Female Clients								Total	
	Never		Rarely		Occasionally		Frequently			
	N	%	N	%	N	%	N	%	N	%
Males	2	5.9	16	47	14	41.2	2	5.9	34	100
Females	16	44.5	17	47.2	3	8.3	0	0	36	100

Significantly more females than males are attracted to male clients (Chi-Square = 2, 14.324, p = .001), while significantly more males than females are attracted to female clients (Chi-Square = 2, 19.996, p<.0005).

4.2.1.8 Sexual Attraction and Theoretical Orientation

There were no significant differences in reported rates of sexual attraction between subjects of different theoretical orientations, as tested by Chi-Square analyses.

4.2.1.9 Sexual Attraction, Personal Therapy and Supervision

Significantly more subjects who have in the past attended, or currently attend, their own personal therapy, reported sexual attraction (84.3%) than those who have never undertaken personal therapy (p= .001). Table 4 presents this result.

Table 4

Sexual Attraction and Personal Therapy (n=111)

	Currently attend, or have in the past attended, personal therapy	Have never attended personal therapy	Total
Sexually Attracted	59	11	70
Not Sexually Attracted	23	18	41
Total	82	29	111

(Chi-Square = 1, 10.645, p = .001).

Significantly more subjects who attend supervision (60%), report sexual attraction than do those who do not (40%) attend supervision (p = .033). This result is presented in Table 5.

Table 5

Sexual Attraction and Supervision (n=111)

	Currently attend Supervision	Do not currently attend supervision	Total
Sexually Attracted	42	28	70
Not Sexually Attracted	16	25	41
Total	58	53	111

(Chi-Square = 1, 4.560, p=.033).

4.2.1.10 Sexual Attraction and Training

Subjects were asked: 'Was your training useful in assisting you to make informed decisions about sexual involvement with clients?' (Section 3, Question 3). Significantly more subjects who answered in the affirmative reported sexual attraction (66.7%) than did those who said that their training was not useful (p = .037). This result is presented in Table 6 below.

Table 6

Sexual Attraction and Usefulness of Training (n=93)

	Was your training useful in assisting you to make informed decisions about sexual involvement with clients?		Total
	Yes	No	
Sexually attracted	38	19	57
Not sexually attracted	31	5	36
Total	69	24	93

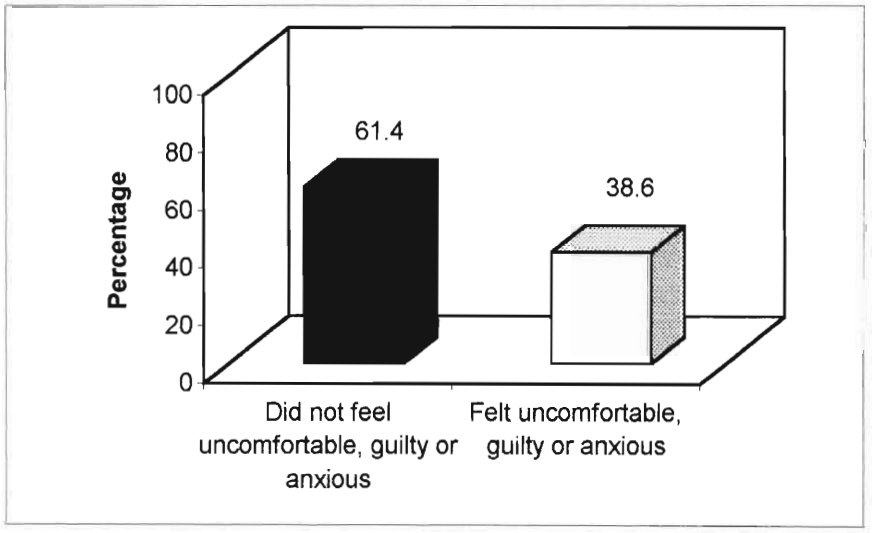
(Chi-Square = 1, 4.357, p=.037).

4.3 EMOTIONAL RESPONSE TO SEXUAL ATTRACTION

Hypothesis 3: Contrary to expected, most subjects (61.4%, n=43) who had been sexually attracted to clients reported that this experience *did not* make them feel uncomfortable, guilty or anxious, while 27 (38.6%) reported that it did. This result closely approached significance (Chi-Square = 1, 3.657, p = .056). Figure 4 presents subjects' emotional response to their sexual attraction expressed as percentages reporting feeling uncomfortable, guilty or anxious or not.

Figure 4

Emotional Response to Sexual Attraction (n=70)



4.3.1 Gender Differences in Emotional Response to Sexual Attraction

Hypothesis 4: As expected, significantly more females than males reported that their sexual attraction to clients made them feel uncomfortable, guilty or anxious ($p < .043$). Table 7 presents male and female subjects' emotional response to their sexual attraction, expressed as numbers and percentage of those reporting uncomfortable, guilty or anxious feelings or not.

Table 7

Male and Female Subjects' Emotional Response to their Sexual Attraction (n=70)

	Males		Females		Total
	N	%	N	%	
Not uncomfortable, guilty or anxious	25	73.5	18	50	27
Uncomfortable, guilty or anxious	9	26.5	18	50	43
Total	34	100	36	100	70

Chi-Square = (1, 4.086, p = .043)

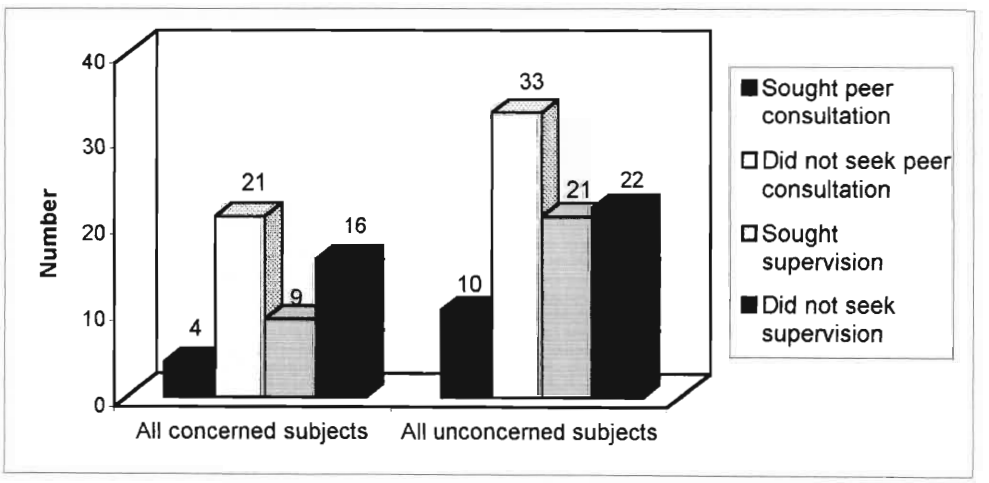
There were no significant differences between younger and older subjects (Chi-Square = 1, .814, p = .367), nor between less experienced and more experienced subjects (Chi-Square = 1, .000, p = .983) in their emotional response to their sexual attraction to clients.

4.3.1.1 Emotional Response to Sexual Attraction and Supervision and Peer Consultation

Hypothesis 5: Contrary to hypothesis, there were no differences in seeking consultation (Chi-Square = 1, .509, p = .476) and supervision (Chi-Square = 1, 1.057, p = .304) between those subjects who felt uncomfortable, guilty or anxious about their sexual attraction to clients and those who did not. However, fewer subjects who were concerned about their sexual attraction (i.e. those who said it tended to make them feel uncomfortable, guilty or anxious) sought supervision and peer consultation than those who were not concerned. This result was in the opposite direction to expectation. The number of concerned and unconcerned subjects who seek peer consultation and supervision are presented in Figure 5.

Figure 5

Number of Concerned and Unconcerned Subjects' who Sought Supervision and Peer Consultation (n=68)



4.3.1.2 Emotional Response to Sexual Attraction and Training

Hypothesis 6: As expected, significantly more subjects who reported adequate training about the ethics of therapist-client sexual involvement did not feel uncomfortable, guilty or anxious about their sexual attraction to clients than those who report inadequate training ($p = .029$). Subjects' rating of training about the ethics of therapist-client sexual involvement and their emotional response to sexual attraction are presented in Table 8.

Table 8

Training in Ethics of Therapist-Client Sexual Involvement and Subjects' Emotional Response to Sexual Attraction (n=58)

	Training about the Ethics of Therapist-Client Sexual Involvement				
	No Training	Very little	Some	Adequate	Total
	N	N	N	N	N
Feel uncomfortable, guilty or anxious	6	9	8	0	23
Do not feel uncomfortable guilty or anxious	10	8	7	10	35
Total	16	17	15	10	58

Chi-Square = 3, 9.029, p = .029)[14]

There were no significant differences in emotional response to sexual attraction between subjects who reported adequate training about therapists *sexual attraction* to their clients and subjects who reported inadequate training on this topic (Chi-Square = 3, 3.964, p = .265).

4.4 ASSESSMENT OF THE IMPACT OF SEXUAL ATTRACTION ON THE PSYCHOTHERAPY PROCESS

Hypothesis 7: Subjects were asked: 'Do you believe that your sexual attraction to a client has ever been *beneficial* to the therapy process?' (Section 2, Question 7). More subjects than not (58.2%, n=39) said that their sexual attraction had benefited the therapy process, at least occasionally. Contrary to expectation, this result was not statistically significant ($p > .10$). 28.4% said that their sexual attraction had rarely benefited therapy, 26.9% felt that it had been occasionally beneficial, while 3% said that it had frequently been beneficial. Subjects'

[14] Note: This result needs to interpreted with caution as one cell has an expected count less than 5.

assessment of the benefit of their sexual attraction to the therapy process is presented in Table 9 as numbers and percentages of respondents.

Table 9

Subjects' Assessment of the Benefit of Sexual Attraction to the Therapy Process (n=67)

Never Beneficial		Rarely Beneficial (once or twice)		Occasionally Beneficial (3-10 times)		Frequently Beneficial (more than 10 times)	
N	%	N	%	N	%	N	%
28	41.8	19	28.3	18	26.9	2	3

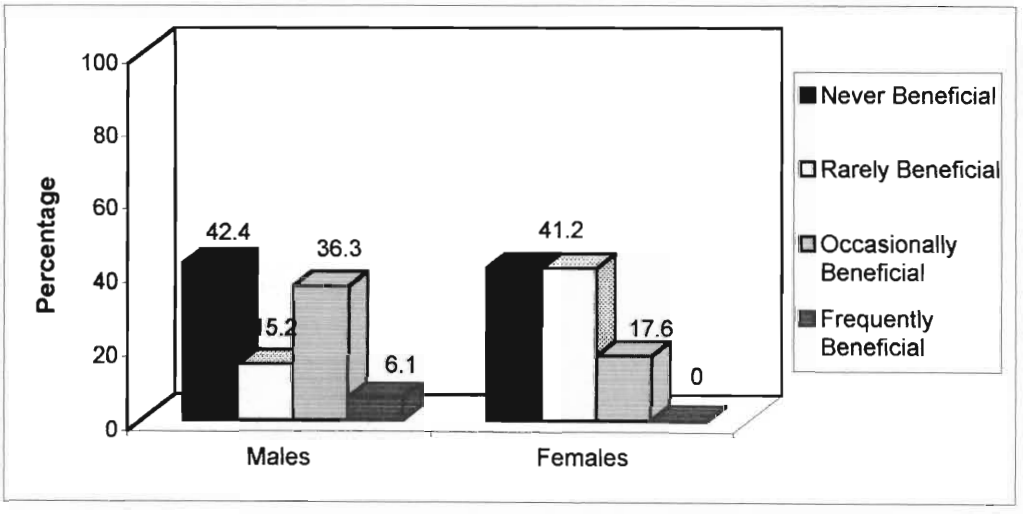
(Chi-Square=1, 1.806, p> .10). Note: for Chi-Square test, categories were collapsed into 'never beneficial' and 'beneficial', as the Chi-Square test with 3 degrees of freedom produced a misleading significant result.

4.4.1 Gender Differences in Assessment of the Impact of Sexual Attraction on the Therapy Process

Hypothesis 8: As expected, males reported significantly more frequent perceived benefit of their sexual attraction to the therapy process than did females (Chi-Square = 3, 8.250, p = .041). Male and female subjects' assessments of the benefit of sexual attraction to the therapy process are presented in Figure 6.

Figure 6

Male and Female Subjects' Assessment of the Benefit of Sexual Attraction to the Therapy Process (n=67)



Hypothesis 9: Contrary to expected, a significant majority of subjects (76.1%, n=51) reported that their sexual attraction to clients had never been harmful or an impediment to the therapy process ($p < .0005$). 13 (19.4%) felt it had rarely been harmful, while only 3 (4.5%) said that it had occasionally been harmful. No subjects of either gender reported that they perceived their attraction to have caused frequent harm. Table 10 presents subjects' assessment of the harm/impediment of sexual attraction to the therapy process expressed as numbers and percentages of subjects indicating each rating (2 females and 1 male did not answer).

Table 10

Subjects' Assessment of the Harm/impediment of Sexual Attraction to the Therapy Process (n=67)

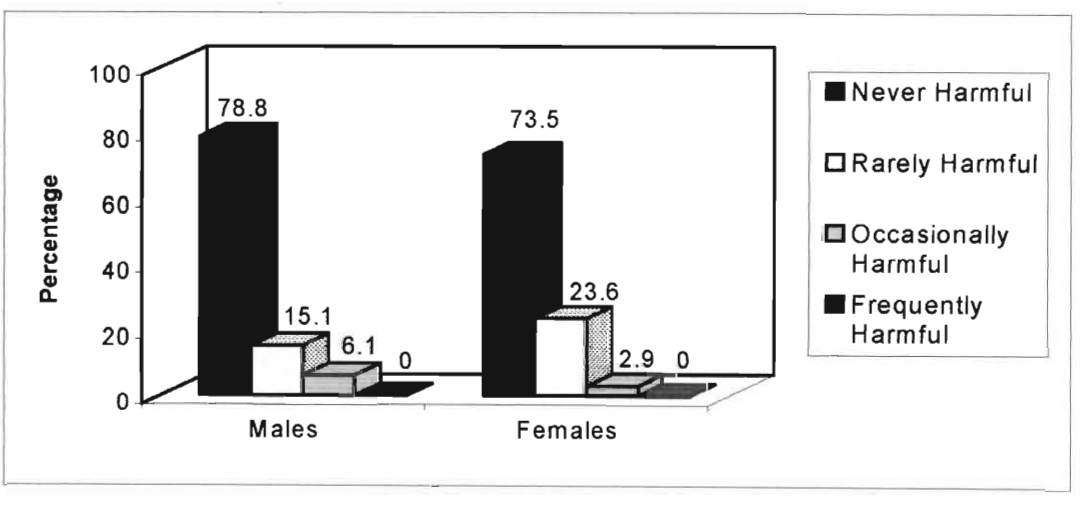
Never Harmful		Rarely harmful (once or twice)		Occasionally Harmful (3-10 times)		Frequently Harmful (more than 10 times)	
N	%	N	%	N	%	N	%
51	76.1	13	19.4	3	4.5	0	0

(Chi-Square = 3, 57.433, $p < .0005$).

Males and females did not differ significantly in their assessment of the harmfulness or impediment of sexual attraction to the therapy process (Chi-Square = 3, 1.031, p = .597). Male and female subjects' assessment of the harm/impediment of sexual attraction to the therapy process is presented in Figure 7 expressed as percentages of subjects indicating each rating.

Figure 7

Male and Female Subjects' Assessment of the Harm/impediment of Sexual Attraction to the Therapy Process (n=67)



4.5 MANAGEMENT OF SEXUAL ATTRACTION

Subjects were asked: 'In those situations in which you have felt sexually attracted to a client, what have you done?' (Section 2, Question 12). A checklist of 8 possible responses was provided and subjects were requested to check all the responses that apply to them. The percentages of subjects endorsing each option are presented in Table 11. Results of the study by Stake and Oliver (1991) are included for comparison. The options 'Sought peer consultation' and 'Other' were not included in the Stake & Oliver (1991) study.

Table 11

Subjects' Management of Sexual Attraction (n=69)

	% Endorsement	
Therapist Response	**Current Study (n=69)**	**Stake & Oliver (1991)**
Worked through feelings by oneself	68.1	69.5
Sought supervision	43.5	49.3
Discussed feelings with own therapist	34.8	18.8
Sought peer consultation	20.3	
Other	11.6	
Referred client to another therapist	10.1	22.1
Told Client, did not act on feelings	5.8	17.1
Told client and acted on feelings	1.4	1.3

Note: Percentages sum more than 100% as subjects were requested to tick all alternatives that applied to them.

The most frequently endorsed response in the present study was 'worked through feelings by oneself' (68.1%), followed by 'sought supervision' (43.5%). This was similar to results of the Stake and Oliver (1991) study. Of the 47 who had worked through feelings by themselves, 22 (46.8%) did so exclusively (i.e. 31.9% of the 69 subjects who responded), 16 (34%) also sought supervision, 10 (21.3%) also sought peer consultation, and 5 (10.6%) sought both peer consultation and supervision. 3 (4.3% of total) exclusively sought supervision, while 9 (13% of total) sought supervision *and* peer consultation. Of all respondents, 50.7% sought supervision and/or peer consultation. If those who also discussed feelings with their therapist are included, then 60.8% of all subjects sought help from others in managing their sexual attraction. See Appendix C for responses in the 'other' category (Section 2, Question 12).

4.5.1 Gender Differences in Management of Sexual Attraction

A Chi-Square test conducted to investigate whether males and females differ in their management of sexual attraction, found that significantly more males than females told clients about their feelings without acting on them (Chi-Square = 4.508, p = .034).[15] There were no other significant differences between males and females, although more males than females seek peer consultation, while more females than males discuss the sexual attraction with their own therapist. Table 12 presents male and female subjects' management of sexual attraction expressed as numbers and percentages of subjects endorsing each response.

Table 12

Male and Female Subjects' Management of Sexual Attraction (n=69)

	Males (n=33)		Females (n=36)	
	No.	%	No.	%
Worked through feelings by oneself	23	69.7	24	66.7
Sought supervision	13	39.4	17	47.2
Discussed feelings with own therapist	9	27.2	15	41.7
Sought peer consultation	9	27.2	5	13.9
Other	4	12.1	4	11.1
Referred client to another therapist	4	12.1	3	8.3
Told Client, did not act on feelings	4	12	0	0
Told client and acted on feelings	1	3	0	0

4.5.1.1 Reasons for Refraining from Sexual Involvement when Sexually Attracted

Subjects were asked to rank 14 reasons for refraining from sexual involvement when sexually attracted to a client, where 1= primary reason and 14= least important reason (8 females and 5 males did not answer). To assess subject's overall prioritising of reasons, counts of all priority given to each reason were summed and rank ordered. These results are presented in Table 13.

[15] Note: This result needs to be interpreted with caution as two cells had an expected count less than 5.

Table 13

Reasons for Refraining from Sexual Involvement – All Priority Given (n= 57)

Reason for Refraining from Sexual Involvement with Clients	Count	Rank	Percentile
Unethical	46	1	100%
Countertherapeutic/Exploitative	40	2	92.3%
Against my personal values	38	3	84.6%
Unprofessional Practice	37	4	76.9%
Disrupts handling of Transference/Countertransference.	21	5	69.2%
Attraction too weak or short-lived	19	6	61.5%
Already in committed relationship	17	7	46.1%
Common sense	17	7	46.1%
Damaging to me	13	9	38.4%
Self-control	10	10	30.7%
Fear of retaliation by client	7	11	15.3%
Fear of censure/loss of reputation	7	11	15.3%
Fear of being sued for damages	6	13	7.6%
Other	4	14	.0%

(Note: Counts sum more than total subjects as some subjects gave highest priority to more than one reason.

The above ranking includes reasons that were given low or no priority by subjects. Therefore, only reasons given the *highest* priority are ranked in Table 14. These results indicate what subjects deem to be the most important reasons.

Table 14

Reasons given the *Highest* Priority for Refraining from Sexual Involvement (n= 57)

Reason	Count	Rank	Percentile
Unethical	24	1	100%
Against my personal values	17	2	92.3%
Countertherapeutic/exploitative	12	3	84.6%
Unprofessional practice	6	4	76.9%
Disrupts handling of Transference/Countertransference.	4	5	69.2%
Already in committed relationship	3	6	53.8%
Attraction too weak or short-lived	3	6	53.8%
Damaging to me	2	8	46.1%
Common sense	1	9	30.7%
Other	1	9	30.7%

The most important reasons for refraining from sexual involvement with clients is that such behaviour is unethical and countertherapetuic/exploitative. Fear of being sued for damages, fear of censure/loss of reputation, fear of retaliation by client, and self-control were not given *highest* priority by any subjects.

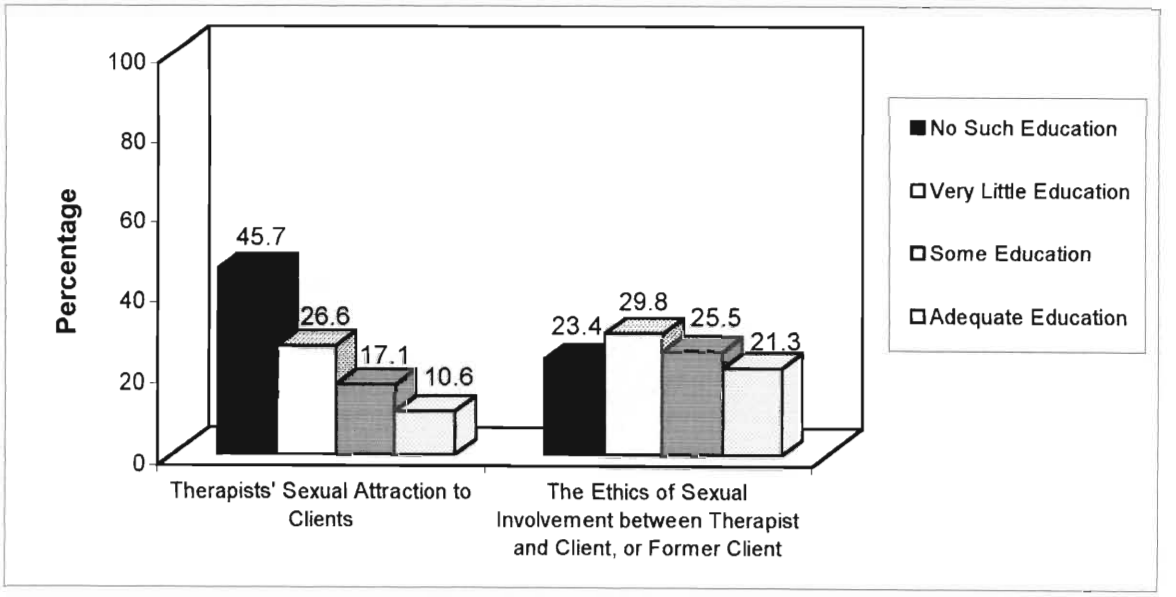
4.6 TRAINING ABOUT THERAPIST-CLIENT SEXUAL INVOLVEMENT AND THERAPISTS' SEXUAL ATTRACTION TO CLIENTS

Seventeen subjects (15.3% of total) did not complete the section related to training. Of the 94 subjects (84.7% of all subjects) who did, the following results were obtained.

Subjects were asked whether their post-graduate training/internship provided courses or other structured education about therapists' sexual attraction to clients, and about the ethics of sexual involvement between therapist and client or former client. They were requested to rate their training on a scale of 1-4, where 1 = 'no such education', 2 = 'very little education', 3 = 'some education', and 4 = 'adequate education'. Figure 8 presents these results expressed as percentages of subjects endorsing each rating.

Figure 8

Subjects' Rating of Training about Therapists' Sexual Attraction to Clients and the Ethics of Sexual Involvement Between Therapist and Client, or Former Client (n=94)



Hypothesis 10: As expected, the majority of subjects (72.3 %) reported either no education or very little education about therapists' sexual attraction to clients, 17.1% reported some education, while only 10.6% reported adequate education. Thus the more extensive the training, the fewer the subjects who had received it. (Chi-Square =3, 26.426, p< .0005).

Only 23.4% reported no education about the ethics of sexual involvement between therapist and client, 29.8% reported very little education, 25.5% reported some education on this topic, while 21.3% reported adequate education. The differences were not statistically significant (Chi-Square = 3, 1.489, p = .685). Training programmes and internships provide significantly more training about the ethics of sexual involvement between therapist and client (Mean = 2.45), than about therapists' sexual attraction to clients (Mean = 1.93). (t = -5.848, p = .0005).

4.6.1.1 Rating of Training by More Recently Trained and Less Recently Trained Subjects

In order to investigate whether more recently trained and less recently trained subjects differ in their rating of training, based on the mean and for the sake of descriptive convenience, those who qualified in 1991 or earlier were designated 'less recently trained', and those who qualified from 1992 onwards were designated 'more recently trained'. There were no statistically significant differences between the two groups in rating of adequacy of training about therapists' sexual attraction to clients (p = .404) or the ethics of sexual involvement between therapists and clients (p = .147). Tables 15 and 16 show more recently trained and less recently trained subjects' rating of their training on these topics.

Table 15

More Recently Trained and Less Recently Trained Subjects' Rating of Training about the Ethics of Therapist-client Sexual Involvement (n=91)

	No Training	Very little	Some	Adequate	Total
	N	N	N	N	N
Less recently qualified (1991 and before)	14	8	10	8	40
More recently qualified (1992 and later)	8	18	14	11	51
Total	22	26	24	19	91

(Chi-Square = 3, 5.372, p=.147).

Table 16

More Recently Trained and Less Recently Trained Subjects' Rating of Training about Therapists' Sexual Attraction to their Clients (n=91)

	No Training	Very little	Some	Adequate	Total
	N	N	N	N	N
Less recently qualified (1991 and before)	18	8	9	5	40
More recently qualified (1992 and later)	23	17	7	4	51
Total	41	25	16	9	91

Chi-Square = 3, 2.934, p = .404.

The majority of respondents (74.2%, n=93) said that their training was useful in assisting them to make informed decisions about sexual involvement with clients (Chi-Square = 1, 21.774, p< .0005). The vast majority (92.5%, n=93) also believe that education about therapists' sexual attraction to, and sexual involvement with clients or former clients should be a required part of the training curriculum for clinical psychologists (Chi-Square =1, 67.11, p< .0001). Eighteen subjects did not answer these two questions.

If subjects believed that their training was inadequate in addressing sexual issues in psychotherapy, they were asked to indicate, in an open-ended question, what they believe would constitute appropriate training. 37 subjects volunteered suggestions. These responses are presented in full in Appendix C (Section 3, Question 4). In summary, suggestions included experiential training (including group work, workshops, videos and role plays), structured formalised courses, training in maintenance of boundaries and transference and countertransference issues, ongoing supervision, case studies, open discussion and normalisation of sexual attraction.

4.6.1.2 Ethical Codes Consulted

Subjects were asked to state what ethical codes/guidelines they practice. 48 respondents (43% of the sample) did not answer the question. Responses of the 63 subjects who answered the question are rank ordered with percentiles in Table 17.

Table 17

Rank Ordering of Ethical Codes Consulted (n=63)

Ethical Code	Count	Rank	Percentile
Health Professions Council of South Africa (HPCSA)	20	1	100%
Other	13	2	92.8%
Professional Board For Psychology (PBP)	8	3	85.7%
Alfred Allan (1997) "The Law for Psychotherapists and Counselors"	6	4	71.4%
Jane Steere (1984) "Ethics in Clinical Psychology"	6	4	71.4%
Christian	5	6	57.1%
APA	5	6	57.1%
SA Code For Clinical Psychologists	4	8	50%
Canadian	2	9	35.7%
Psychoanalytic Principles	2	9	35.7%
American Association of Marriage & Family Therapists (AAMFT)	1	11	.0%
Licensed Professional Counselors (LPC)	1	11	.0%
APS	1	11	.0%
BPS	1	11	.0%
R.J Cohen	1	11	.0%

(Note: Total counts sum more than number of subjects as some subjects indicated more than one ethical code.

Most subjects consult the HPCSA (formerly SAMDC), 'other' codes or the PBP. Responses offered in the other category are presented in Appendix C (Section 3, Question 6).

4.7 ATTITUDES TO SEXUAL INVOLVEMENT WITH CURRENT AND FORMER CLIENTS AND TO OTHER FORMS OF TOUCH IN PSYCHOTHERAPY

Subjects were asked to rate on a scale of 1-5 how ethical and how harmful they deemed these behaviours to be, where 1= 'never ethical' and 'always harmful' and 5= 'always ethical' and 'never harmful'. All ratings of harmfulness and ethicality were found to be significantly correlated at the 0.01 level (2-tailed). Therefore, only ratings of ethicality are described. Table 18 presents a rank ordering of mean scores for each behaviour where 1= most ethical and 8= least ethical and Table 19 presents ratings for each behaviour with outcomes expressed as percentages of subjects endorsing each response.

Table 18

Rank Ordering of Mean Scores for Rating of Ethicality of Sexual Involvement with Current and Former Clients and other forms of Touch (n=95)

Behaviour	Rank	Mean Score	Percentile
Handshake	1	4.58	100%
Patting on arm	2	3.51	85.7%
Touching arm/shoulder etc.	3	3.13	71.4%
Holding hands	4	2.23	42.8%
Hugging	4	2.23	42.8%
Sexual involvement with a former client	6	1.46	28.5%
Kissing	7	1.19	14.2%
Sexual involvement with a current client	8	1.01	0%

(Note: higher mean scores = less unethical)

Table 19

Attitudes Towards Sexual Involvement With Current and Former Clients and to other Forms of Touch in Psychotherapy (n=95)

	Rating				
Behaviour	Never Ethical	Rarely Ethical	Occasionally Ethical	Frequently Ethical	Always Ethical
	%	%	%	%	%
Sexual Involvement with a current client	98.9	1.1	0	0	0
Kissing	83.2	12.6	4.2	0	0
Sexual Involvement with a former client	65.2	26.3	5.3	3.2	0
Holding hands	30.5	32.6	23.2	10.5	3.2
Hugging	28.4	28.4	35.8	6.3	1.1
Touching arm, shoulder etc	6.3	17.9	40	28.4	7.4
Patting on arm	3.2	14.7	28.4	35.8	17.9
Handshake	1.1	1.1	3.1	28.4	66.3

4.7.1 Sexual Involvement with a Current Client

Sexual involvement with a current client is considered to be the most unethical behaviour (Mean = 4.58). The majority of subjects (98.9%) believe that it is never ethical, only 1.1% of subjects believe it is rarely ethical, while no subjects believe it to be occasionally, frequently or always ethical.

1.1.1 Sexual Involvement with a Former Client

Sexual involvement with a former client is considered to be less unethical than with a current client (65.2%). 26.3% consider sexual involvement with *former* clients to be rarely ethical, 5.3% considers it to be occasionally ethical and 3.2% consider it to be frequently ethical. No subjects considered such relationships to be always ethical.

1.1.2 Attitudes to Other Forms of Touch in Psychotherapy

Handshake, patting on arm, touching arm/shoulder, holding hands and hugging are considered less unethical than kissing, sexual involvement with a former client and sexual involvement with a current client. Kissing is considered less ethical than sexual involvement with a former client. Subjects largely agreed that a handshake is ethical behaviour (more than two thirds of subjects 66.3% felt that it is 'always ethical'). The majority of subjects believe that kissing (83.2%) is never ethical. There was less consensus about hugging and holding hands. Hugging was considered rarely ethical by 28.4%, occasionally ethical by 35.8% and frequently ethical by 6.3%. Holding hands was considered by 63.1% to be never or rarely ethical, while 36.9% felt that it is occasionally, frequently or always ethical.

1.1.3 Gender Differences in Attitudes

A Mann-Whitney test was conducted to investigate whether males and females differ in their attitudes to sexual involvement with current and former clients and to other forms of touch in psychotherapy. Females rate sexual involvement with current clients as more harmful than do males ($U= 980$; $p= .015$). Males rate kissing as less unethical than do females ($U = 895.000$, $p = .032$), while females rate touching an arm or shoulder as more ethical than do males ($U = 722.5$, $p = .003$). While this result only approached significance, males rate sexual involvement with former clients as more ethical than do females ($U = 888.5$; $p< = .066$). Although not statistically significant, females rate sexual involvement with former and current clients as *more* unethical than do males, while they rate hugging and holding hands as *less* unethical and less harmful than do males. Table 20 presents males and females mean rank scores of rating of ethicality and harmfulness of sexual involvement with current and

former clients and other forms of touch in psychotherapy.

Table 20

Male and Female Mean Rank Scores of Rating of Ethicality and Harmfulness of Sexual Involvement with Current and Former Clients and other Forms of Touch in Psychotherapy (n=95)

Ethicality			
Behaviour	**Sex**	**N**	**Mean Rank Score**
Sexual Involvement with a current client	Male	39	48.72
	Female	56	47.50
Sexual Involvement with a former client	Male	39	53.22
	Female	56	44.37
Handshake	Male	39	51.64
	Female	56	45.46
Patting on arm	Male	39	42.38
	Female	56	51.91
Holding hands	Male	39	45.13
	Female	56	49.11
Touching arm/shoulder etc	Male	39	38.53
	Female	56	54.60
Hugging	Male	39	44.56
	Female	56	50.38
Kissing	Male	39	52.05
	Female	56	44.27
Harmfulness			
Behaviour	**Sex**	**N**	**Mean Rank Score**
Sexual Involvement with a Current client	Male	39	50.87
	Female	56	46.00
Sexual Involvement with a Former Client	Male	39	53.42
	Female	56	44.22
Handshake	Male	39	45.76
	Female	56	49.56
Patting on arm	Male	39	43.69
	Female	56	51.00
Holding hands	Male	39	46.41
	Female	56	49.11
Touching arm/shoulder etc	Male	39	42.64
	Female	56	51.73
Hugging	Male	39	46.19
	Female	56	48.43
Kissing	Male	39	50.67
	Female	56	45.35

Note: Higher mean scores = less unethical and less harmful.

This study included one question to investigate whether subjects believe that there are any circumstances in which sexual involvement with a current client might be appropriate. Of the 101 subjects who responded to the 8 options presented, 95 (94.1%) endorsed 'under no circumstances', while 6.9% (n=7) endorsed 'other'. No subjects believe that the following factors justify sexual involvement with current clients: 'enhancement of clients' self esteem', 'sexual dysfunction', 'corrective emotional experience', 'to change sexual orientation', 'to shorten grief reaction' or 'therapist in love with client'. Responses volunteered in the 'other' category are presented in Appendix C (Section 4, Question 3). In summary, most responses indicated that the only circumstance in which such involvement would be ethical is if therapy has been terminated.

Pearson correlations revealed no significant relationships between attitudes and theoretical orientation.

4.7.4.1 Factors Regarded as Important in Determining the Ethicality of Post-Termination Sexual Involvement with Clients

Subjects were asked: 'What factors do you regard to be important in determining the ethicality of sexual involvement between therapist and former clients?' (Section 4, Question 4). They were requested to tick as many of the 14 factors presented as applied. Of the 110 respondents who completed this question, 58 (52.7%) felt that sexual involvement with former clients is never appropriate. Of the remaining factors 'time since termination' was ranked highest – 47.3% of subjects endorsed this response. 'Mental health of the client' was considered by 32.7 % to be an important factor, while 'whether there has been harm to the client' was considered important by 31.8%. Table 21 presents the rank ordering of responses with percentiles.

Table 21

Factors Regarded as Important in Determining the Ethicality of Post-termination Sexual Involvement between Therapist and Client (n=110)

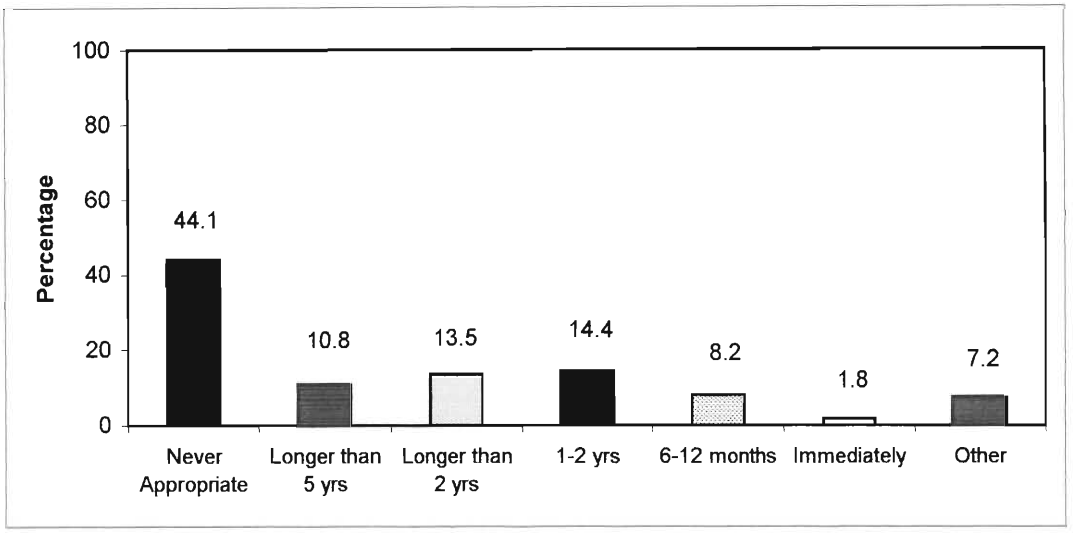
Factor	Count	Rank	Percentile
Never ethical	58	1	100%
Time since termination	52	2	91.6%
Mental health of client	36	3	83.3%
Whether there is harm to the client	35	4	75%
Nature of termination	30	5	66.6%
Transference issues	27	6	58.3%
Whether therapy will be reactivated	25	7	50%
Nature of therapy	24	8	41.6%
Freedom of Choice	23	9	25%
Reciprocity	23	9	25%
Whether exploitation occurred	22	11	16.6%
Length of therapy	17	12	8.3%
Other	8	13	0%

4.7.4.2 Time Interval Between Termination of Therapy and Sexual Involvement with Clients

Subjects were asked: 'What, if any, do you regard to be an appropriate time interval between termination of therapy and sexual involvement between therapist and client?' (Section 4, Question 4). Of the 8 options presented, 44.1% (n=49) said that it is 'never appropriate'; 'longer than five years' was endorsed by 10.8% of subjects (n=12); 'longer than two years' by 13.5% (n=15); '1-2 years' by 14.4% (n=16); '6-12 months' by 8.2% (n=9) and 'immediately' by 1.8% (n=2). 7.2 % (n=8) included other criteria. Figure 9 presents subjects' rating of an appropriate time between termination of therapy and sexual involvement between therapist and client (n=111).

Figure 9

Appropriate Time Interval between Termination of Therapy and Sexual Involvement between Therapist and Client (n=111)



The following responses were volunteered in the 'other' category (n=8): 'depends on the circumstances', 'depends on both parties to a large degree', 'the longer the better, preferably never', 'depends on therapy process', 'when involvement starts, therapy should stop – involvement may continue', 'time to me is one of the least important elements', 'depends on other factors, especially nature of therapy', 'proper open discussion between therapist and patient', and 'not sure'.

4.8 SUMMARY OF RESULTS

Before discussing the results in chapter five, a summary is presented of the results.

Demographic data indicate that more than half of the subjects were females (61.3%), most were heterosexual (88.3%) and most were married (64%). 51.4% were older (39 years +), while 48.6% were younger (>38 years old). The sample is predominantly psychodynamic/analytic in orientation, with a moderate systemic and eclectic influence. The primary work setting is private practice, followed by health services, while most subjects

worked with adults (78.4%). Many subjects attend supervision (52.3%) and personal therapy (73.9%). Mean years in practice was 9.28 years. A doctorate had been completed by 14.4%.

Sexual attraction to clients was reported by the majority of clinical psychologists in this sample (63.1%) at least on occasion ($p = .006$). Of those who reported sexual attraction, most were not sure if their sexual attraction was mutual (60.3%), while more than half believed that the client was unaware of the attraction (55.1%). The majority of subjects reported that they had never had sexual fantasies about current or former clients (75.7%, $p< .0005$), never seriously contemplated sexual involvement with a client (89.9%, $p<.0005$), nor become sexually involved with a client (97.1%, $p=< .0005$). Males and females did not differ significantly in their contemplation of sexual involvement. However while no females acted on their sexual attraction to clients, 2.9% of males rarely (once or twice) became sexually involved with a client.

More males (79.1%) than females (52.9%) reported sexual attraction to clients ($p = .005$), and more older (73.7%) than younger (51.9%) subjects reported sexual attraction to clients ($p = .017$). Significantly more males than females were attracted to female clients, and more females than males were attracted to male clients. More subjects who attend, or have in the past attended, their own therapy reported sexual attraction (84.3%) than did those who have never attended personal therapy ($p = .001$). More subjects who attend supervision reported sexual attraction (60%) than do those who do not currently attend supervision ($p = .033$). More subjects who felt their training was useful in helping them make informed decisions about the ethics of therapist-client sexual involvement reported sexual attraction (66.7%) than those who felt their training was not useful ($p = .037$). Experience and theoretical orientation were not significant variables in frequency of sexual attraction.

Contrary to expected most subjects who reported sexual attraction to clients did not feel uncomfortable, guilty or anxious (concerned) about the attraction (61.4%). This result approached statistical significance and was in the opposite direction to hypothesis ($p = .056$). More females (50%) than males (26.5%) reported that they were concerned about their sexual attraction to clients ($p = .005$). Although not statistically significant, subjects who were concerned about their sexual attraction to clients were less likely to seek supervision, or

consultation (36.8%) than those who were not concerned (63.2%). More subjects who reported adequate training about the ethics of therapist-client sexual involvement did not feel concerned about their attraction than those who reported inadequate training ($p = .029$).

More subjects than not indicated that their sexual attraction had been beneficial to the therapy process, at least on occasion (58.3%), although this result was not statistically significant. Males reported more frequent perceived benefit than did females ($p = .041$). The majority of subjects (76.1%) felt that their sexual attraction to clients had never harmed or been an impediment to the therapy process ($p < .0005$). Males and females did not differ significantly on this variable.

In managing their sexual attraction, the majority of subjects seek support from supervisors, peers and their own therapists in managing their attraction (60.8%), while 31.9% work through their feelings of sexual attraction exclusively on their own. While 12% of males told their clients about the attraction, no females did ($p = .034$). Although not statistically significant, females tended to discuss their sexual attraction with their own therapists while males tended to seek peer consultation. Ethical conduct and welfare of the client were more important reasons for refraining from sexual involvement with clients than fear of legal or professional consequences for the therapist.

As expected the majority of subjects (72.3%) reported very little or no training about therapists sexual attraction to clients ($p < .0005$). However, training about the ethics of therapists' sexual involvement with clients is rated as significantly more adequate (Mean = 2.44) than that about therapists' sexual attraction to clients (Mean = 1.92). This is probably why most subjects (74.2%) said that their training was useful in helping them to make informed decisions about sexual involvement with clients ($p < .0005$). There were no significant differences in rating of training between more recently and less recently trained subjects. Most subjects (92.5%) believe that education about therapists' sexual attraction to clients and about therapist-client sexual involvement should be a mandatory part of clinical psychologists' post-graduate training ($p < .0001$). Suggestions on appropriate training were volunteered. Many subjects do not to consult recognised and standard codes of ethics.

Sexual involvement with a current client is considered by the majority of subjects (98.9%) to

be always unethical. In addition 94.1% of subjects believe that there are no circumstances in which such contact might be appropriate. Sexual involvement with former clients, however is considered to be less unethical (65.2%) than with current clients. More than half of the sample (55.9%) felt that there were circumstances in which such contact might be appropriate. The factor regarded as most important in determining the ethicality of sexual involvement with former clients is time since termination, followed by the client's mental health, and whether the client was harmed. Subjects differ in their beliefs about what constitutes an appropriate time interval between termination of therapy and sexual involvement with clients, ranging from immediately (1.8%) to never (44.1%).

A handshake, patting on arm, touching arm/shoulder and hugging were considered more ethical and less harmful than kissing, and sexual involvement with current and former clients. However, kissing is rated as less ethical (Mean = 1.19) than sexual involvement with a former client (Mean = 1.46). Most subjects rate a handshake as always ethical (66.3%), and kissing as never ethical (83.2%). There is more variability in attitudes to hugging and holding hands. Females rate sexual involvement with current clients as more harmful than do males ($p = .015$), while males rate kissing as less unethical than do females ($p = .032$). Females rate touching an arm or shoulder as more ethical than do males ($p = .003$). Although not statistically significant, females generally regard sexual involvement with current and former clients to be more unethical and more harmful than do males. However, they tend to regard hugging and holding hands as more ethical and less harmful than do males. The importance of contextual factors in determining ethicality of touch in psychotherapy was volunteered by a number of subjects. Theoretical orientation was not shown to be a significant variable in attitudes.

5 CHAPTER 5: DISCUSSION

In this chapter results summarised in chapter four will be discussed in terms of the original hypotheses and research questions of this study and the literature reviewed in chapter two.

5.1 CLINICAL PSYCHOLOGISTS' SEXUAL ATTRACTION TO CLIENTS

5.1.1 Incidence of Clinical Psychologists' Sexual Attraction to Clients

Hypothesis 1: Given that a significant percentage (63.1%) of subjects reported sexual attraction to clients, at least occasionally, confirms the view that this is a fairly widespread and natural experience for clinical psychologists (Section 2.12.1.1 and Section 2.12.3.).

However, although the reported incidence of attraction was slightly higher than in a previous South African study (Trent & Collings, 1997), it was significantly lower than in all the other studies in the USA which were reviewed (Bernsen et al., 1994; Pope et al., 1986; Pope & Tabachnick, 1993; Pope et al., 1987; Rodolfa et al., 1994; Sehl, 1998). Whether fewer South African psychologists experience sexual attraction to clients than American ones, or simply report it less is not known. However, it could be speculated that South African psychologists are more conservative in disclosing information of a sensitive and sexual nature than American ones due to cultural differences. A number of subjects volunteered comments noting the sensitive nature of the topic (see Appendix C, Section 5). There are a number of other possible reasons for these differences. Firstly, the study did not distinguish between those psychologists who work with adults and those who work with children in statistical analyses of incidence of sexual attraction, which may have resulted in lower reported incidence of sexual attraction. Secondly, combining questions on sexual attraction and sexual involvement in the same survey may have conflated the two issues for subjects (a common scenario as discussed in the literature review) and made subjects less likely to admit to sexual attraction. The present study did not investigate whether subjects believe sexual attraction to be unethical, however this has been shown to be the case in other studies (Housman & Stake, 1999; Pope et al., 1987). In the Housman and Stake study fewer respondents reported sexual attraction to clients (50%) than in other studies. If respondents in the present study also believe sexual attraction to be unethical, this may have led to underreporting. These reasons

are, however, speculative.

5.1.1.1 Client Awareness of and Mutuality of Attraction

Results show that, overall, subjects believe that clients are unaware of their sexual attraction to them (55.1%), and are not sure if their sexual attraction to clients is mutual (60.3%). As one subject said: 'I cannot know my clients' experience unless I ask them.' This result suggests that when psychologists do experience sexual attraction to their clients, they do not acknowledge or explore this with their clients in the psychotherapy process. This conclusion is supported by the finding that only 7.2% of subjects tell their clients about their sexual attraction. There were no differences between younger and older subjects on these two variables.

5.1.1.2 Sexual Fantasies

As expected, and consistent with other research findings (e.g. Pope et al., 1986), most subjects (75.7%) said they had never had sexual fantasies about clients or former clients. However, it needs to be noted that, following the format of the Pope et al. (1986) study, subjects were asked if fantasies occurred while engaging in sexual activity with someone other than the client. Subjects may have more fantasies about clients than reported in this study, only that these do not occur when they are engaging in sex with other partners. It has been argued that the cognitive ego function of fantasising may play a beneficial role in allowing therapists to contain and work through sexual feelings without acting on them (Gabbard, 1994b). As one respondent in this study volunteered: 'there is a marked difference between fantasy and acting out of such fantasy. If fantasy is present I regard that as some useful information that can further understanding of the therapeutic relationship.' Gabbard also suggests that a rich symbolic realm of fantasy opens up the possibility for therapists who experience sexual attraction to their clients to seek consultation/supervision, which has been argued to reduce the risk of therapists becoming sexually involved with their clients.

Unexpectedly there were no differences between males and females in their reporting of sexual fantasies. This is contrary to findings in other studies in which males reported having such fantasies more than females (e.g. Pope et al., 1986; Pope et al., 1987, Rodolfa et al., 1994). This is also surprising given the research that shows that males generally have higher rates of sexual fantasising than females (e.g. Pope, 1982, in Pope et al., 1987).

5.1.1.3 Contemplation of Sexual Involvement with Clients and Actual Sexual Involvement

The vast majority of subjects reported that they had never seriously contemplated becoming sexually involved with a client (89.9%) or had a sexual relationship with any client (97.1%). This result is consistent with more recent lower reported rates of psychologist-client sexual involvement (Section 2.6.5.3). Whether these figures indicate a decrease in actual behaviour or simply in reporting of such behaviour for fear of censure remains unanswered. It is likely that asking subjects to disclose their own experience of sexual involvement probably resulted in a conservative estimate of the prevalence of such involvement (e.g. Garrett & Davis, 1994).

5.1.1.4 Gender Differences in Sexual Attraction

Hypothesis 2: As expected, significantly more males (79.1%) than females (52.9%) reported sexual attraction to clients. This result is consistent with findings in all the other studies investigating therapists' sexual attraction to clients (Blanchard & Lichtenberg, 1998; Pope et al., 1986; Rodolfa et al., 1994; Sehl, 1998; Stake & Oliver, 1991; Trent & Collings, 1997). However, whether more males actually experience attraction than do females, or whether differences are in the *reporting* of the experience is not known. It is interesting that this gender bias mirrors a second finding of this research, namely that while no females reported actual sexual involvement with clients 2.9% of males did. Again this is consistent with widely reported findings that more males engage in sexual involvement with clients than females (Section 2.6.5.1). It can, therefore, be concluded that more male South African clinical psychologists in this sample report sexual attraction and act on this attraction than do female psychologists. In addition, given that males and females do not differ in frequency of fantasies or contemplation of sexual involvement with clients, it could be speculated that the differences occur primarily at a behavioural rather than at a cognitive, fantasy level.

The reasons for these gender differences in reports of both sexual attraction to clients, and sexual involvement with clients are many, complex and multi-facetted and beyond the scope of the present discussion to elucidate in detail. However a few explanations offered in the reviewed literature are worth noting.

Firstly, cognisance needs to be taken of the psychological differences between males and females, generally, which may also be operative in the psychotherapeutic relationship/dyad. Rutter (1989) suggests that the particularly intense allure of the sexually forbidden for men is a gender bias playing a role in sexual involvement between male therapists and female clients. Epstein (1994) contends that males may be more likely to use denial and projection to regulate feelings of shame, and resort to 'power remedies' (in this case sexual involvement) to boost self-esteem. Person (1985) suggests that males also tend to organise their sense of identity around autonomy and achievement, and sexual involvement with clients may be one such 'accomplishment' (cited in Epstein, 1994). Shor and Sanville (1974) suggest that male therapists are likely to share the gender-specific fantasy with other men in society that they can free a female client from unhappiness through the gift of their virility and that there is a small step from such a fantasy to enactment (cited in Pope et al., 1997). In addition, they assert that a pervasive female fantasy is that she (the therapist) may help a male client by 'mothering' him. This 'mother fantasy' may tend to block recognition, acknowledgement and understanding of sexual feelings and issues in a female therapist – male client relationship.

Secondly, the broader social and political context in which psychotherapy is embedded needs to be understood (e.g. Housman & Stake, 1999; Pope et al., 1997; Stake & Oliver, 1991). Gender expectations, different socialisation of males and females and power relationships between genders that are deeply engrained and pervasive in our society tend to foster dependent passive relational styles in women and feelings of entitlement and dominance in men. Men are expected to pursue women for sex and are held less responsible than women for having and acting on sexual feelings (Gilber, 1987; Quadrio, 1996, both in Housman & Stake, 1999). Some psychoanalytically orientated authors argue that a male therapist faced with a female client who appears helpless and overwhelmed may experience sexual feelings because he unconsciously experiences her as humiliated, while he retains a position of power and strength (Stoller, 1979, in Gabbard, 1994d; Marmor, 1976, in Epstein, 1994; Tansey, 1994). As White (1995) states, it is important to view sexual exploitation of clients as part of a broader continuum of aggression and violence toward the culturally disempowered, particularly women and children.

Gender expectations and male-female power dynamics may partly account for more males than females in the study reporting both sexual attraction to, and sexual involvement with,

clients. This finding highlights the importance of understanding how the pervasive effects of gender belief systems affect the therapeutic relationship, generally and sexual intimacies with clients, specifically (e.g. Gilbert, 1987a, 1987b, cited in Vasquez, 1988).

5.1.1.5 Age Differences in Sexual Attraction

Hypothesis 5: In this study, unlike in the Pope et al. (1986) and Rodolfa et al. (1994) studies, more older than younger psychologists reported sexual attraction to clients. It could be argued that older psychologists feel more comfortable and less anxious than younger ones about having sexual feelings, possibly because of maturity factors, and are therefore more likely to report their feelings of attraction. However, in general, older therapists may experience more sexual attraction than younger ones, given that studies have shown that more older male therapists tend to become sexually involved with clients than do younger ones (Garrett & Davis, 1994; Jehu, 1994, Kardener, 1974; Lamb & Catanzaro, 1998; Pope & Bouhoutsos, 1986). Other variables discussed in the literature review may play a part as well, e.g. older therapists may be more lonely, 'burned out', experience marital distress or mid-life crises (see Section 2.6.5.1 and Section 2.12.2.3). Conversely, younger therapists may be denying their sexual attraction to clients, and it could be questioned whether this then puts them at greater risk for acting on this attraction.

5.1.1.6 Sexual Attraction and Experience

Some authors assert that a typical response of inexperienced therapists is to ignore or deny sexual feelings (Bridges, 1994; Strean, 1993), however the present study found no differences between more and less experienced subjects in reported incidence of sexual attraction. Blanchard and Lichtenberg (1998) also reported no differences in incidence of sexual attraction based on the variable of experience. This is somewhat surprising, as intuitively, it would be expected that with increased experience therapists would have had more occasion to experience such feelings. However, perhaps subjects with more experience are more aware of the risks of such attraction, and therefore less likely to report it.

5.1.1.7 Sexual Attraction to Male and Female Clients

Given that the majority of subjects were heterosexual, it is understandable that more males than females were attracted to female clients, while more females than males were attracted to male clients. It is worth noting that only 2 respondents (2.9%) reported that they have

been frequently attracted to clients (operationalised as more than 10 times) and both these were males attracted to female clients.

5.1.1.8 Theoretical Orientation and Sexual Attraction

There were no significant differences between subjects of different theoretical orientations in reported frequency of sexual attraction. It will be noted at this point in the discussion that theoretical orientation was not a significant variable in any of the interactions tested. This may be because what is defined as a psychodynamic/psychoanalytic psychologist in this country is less formal than in the USA or the United Kingdom. Therefore, subjects in the present sample may be less distinguishable from each other on the basis of theoretical orientation than in other countries where there is more formal registration and training for such categories of psychologists. However, Sehl (1998) also reported no differences in rate of sexual attraction based on this variable. This is somewhat surprising, given that the psychodynamic school offers constructs and a framework for understanding and managing sexual feelings towards clients, and that this could arguably permit therapists to acknowledge such feelings to themselves and others. Perhaps however, the absence of differences is not in reporting but in actual experience of sexual attraction to clients.

5.1.1.9 Sexual Attraction, Personal Therapy and Supervision

An unexpected finding is that significantly more subjects who do, or have in the past, undertaken personal therapy report sexual attraction than do those who have never attended personal therapy. It might be argued that personal therapy offers containment for sexual feelings, and an opportunity for discussing and exploring their meaning. This might enable psychologists to feel more comfortable with their sexual attraction to clients and therefore make it more likely that they will report these feelings. Results indicate that 34.8% of subjects do discuss these feelings with their own therapists. Conversely, perhaps more subjects who experience sexual attraction seek their own therapy to address this experience, and that is why more subjects who attend therapy report sexual attraction than do those who do not. Without further clarifying research, the direction of the relationship remains speculative.

Although there is no conclusive evidence that undertaking personal therapy improves a therapist's ability, it has been argued to help therapists learn more about themselves and

identify blind spots and errors in their thinking (e.g. Garfield & Kurtz, 1976, in Layman & McNamara, 1994). Generally, personal therapy is undertaken by a majority of therapists whose opinion of it is overwhelmingly favourable (Layman & McNamara, 1997). Studies which have investigated whether there is a relationship between attending personal therapy and sexual involvement with clients are equivocal. Gartrell, et al. (1986) in their survey of psychiatrists found that most respondents who had been sexually involved with clients had undergone personal psychotherapy or psychoanalysis. However, in Gechtman's (1989) sample of social workers there was no significant association between personal therapy and sexual involvement with clients. Possibly this area warrants further research to determine whether personal therapy reduces the risk of sexual involvement with clients, or whether therapists attend therapy because they have become sexually involved with clients.

A second related finding is that significantly more subjects who attend supervision than those who do not report sexual attraction to clients. In addition, 43.5% of subjects do in fact discuss their sexual feelings with supervisors, while 20.3% seek peer consultation. As with the above results the direction of the relationship is not known (i.e. do more subjects seek supervision because they experience sexual attraction, or does supervision allow more subjects to acknowledge and report the attraction?). Also while it has been argued that supervision and consultation are important in reducing the risk of therapists becoming sexually involved with clients (e.g. Folman, 1991) there is no empirical evidence for this conclusion (Samuel & Gorton, 1999).

5.1.1.10 Sexual Attraction and Training

In addition, significantly more subjects who reported that their training was useful in assisting them to make informed decisions about sexual involvement with clients, reported sexual attraction than did those who said that their training was not useful. This finding suggests that training in sexual issues in psychotherapy might facilitate awareness and acknowledgement of sexual attraction.

Taken as a whole the above three results could be argued to support the contention of Bridges (1994) that: 'the capacity to bear anxiety and contain unpleasant and intense urgencies while maintaining one's therapeutic balance is a crucial treatment skill that is acquired through experience, supervision, and often personal treatment' (p. 431).

5.2 EMOTIONAL RESPONSE TO SEXUAL ATTRACTION

Hypotheses 3, 4, 5, and 6: Contrary to expectation, the majority of subjects (61.4%) reported that their sexual attraction *did not* tend to make them feel uncomfortable, guilty or anxious (*Hypothesis 3*). This is an interesting, and encouraging, finding given that in the Pope et al. (1986) and Rodolfa et al. (1994) studies, the majority of subjects felt *concerned* about their sexual attraction. There are a number of possible explanations for this result. Firstly, many subjects seek support from others (supervision, peer consultation and discussions with their own therapists) in managing their sexual attraction (56.5%), and these sources of support may well reduce psychologists' concern about their sexual attraction. Secondly, the vast majority reported that they have never acted on their sexual attraction. This might mean that subjects do not feel that their attraction puts them at risk for this ethical transgression. Thirdly, the majority of subjects (76.1%) believe that their sexual attraction has never harmed or been an impediment to the therapy process, while more than half believe that it has been beneficial (58.3%). Fourthly, as expected, significantly more subjects who reported adequate training about the ethics of sexual involvement between therapists and client did not feel discomfort, guilt or anxiety about their sexual attraction, than those who received inadequate training *(Hypothesis 7).* In conclusion, it appears that adequate training and seeking support from others, and a belief that sexual attraction is not harmful to therapy, might reduce psychologist's feelings of discomfort, guilt and anxiety about their sexual attraction. Finally, it could be speculated that it is those of the original sample who did not respond to the study who are concerned about their sexual attraction to clients and therefore did not participate. Although the present study provides no support for this supposition, it might be interesting to ask whether therapists who feel uncomfortable, guilty or anxious about their sexual attraction might be more vigilant and careful in managing this attraction, which might in turn ameliorate against acting on it. Blanchard and Lichtenberg (1999) speculate whether an increase in self-assurance may lead therapists to become overconfident and careless in how they address and handle sexual feelings when they do arise in therapy. That there was no significant difference on this variable between those subjects who reported adequate training about *sexual attraction* and those who reported inadequate training, may be explained by the fact that subjects received more adequate education about the former than the latter topic.

5.2.1 Gender Differences in Emotional Response to Sexual Attraction

Hypothesis 4: As expected, significantly more females than males reported that their sexual attraction to clients tends to make them feel uncomfortable, guilty or confused. This result is consistent with the finding by Blanchard and Lichtenberg (1999) that male psychologists feel greater self-assurance and less general negativity about their sexual attraction than do females, but was contrary to the South African study (Trent & Collings, 1997) in which more males than females reported concern about their sexual attraction to clients. Again sex role stereotypes and expectations and socialisation of women may partly account for females feeling more concern about their attraction (e.g. Sehl, 1998). Russ (1993) argues that female therapists may be more threatened by acknowledging sexual feelings, because being identified as a sexual woman may conflict with a need for professional recognition. From a psychodynamic perspective, Welles and Wrye (1991) maintain that female therapists may defend against sexual feelings for a number of reasons: fear of humiliation and frustration, the need to avoid sado-masochistic issues of oedipal and pre-oedipal eroticism and the desire to avoid the wish and fear of merging with patients (cited in Sehl, 1998).

It might have been expected that older, and/or more experienced subjects might feel less uncomfortable, anxious or guilty about their sexual attraction to clients. However, this study showed this not be the case. This finding is contrary to other research which has indicated that more experienced therapists are more comfortable with sexual feelings than those who are less experienced (e.g. Gornick, 1994, cited in Sehl, 1998).

5.2.1.1 Response to Sexual Attraction and Supervision and Peer Consultation

It is worth noting that 38.6% of subjects *do* feel discomfort, guilt and anxiety in response to their sexual attraction to clients. In addition, and contrary to expectation (*Hypothesis 5)*, those subjects who felt concerned were less likely to seek peer consultation and supervision than those who were not concerned. The difference between these two groups was, however, not statistically significant. However, it could be argued that psychologists who are concerned about the attraction keep it to themselves, paradoxically the very ones who may require support in understanding and alleviating the concern. This finding also appears to confirm the arguments in the review that many psychologists do not share their feelings of sexual attraction to clients for any, some or all of the taboos highlighted (Section 2.12.2). In

addition, it raises interesting questions about what factors might facilitate or prevent psychologists from seeking supervision and consultation. These potential factors were discussed in the review (Sections 2.11.5.1). This result might also support the argument for training programmes and the profession of psychology, generally, to address this issue more openly and proactively to support psychologists who do feel uncomfortable, guilty or anxious about their sexual attraction to clients.

5.3 ASSESSMENT OF THE IMPACT OF SEXUAL ATTRACTION ON THE PSYCHOTHERAPY PROCESS

Hypotheses 7: Although this result only approached statistical significance, as expected, more subjects than not (58.2%) felt that their sexual attraction had been beneficial to the therapy process, at least on occasion. This is consistent with findings in other studies in which a majority of subjects reported perceived benefits (Pope et al., 1986; Rodolfa, et al., 1994; Sehl, 1998). The present study did not investigate what the perceived benefits were, however, a number of subjects volunteered that understanding sexual attraction as countertransference facilitated an understanding of clients and the therapy process (see Appendix C, Section 5). This is consistent with the finding in the Rodolfa et al. (1994) study where benefits included these factors and greater empathy. The high percentage of psychoanalytically orientated subjects in the present study may also have influenced this perception. This finding also reflects the fact that this is the only school of psychotherapy to provide theoretical constructs for understanding the meaning of therapists' sexual feelings for clients.

5.3.1 Gender Differences in Evaluation of the Impact of Sexual Attraction on the Psychotherapy Process

Hypothesis 8: Also as expected males report more frequent benefits of their sexual attraction to the therapy process than do females. Again this is consistent with findings of other studies (Pope et al., 1986; Rodolfa et al., 1994; Sehl, 1998). However, it is contrary to the South African study in which psychologists said that their sexual attraction had little or no effect on the therapy process (Trent & Collings, 1997). Different socialisation of males and females and sex role stereotypes and expectations might account for this result.

Hypothesis 9: Contrary to expected, the vast majority of subjects (76.1%) felt that their

sexual attraction to clients had never been harmful or an impediment to the therapy process. Males and females did not differ significantly on this variable. This finding was also contrary to the Pope et al. (1986) study in which half of the subjects indicated that their sexual attraction had exerted a negative influence on therapy.

It can be concluded therefore, that subjects in the present study believe that at best their sexual attraction to clients can be beneficial to the therapy process and at worst is benign.

5.4 MANAGEMENT OF SEXUAL ATTRACTION

More than two thirds of subjects reported that they worked through their feelings of sexual attraction on their own. This result might be argued to suggest that therapists may be reluctant to discuss such feelings with other professionals for the reasons noted previously in the literature review (Section 2.12.2.6). However, many of these subjects also consulted peers, sought supervision, or discussed their sexual attraction with their own therapists. Therefore, a more accurate conclusion would be that the majority of subjects seek support from others (60.8%), while a minority (31.9%) chooses to work through these feelings alone. These results are consistent with other research which reports that between 50% and 60% of psychologists seek supervision or consultation in response to their sexual attraction (Pope et al., 1986; Rodolfa, et al., 1994, Stake & Oliver, 1991).

This study did not explicitly explore reasons for these choices. It would be interesting to know what other reasons may differentiate those who seek support from those who do not. In the Rodolfa et al. (1994) study for example, psychologists sought supervision and consultation because they were concerned for client welfare, felt they had lost their objectivity, or desired to gain understanding of their attraction. In addition, a generally positive supervisory or collegial relationship influenced consultation seeking.

It is noteworthy that subjects' responses to their sexual attraction were markedly similar to the findings of the Stake and Oliver (1991) study. The most apparent difference between the two studies is that 'referred client to another therapist' was ranked higher in the Stake and Oliver study. This was an option seldom chosen by subjects in this study. This result might be explained by the fact that most subjects are not concerned about the attraction and believe

that it is not harmful to the therapy process, and therefore are unlikely to see the need to refer the client. Also, as noted above, many subjects commented that sexual attraction understood as countertransference could benefit the therapy process.

5.4.1 Gender Differences in Management of Sexual Attraction

The gender differences that were found were also interesting. Significantly more males than females told their clients about their sexual attraction. This result is also consistent with other research findings (Pope et al., 1987; Stake & Oliver, 1991). There is much debate about therapists' disclosure of feelings, particularly those of a sexual nature, to a client. Some argue that selective intentional disclosure can be useful (e.g. Davies, 1994, cited in Fitzpatrick, 1999), while others have highlighted the dangers involved (e.g. Gabbard, 1995). As one psychologist stated: 'I did not tell client – this information is not beneficial for client therapeutically.' This remains a controversial area. While not statistically significant, it is worth noting that more than twice the number of males as females seek peer consultation, whereas almost twice the number of females as males discuss the feelings with their own therapist. This provides useful information on what resources for managing their sexual attraction might be preferred by males and females.

5.4.1.1 Reasons for Refraining From Sexual Involvement when Sexually Attracted to Clients

Results suggest that clinical psychologists in this sample have a fairly high degree of awareness of the ethical guidelines about and rationales for proscribing sexual involvement between therapist and client. This conclusion is borne out by the fact that 'unethical' and 'countertherapeutic/exploitative' were the most highly ranked reasons for refraining from sexual involvement with clients. In addition, most subjects felt that their training was useful in helping them to make informed decisions about sexual involvement with clients. Also 94.1% of respondents believed that there are no circumstances in which sexual involvement with a current client may be appropriate. The reason given by most of the 6.9% who felt there might be circumstances where such behaviour was appropriate was if therapy had been terminated. Ethical considerations and the welfare of the client were more important motivations for not engaging in sexual involvement with clients, than fear of legal or professional consequences as has been argued by some authors (e.g. Williams, 1992; Samuel & Gorton, 1997). This conclusion is supported by the fact that no subjects cited any reasons

related to negative consequences to themselves as of highest priority for refraining from sexual involvement. Therefore, it might be concluded that psychologists in this sample are not behaving ethically for unethical reasons, a possibility discussed in the review (Section 2.9.4).

A few caveats to these conclusions do however need to be made. Firstly, these responses were prompted via a list based on the results of the Pope et al. (1986) study. Had responses been open-ended, they may have yielded different results. In addition, it is not known to what extent demand characteristics or social desirability may have biased or influenced responses. Perhaps a by-product may be to raise awareness of these factors, if they had not been volunteered. Secondly, 'against my personal values' and 'already in a committed relationship' were ranked 3rd and 7th respectively overall by subjects, and could be argued to be irrelevant to the ethical considerations required in fiduciary, professional relationships.

The ranking of reasons was fairly similar to those of the Pope et al. (1986) study. One notable difference was that fear of censure/loss of reputation was ranked much higher in the Pope et al. (1986) study. This is understandable given the 'culture of litigation' in that country, as well as widely publicised cases of professional and legal censure and published research.

5.5 TRAINING ON THERAPIST-CLIENT SEXUAL INVOLVEMENT AND THERAPISTS' SEXUAL ATTRACTION TO CLIENTS

Hypothesis 10: Results of this section indicate that, as expected, the significant majority of subjects rated their training about therapists' sexual attraction to clients to be inadequate – 72.3% reported either no or very little education on this topic, while only 10.6% had received adequate training. This confirms the argument that this is a highly neglected area of education (Pope et al., 1997). Training about the ethics of sexual involvement between therapist and client or former client was rated as significantly more adequate than training about therapists' sexual attraction to clients. This is probably why most subjects (74.2%) felt that their training was useful in helping them to make informed decisions about sexual involvement with clients. However, it must be noted that 53.2% of subjects reported either no or very little training on this topic, confirming the findings of other research which highlights the lack of training in sexual issues in ethics generally (e.g. Bernsen et al., 1994; Glaser & Thorpe, 1986;

Pope & Tabachnick, 1993; Pope et al., 1986; Rodolfa et al., 1990; Rodolfa et al., 1994).

That there were no differences between less recently trained and more recently trained subjects in their ratings of the adequacy of their training suggests that training in sexual issues in psychotherapy has not improved more recently, despite the wide research and media publicity of the topic of therapist-client sexual involvement.

Interestingly, suggestions made by subjects for what would constitute appropriate training bear marked similarities to those proposed by researchers in the field (Section 2.11.5.4).

5.5.1.1 Ethical Codes/Guidelines Consulted

Based on a number of factors, results suggest that many clinical psychologists, in this sample, do not use or consult standard and recognised ethical codes of conduct. Firstly, many respondents omitted to indicate what ethical codes/guidelines they consult (43%). Secondly, ranked second was 'other' which included many vague responses (see Appendix C, Section 3, Question 6). Thirdly, ranked 6th out of 11 was Christian, which might be argued to suggest a lack of understanding of the specific ethical issues involved in fiduciary, professional relationships. Fourthly, five subjects responded with a 'question mark'. Whether this indicated that they did not have an answer, or whether they did not understand the question, is unclear. It might be argued that this question was ambiguous or confusing (i.e. it may have been preferable to ask: 'What ethical codes guidelines do you *consult*, rather than *practice*?'). However, given that many respondents did offer recognised ethics codes, does not seem to support this argument. The most widely consulted professional guidelines are those of the 'Health Professions Council', and the 'Professional Board for Psychology', while Alfred Allan's '*The Law for Psychotherapists and Counselors*' and Jane Steere's '*Ethics in Clinical Psychology*' were the most frequently cited references. Surprisingly only 4 subjects cited the South African Code for Clinical Psychologists.

These results appear to reflect the lack of a uniform South African code of conduct and ethical guidelines for psychologists to consult (Section 2.4). It might also be concluded that the above results indicate a failure on the part of training institutions to provide psychologists with ethical codes and guidelines to consult.

5.6 ATTITUDES TO SEXUAL INVOLVEMENT WITH CURRENT AND FORMER CLIENTS AND TO OTHER FORMS OF TOUCH

5.6.1 Sexual Involvement with Current Clients

That the vast majority of subjects believe that sexual involvement with current clients is never ethical (98.9%) and always harmful (95.8%) is consistent with other findings (e.g. Gartrell et al., 1995; Herman, et al., 1987; Pope et al., 1986; Pope et al., 1987; Stake & Oliver, 1991). In addition the only circumstance in which subjects felt sexual involvement might be appropriate was after termination of therapy.

5.6.2 Sexual Involvement with Former Clients

Three main conclusions can be drawn from results. Firstly, subjects in the study consider sexual involvement with former clients to be less unethical and less harmful than sexual contact with current clients. This is consistent with other research findings (Akamatsu, 1988; Borys & Pope, 1989; Gartrell et al., 1986; Herman et al., 1987; Lamb & Catanzaro, 1998; Pope et al., 1987; Thoreson, et al., 1993; Thoreson et al., 1995; Trent & Collings, 1997). Results indicate that many subjects regard sexual contact with former clients as ethical under certain circumstances and after a circumscribed time period.

Secondly, there are also divergent views about what factors are deemed important in determining the ethicality of sexual involvement with former clients. More than half of the subjects (52.7%)[16] stated that sexual involvement between therapists and former clients is never ethical (ranked 1). Of the 47.3 % who felt that there *were* circumstances in which such contact might be ethical, ranked first was 'time since termination'. This result is consistent with findings of other research (e.g. Akamatsu, 1988; Herman et al., 1987; Trent & Collings, 1997). Mental health of client, whether there has been harm to client, nature of termination, and transference issues were also considered by subjects to be important factors in

[16] There were two questions assessing ethicality of sexual involvement with former clients (Section 4, Question 1 & Section 4 Question 4), which yielded different results (in the first question 65.2% stated such behaviour is never ethical, while in the second question this view was held by 52.7%). However, more subjects answered the second question (110 versus 95). It could be concluded, therefore, that the second percentage is more indicative of the attitudes of the sample, overall. However, this difference may be a result of different wording of questions or of subject errors in filling in the questionnaire.

determining the ethicality of post-termination sexual involvement. It is, perhaps, disturbing that whether exploitation occurred was ranked 11 out of 13. A primary function of ethical guidelines is to protect clients and many ethics codes require that psychologists must prove that there is no harm to or exploitation of the client when considering a post-termination sexual relationship (e.g. APA, 1992; Canter, et al., 1994; CPA, 1991).

Thirdly, there are also divergent beliefs about what constitutes an appropriate time interval between termination of therapy and commencement of sexual involvement, ranging from never to immediately. These results are consistent with the view that therapists differ widely in their beliefs about when therapy ends (e.g. Folman, 1991). For some the belief is 'once a client always a client', for others the relationship is seen to end immediately after the termination of therapy. As one subject volunteered: 'When a sexual relationship begins, therapy must end – the relationship may continue'. In addition many subjects stated that the ethicality of sexual involvement with former clients depends on circumstances and other factors such as nature and length of therapy and nature of termination.

There are a number of possible reasons for these results. Firstly, subjects may be unaware of, or fail to understand ethical guidelines and proscriptions as they relate to post-termination sexual involvement. If this were the case, it would bring into question the adequacy of ethics training as it relates to this issue. Results discussed previously support this conclusion.

Secondly, this result may also reflect the fact that, as discussed in the review ethics codes and guidelines are not internationally uniform, and that there is still considerable debate about the ethicality of sexual involvement between therapist and client (Section 2.7). It may also reflect the lack of nationally endorsed guidelines for psychologists in South Africa (Section 2.4).

Thirdly, it could be argued that respondents are aware of ethical guidelines, but are not in agreement with them. If this is the case, then a blanket proscription of such relationships that is recommended by many authors and under consideration by the APA (see Section 2.7.2) might not reflect the actual values and beliefs of clinical psychologists. Although ethical codes cannot be based on majority rule (e.g. Akamatsu, 1988; Stake & Oliver, 1991), they do have to take cognisance of and reflect the values and beliefs of their practitioners. Wassenaar (1998) states that it is important that the new PsySSA ethics code in the process of being

finalised 'is seen as being the product of a consultative process and as reflecting the best interests of consumers as well as of the profession' (p. 139).

In summary, these findings confirm that post-termination sexual involvement between psychologists and clients remains an ethical 'grey area' requiring ongoing debate, reflection, and research in the process of developing workable, thoughtful and appropriate ethics codes and guidelines which will best serve the interests of clients and psychologists.

5.6.3 Attitudes to other Forms of Touch in Psychotherapy

In general, results of this section suggest that subjects believe that there are instances in which certain forms of touch in psychotherapy may be ethical and unharmful. This result is consistent with research reviewed in this study (e.g. Edwards, 1981, in Garrett & Davis, 1994; Durana, 1988; Holroyd & Brodsky, 1977; Horton et al., 1995; Simon, 1992, in Smith & Fitzpatrick, 1995). In addition, results suggest that there is a lack of consensus about what forms of touch are ethical (e.g. Durana, 1998). Some themes did emerge, that are consistent with findings in other research. As expected, handshake, patting on arm, touching arm/shoulder and hugging were considered less unethical and harmful than kissing. Many subjects agreed that a handshake is ethical behaviour (66.3% felt that it is 'always ethical'). This is consistent with other research findings (e.g. Pope et al., 1987). There were fewer consensuses about hugging and holding hands. That most subjects agreed that kissing is never ethical (83.2%) is also consistent with published research (ibid.; Herman et al., 1987; Stake & Oliver, 1991). This may be because kissing is more overtly sexual than other forms of touch. Of interest is that kissing was viewed as more harmful and less ethical than sexual involvement with a former client. This might be because kissing occurs within the boundaries of therapy, while sexual involvement with former clients might be perceived to fall outside this frame. The questionnaire did not define the type of kissing, but presumably subjects interpreted this as being of a sexual nature, rather than a Mediterranean-type greeting.

As highlighted in the literature review many factors need to be taken into account in determining the ethicality of a non-sexual touch in psychotherapy. A number of subjects volunteered comments to this effect (see Appendix C, Section 4, Question 1). As one psychologist put it: 'I think slightly different rules apply around more innocuous contact (e.g. handshake, touching arm) depending on nature of therapy and age of client e.g. touch is

unavoidable in play therapy with young children. Not to touch would be sadistic and unnatural in this context.' Therapists need to be cognisant of age, race, gender, social and cultural norms, type of therapy, client's mental health and situational factors when deciding whether to use touch in psychotherapy. This raises difficult challenges for developing ethical guidelines in this regard. As discussed in the literature, supposedly ethical behaviours can be employed for unethical reasons and vice versa. Where one delimits the boundaries, may be necessarily arbitrary and fraught with difficulties. Zelen (1985) points out, that cognisance needs to be taken of the therapist's intentions as well as context, while Brown (1994) argues that boundary violations occur if the client is objectified, if the aim is gratification of the therapist's impulses and if the therapist's needs are put first. This discussion suggests a need for guidelines on the use of touch which are sensitive to cultural and contextual factors, and which are based on ethical principles rather than proscriptive rules. As one psychologist said about holding hands and hugging: ''I am aware that these behaviours are not considered ethical, however at times patients need consoling e.g. death of spouse.'

5.6.4 Gender Differences in Attitudes

A noteworthy finding of the present study is that in most questions where gender differences were found, female respondents tended to support a more conservative position. This is consistent with findings of previous surveys (e.g. Akamatsu, 1988; Borys & Pope, 1989; Gartrell et al., 1986; Holroyd & Brodsky, 1977; Pope et al., 1986). The most notable finding with regard to gender differences in attitudes is that overall females tend to view sexual involvement between current and former clients as more unethical and more harmful than do males. It appears, therefore, that females may be more sensitive to and aware of the negative consequences of these behaviours. Stake and Oliver (1991) argue that this is because most clients who are involved in sexual misconduct cases are women, while Lyn (1995) contends this may be because many initial writings on the topic of therapist-client boundary violations came from the feminist psychotherapy community. An interesting finding was that females rate hugging, holding hands and touching an arm or shoulder as less unethical than do males. This finding might reflect the fact that females have been shown to use these forms of touch more than males. Pope et al. (1987) found that female therapists were more likely than males to hug a client, while in the Stake and Oliver (1991) study female psychologists reported more touching of female clients. In addition, males might be more aware that touching their female clients could be misconstrued as a sexual gesture and therefore view it as less ethical.

5.7 CONCLUSION

5.7.1 Limitations of the Present Study

5.7.1.1 Low Response Rate

The first consideration to address is the low response rate (23%). Although it could be argued that this is to be expected in mail survey research, where returns of less than 40-50% are common (Kerlinger, 1986), it is still low. This means that the results of the present study must be interpreted with caution. It may not be possible to make valid generalisations to all South African clinical psychologists, and in addition the inferences which can be made are limited. There are a number of possible reasons for the low response rate. Firstly, clinical psychologists in South Africa tend to be over sampled in local research, which may have resulted in reluctance to fill in yet another questionnaire. Work pressure and general apathy could also be cited as contributing factors. Also, while the questionnaire had a tick-response format, it could be argued to have been overly long (39) questions. If this is the case, it may also go some way to explain why so many participants left out the section on 'training'. Unfortunately, an unknown percentage of mailings inadvertently excluded the 'free-post' envelope, which very likely also contributed to the low response rate. During this research, the author learned that the topic of sexual attraction is currently being investigated by another researcher, and it is likely that some subjects may have received two questionnaires concurrently, further influencing the low return rate.

However, perhaps the most persuasive reason for the low response rate is the sensitive nature of the subject matter. As described in the literature review, a taboo exists around the discussion and exploration of sexual issues in psychotherapy, and this may well have made potential participants reluctant to engage in the study. Despite being assured of confidentiality and anonymity, the study still required of participants a self-scrutiny and reflectiveness which may have raised anxieties or feelings of discomfort. The sample, in this respect is therefore self-selected, and it remains unknown what the potential biases in this regard are. It could be speculated that because many subjects were not concerned about their sexual attraction to clients, those who did not complete the questionnaire, are the ones who do experience difficult emotional responses to their attraction when it occurs. In addition, it

may be those psychologists who have been sexually involved with clients that did not respond and may suggest that actual rates of such involvement may be higher than indicated in the present study. This further limits the validity of the findings. These suggestions are, however, speculative because as Williams (1992) notes, when questionnaires are not returned one does not know whether this failure is systematic and related or unrelated to findings in the study. Furthermore, if it were related, it would remain unclear how it might skew or bias the apparent results.

5.7.1.2 Selection of Participants – Possible Biases

Although participants were randomly selected from a list of clinical psychologists registered with the HPCSA, the sample size was small, 485, and it is also unknown whether the sample is representative of the total population of South African clinical psychologists. For example, the sample appears to be skewed in the direction of psychodynamically oriented psychologists working primarily in private practice. These are further reasons for exercising caution in both interpreting the validity of results and in generalising results to all South African clinical psychologists.

5.7.1.3 Limitations of Self-Report Surveys

Self-report surveys are notoriously fraught with difficulties. As noted above, low response rate is a primary reason, as is the inability to check given responses, or information about non-respondents (Kerlinger, 1986). Prior research has demonstrated the extent to which demand characteristics can influence research results (e.g. Barber, 1976, cited in Pope & Tabachnick, 1993). More specifically participants may tend to provide what they believe to be 'socially approved' or 'socially desirable responses' (e.g. Tanur, 1991, cited in ibid.). It could also be argued that given the sensitive nature of the topic, a potential response bias might be to underreport sexual attraction and sexual involvement and to offer more conservative or 'politically correct' attitudes to sexual involvement and other forms of touch in psychotherapy. In addition, self-reports are subject to memory imperfections when participants are required to make retrospective reports (Pope, 1990b), in this case about training and past feelings of sexual attraction in psychotherapy. Finally, the question of how honest self-reports ever are, remains a crucial factor (Parten, 1950). Again, based on the literature, underreporting of both sexual attraction and sexual involvement is likely.

5.7.1.4 Validity of Survey Questionnaire

The survey questionnaire used in the present study was a composite of those employed in other studies in the field in order to facilitate comparison of results. The instrument was not given to other psychologists to read, nor was it pre-tested (Parten, 1950). As a result, the validity and reliability of the measuring instrument is not known, which also limits generalizability and inferences that can be drawn from results. In addition, the validity of forced-choice data is questionable. For example, it is unclear whether sexual attraction 'per se' is beneficial to the psychotherapy process, or whether benefit results from the psychologist's working with and understanding the meaning of the attraction. In addition there are a number of specific problems with the measurement instrument that may compromise its validity. Including questions about both behaviour and attitudes in one study, could have resulted in cross-contamination of results (Borys & Pope, 1989; Pope et al., 1987). This too may have led to underreporting of sexual attraction and sexual involvement. The section on training evaluated the amount of training, but not the *quality* of training. Sexual attraction was not defined, and it might have been unclear to subjects whether this referred to actual physiological arousal, emotional feelings of love, or sexual fantasies. Subjects were also not asked whether they believed sexual attraction was unethical. It was not clarified what was meant by kissing (i.e. whether it was a light non-sexual peck or a sexual kiss). Also it was not made explicit in the section examining subjects attitudes to touch that this was referring to psychologists initiating the touch and not clients.

5.7.1.5 Limitations to Inferences that May be Drawn from the Present Study

In many instances where results identified differences between groups, the direction of the relationship cannot be ascertained and possible inferences remain speculative. For example it remains unclear whether subjects seek therapy because they experience sexual attraction or whether attending therapy facilitates an acknowledgement and reporting of sexual attraction. Where comparisons were made with other studies, these need to be interpreted with caution given differences in sample population, wording of questions, definition of terms, different rating scales and sample size.

5.7.1.6 Too Broad in Scope

In retrospect, the present study was probably too broad in scope. It may have been more beneficial to have looked only at sexual attraction and training and not also at attitudes. This

may have resulted in a higher response rate. In addition, it would have permitted more depth of exploration of psychologists' sexual attraction to clients. By choosing to focus on breadth of exploration, rather than depth the present study employed elementary statistical procedures, and it needs to be noted that more subtle and complex interactions were not investigated.

5.7.1.7 Limitations of Quantitative Research

A primary focus of the present research – sexual feelings and attraction – is in many ways a highly complex, personal and subjective experience. Quantitative research in this regard is therefore limited in the extent to which it can tap the subtle nuances and variables associated with this experience. In addition, ethical issues may best be studied in a way that takes cognisance of and allows for the inclusion of subtle situational, cultural and contextual factors, which quantitative research is unable to do. Particularly with regard to the ethicality of post-termination sexual involvement and touch in psychotherapy, a forced choice, tick-response format, is limited in this regard. Future qualitative research might fruitfully explore some of the questions that remain unanswered in the present study in this format. For example, what factors influence whether psychologists feel concerned or not about their sexual attraction? On what basis do they choose how to manage their attraction? In what specific circumstances might sexual involvement with former clients and other forms of touch in psychotherapy be considered ethical? What are the benefits of sexual attraction to the psychotherapy process? What suggestions do psychologists have for developing ethical codes in this field? In addition, it might be informative to gain qualitative data about when and in which circumstances psychologists become sexually involved with clients (e.g. during marital crises, periods of stress or increased vulnerability).

5.7.1.8 Statistical Analyses

Caution in interpreting results is warranted based on certain limitations in statistical analyses. As indicated in chapter 4, in some Chi-Square tests cells have expected counts less than 5. It is recommended that this test not be used in such cases (Runyan, 1977). It may also have been advisable to have set a more conservative significance level (i.e. $p<.003$) to compensate for the possibility of Type-I error for multiple tests. Also as noted, following the lead of Pope et al. (1986) in all one-variable cases with two, or multiple categories, the expected frequencies for categories were treated as equal, which may not have been realistic.

5.7.2 Implications for the Profession of Psychology

Notwithstanding the above limitations, a number of conclusions, implications for the profession of psychology and suggestions for future research can be made.

Given that the present study confirms that sexual attraction to clients is a fairly widespread experience for clinical psychologists, argues for the profession of psychology generally, and training programmes specifically, to address this topic openly and proactively.

That many subjects perceived their sexual attraction to clients to have benefited the psychotherapy process, at least occasionally, lends support to initiatives to develop practical guidelines for the understanding and management of such feelings.

While only a minority of subjects acted on their attraction by becoming sexually involved with clients, it could be argued that if therapists' sexual attraction is not candidly addressed, vulnerable psychologists will be denied forums to grapple with the meaning of such feelings and how to manage them creatively, without acting on them to the potential detriment of their clients, themselves and the profession of psychology. As one psychologist stated: 'You can have all the ethical guidelines in the world, but if you don't deal with the ordinary/legitimate dialectics of the therapist's desire in training, then ethics mean nothing'.

According to Zelen (1985) heightening awareness around therapists' sexual attraction to and sexual involvement with clients will 'enable the helping professions to drop the false model of omniscience and omnipotence' (p. 184). Acknowledging vulnerabilities in the profession is a necessary prelude to constructively addressing solutions. In addition, recognising that no psychologist is invulnerable to acting on his/her sexual attraction places an onus on the profession to safeguard not only clients, but psychologists as well. Guidance and support of 'at risk' therapists as well as compassionate rehabilitation for those who transgress, and who are frequently referred to as 'perpetrators' or 'abusers' is needed. Constructive channels for prevention might include the establishment of initiatives such as 'troubled-therapist centres' (Zelen, 1985).

It is encouraging that the present study indicates that psychologists have a fairly high degree

of awareness and understanding about the rationales for proscribing therapist-patient sexual involvement. Most subjects have never seriously considered such involvement, or become involved and most believe it to unethical, harmful and countertherapeutic or exploitative. This appears to be because, despite perceived inadequacies in training, psychologists believe that it has essentially prepared them to make informed choices about sexual relationships with clients.

It is also encouraging that the majority of subjects in the present study do seek supervision and consultation when they experience sexual attraction to clients, because, as has been noted, many authors and ethics codes emphasise the importance of such action in managing the risk of sexual involvement with clients (e.g. APA, 1992; Canter, et al., 1994; Celenza 1995; CPA, 1991; Gabbard, 1994b; Sonne, 1994). In addition colleagues have been viewed as the most effective source of guidance on regulating psychology practice, assisting with ethical decision-making and knowledge about ethics (e.g. Haas, et al., 1986, in Hall, 1987; Pope et al., 1987). However, more than a third of subjects feel uncomfortable, guilty or anxious about their sexual attraction, and are also less likely than their unconcerned colleagues to discuss their attraction with supervisors and peers. Why this is the case and what factors may facilitate or prevent consultation and seeking supervision were not addressed in the study. However, it could be argued that it is important to cultivate an ethos of consultation and supervision seeking, so that when problems arise therapists will feel free to get help before they act on feelings of sexual attraction. The development and fine-tuning of other guidelines such as models and/or frameworks for making ethical choices when confronted with challenging situations such as sexual attraction to clients would also be useful (e.g. Anderson & Kitchener, 1998; Gottlieb, 1993).

The study also supports the need for improved training and education in sexual issues and ethical dilemmas in psychotherapy, including therapists' sexual attraction to clients, that is called for by virtually all researchers in the field (e.g. Folman, 1991; Rodolfa et al., 1994; Stake & Oliver, 1991; Thoreson et al., 1993; Thoreson et al., 1995). This argument is supported by a number of findings. Most subjects rated their training as less than adequate and in addition there is no indication that training has improved more recently. The vast majority of subjects also believe such training should be a required part of the training curriculum for clinical psychologists. In addition, those subjects who reported adequate

training were less uncomfortable, guilty or anxious about their sexual attraction than were those who reported inadequate training.

The study also provided some suggestions about what might constitute appropriate training, which interestingly, are consistent with proposals by researchers in the field (e.g. Folman, 1991, Hamilton & Spruil, 1999; Rodolfa, et al., 1990; Rodolfa, et al., 1994; Strasburger et al., 1992, Vasquez, 1988). These include experiential training, structured formalized courses, ongoing supervision, case studies, open discussion and normalization of sexual attraction. In addition, such training might be useful for qualified psychologists, given the new initiatives in South Africa for compulsory, annual continuing development for psychologists and other health care professionals. Qualitative data volunteered by many subjects indicate that they find psychoanalytic concepts and theory, including the therapeutic frame and transference and countertransference, useful in understanding their sexual attraction, their clients as well as in facilitating the therapeutic process. This argues for the inclusion of these topics in training programmes. However, given that these constructs may be incompatible with the beliefs and practices of many psychologists, argues for exploring contributions that other theoretical orientations can make to understanding and managing feelings of sexual attraction. For example, Hamilton and Spruil (1999) point to the contributions that social psychology can offer. In addition narrative, existential and phenomenological psychotherapy may be able to provide useful contributions.

The study also confirms the importance of differentiating between sexual feelings that are inevitable and acting on these which is unethical and destructive. A number of subjects volunteered this information. One psychologist stated: 'I think that a clear distinction should be made between feeling/experiencing sexual attraction - and in being open to such a possibility, being able to think about and work through it - and acting upon it. The first could inform therapy, the second is unethical.' This point has been stressed by many authors and needs to be addressed in training programmes (Section 2.11.5.3)

In order to address the need for improved training a learning climate, which is conducive to openly exploring sexual ethical dilemmas and challenges, is required. Educators and supervisors, will need to address their own resistance to broaching this topic in practical and personal ways, and to act as role models of ethical behaviours by refraining from sexual

relationships with students and supervisees.

A notable finding of the present research, which is consistent with most studies reviewed, was marked gender differences on virtually all variables investigated. Generally females have more conservative attitudes to sexual involvement with current and former clients, perhaps indicating a greater sensitivity to the potential dangers of such involvement. As discussed this may be because more females than males are 'victims' in sexual misconduct cases. This finding also suggests that it is important to be sensitive to gender differences in understanding the incidence of psychologists' sexual attraction to clients, how they experience, assess, respond to and manage these feelings. For example, females tend to be more anxious and concerned about their attraction than males. They also prefer to speak with their own therapists, while males choose to consult with peers. Essentially what is required, as Gilbert (1987) points out is an:

> '...understanding of the psychology of women, of men's and women's changing roles, of the restrictive effects of gender socialization, of inappropriate sexualization of relationships, and, most especially, of the existing power differential between men and women in society and how this differential can be compounded in a counselling relationship.' (cited in Vasquez, 1988, p. 239).

With regard to post-termination sexual involvement and other forms of touch in psychotherapy there are clearly divergent attitudes and lack of consensus. Many subjects believe certain forms of touch can be ethical in certain circumstances. Sexual involvement with former clients is viewed as less unethical than with current clients and many believe there are situations in which such relationships might be ethical, particularly depending on time since termination of psychotherapy.

This result has a number of implications. Firstly, it argues for ongoing research to investigate the effects on clients of post-termination sexual relationships with their psychologists and other forms of touch, as well as psychologists' attitudes in this regard. As Pope et al. (1987) state: 'Our ability to engage in effective and ethical regulation... is contingent on our willingness to study our own behaviour and our beliefs about that behaviour' (p.1004).

Secondly, if existing and proposed ethical codes fail to reflect the beliefs, values and

behaviours of their practitioners, as the present study suggests, they might need to be candidly and critically re-examined. In this regard, the profession of psychology might benefit from a sensitivity to, and scrutiny of, the cultural myths, biases and beliefs which may explicitly and implicitly inform the development of ethical guidelines. In addition, it might be invaluable to elicit the opinions of members of the profession of psychology concerning ethical guidelines. The informed opinions of practising psychologists and educators may contribute to the development of more sound, workable solutions to the problem of psychologist-client sexual relationships and to guidelines which attain the often difficult balance between interests of clients and members of the profession. As Wassenaar (1998) asserts, ethics codes need to be critical documents which are continually revised, democratically compiled and responsive to the changing social and political context in which they are embedded.

The above discussion appears important in the light of the fact that the Ethics Committee of PsySSA is in the process of finalising new ethical guidelines for South African psychologists (Psy Talk, 1999; Wassenaar, 1998). Given that the present study reflects the lack of such guidelines also argues for this process to be expedited.

The process of formulating guidelines in this area is likely to continue to be fraught with dissenting viewpoints, debate and lack of clarity for those mandated with this complex and challenging task. Hopefully such guidelines will be based on sound principles such as 'due care' (NIP, 1991), the genuine welfare of clients, and sensitivity to the power imbalance in psychotherapy (CPA, 1991) rather than reactive responses aimed at 'saving face' for the profession of psychology. As one psychologist volunteered: 'I find the hysteria around this topic unhelpful.'

5.7.3 Future Research

Given the small sample size, low response rate, methodological limitations and unanswered questions in the present study, it is recommended that future research on the topics addressed be conducted. It might be useful, for comparison, to include other categories of psychologists (i.e. counselling and industrial), as well as other professionals practising psychotherapy such as social workers and psychiatrists.

Given the complex nature of sexual feelings and touch in psychotherapy, qualitative research such as discourse analysis of narratives of therapists' experiences or anonymous interviewing of therapists may be needed to better understand these phenomena. Suggestions as to what such research might include have been mentioned (Section 5.7.1.7). In addition, investigating dilemmas and situations that psychologists identify as being personally problematic and challenging with regard to sexual attraction and other sexual issues in psychotherapy may be warranted. This might include eliciting vignettes of such scenarios (e.g. Slack & Wassenaar, 1999). It might also be fruitful to investigate factors that facilitate and prevent peer and supervision consultation.

While the reviewed literature stresses the importance of ethics training in reducing the incidence of therapist-client sexual involvement, no empirical research has been conducted to verify this assumption (Pope, 1993; Samuel & Gorton, 1998). This appears to be much needed. In addition research to assess the effectiveness of various training efforts and other strategies aimed at reducing and managing the risk of therapist-client sexual involvement might also prove useful, including personal therapy, supervision and peer consultation. The present study did not ask subjects whether training about their sexual attraction to clients did or might enable them to better manage these feelings. This is an issue also warranting further research.

There also appears to be a need for a more detailed investigation of the amount, nature and quality of training offered to clinical psychologists in South Africa in ethics generally and in sexual issues in psychotherapy specifically. This might include whether it incorporates experiential learning and self-awareness development, in addition to knowledge and information about ethical and legal issues; how conducive the learning climate and attitudes of educators/supervisors are to the exploration of sexual ethical dilemmas, as well as whether universities differ in adequacy of training.

Given that therapist-client sexual involvement continues to occur, one way of protecting clients and ensuring 'no harm' is by educating them about their rights (e.g. Zelen, 1985; Thorn, Shealy & Briggs, 1993). Authors have argued that many clients do not know that there are ethical standards prohibiting such involvement, nor that they can file complaints (Hotelling, 1988; Rutter, 1989). In South Africa an information sheet on the rights of users of

psychological services and avenues of redress was published in 1998 and is currently being reviewed (SAMDC, 1998). Investigating additional options in this regard, whether therapists use such materials and the effectiveness of such initiatives in protecting clients, may also be fruitful areas of research.

5.7.4 Summary

While the majority of clinical psychologists in this study experience sexual attraction to their clients only a very small minority become sexually involved with clients. Most consider such behaviour to be unethical, harmful to clients, exploitative and countertherapeutic, and believe that these are more important reasons for refraining from sexual involvement with clients than fear of legal or professional censure. This appears to be because despite perceived inadequacies, their training did prepare psychologists to make informed decisions about such relationships. Many respond to their attraction without discomfort, guilt or anxiety, believing that at worst it has a benign impact on the psychotherapy process and at best is beneficial. Many are proactive in managing their sexual feelings by seeking support from supervisors, peers and their personal therapists. Taken as a whole, these findings suggest a fairly high degree of ethical awareness and behaviour among psychologists in this sample in response to their sexual attraction. These findings might help to reduce the fear and anxieties associated with sexual attraction and dispel some of the myths surrounding the topic. A number of subjects volunteered comments that studies on this topic are necessary and overdue. They also contributed a large and rich amount of qualitative data, which supports the argument for open debate on the topic.

The marked differences in responses between males and females in this study, argues for an understanding of and sensitivity to the gender differences in the experience, response to and management of sexual attraction to clients, and by implication, the political and social context in which psychology is embedded.

That training in sexual issues in perceived is be inadequate, and in addition does not appear to have improved more recently, argues for this topic to be addressed more proactively by academic institutions. Suggestions volunteered as to what such training would incorporate bear marked similarities to those proposed by most researchers in the field.

Psychologists' attitudes to post-termination sexual involvement argue for a critical evaluation of existing and proposed ethics codes relating to this behaviour, as well as the need for these to be a product of consultation with psychologists and inclusive of their values and beliefs.

That many psychologists do not consult recognised ethics codes and guidelines argues for the finalisation of PsySSa's ethics code for psychologists to be expedited.

Divergent attitudes about the ethicality of touch in psychotherapy also suggest the need for the development of guidelines for such behaviour, which are sensitive to cultural and contextual variables, and based on ethical principles rather than rules.

Finally, if the experience of sexual attraction to clients is 'normalised', psychologists will be better able to acknowledge and accept their sexual feelings for clients, and be more prepared to use them appropriately in psychotherapy to understand themselves, their clients and the complex therapist-client relationship. Good training and supervision, ethics codes and guidelines and informative theory, while invaluable and necessary, cannot spare a psychologist from the personal, complex and often unpredictable process of experiencing, exploring and understanding her sexual attraction to clients. It requires an awareness of her own motivations, personal conflicts, needs and vulnerabilities, as much as it does sensitivity to the same in her client. For it is only in this personal and interpersonal journey of discovery that she will be able to tease out the multiplicity of meanings of her sexual attraction to clients.

6 REFERENCES

Abend, S.M. (1989). Countertransference and psychoanalytic technique. Psychoanalytic Quarterly, LVIII, 374-395.

Akamatsu, T. J. (1988). Intimate relationships with former clients: National survey of attitudes and behavior among practitioners. Professional Psychology: Research and Practice, 19 (4), 454-458.

American Psychological Association Ethics Committee. (1988). Trends in ethics cases, common pitfalls, and published resources. American Psychologist, 43, 564-572.

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. American Psychologist, 47, 1597-1611.

American Psychological Association Ethics Committee. (1999). Report of the Ethics Committee, 1998. American Psychologist, 54, 701-710.

Anderson, S.K., & Kitchener, K.S. (1996). Nonromantic, nonsexual posttherapy relationships between psychologists and former clients: An exploratory study of critical incidents. Professional Psychology: Research and Practice, 27 (1), 59-66.

Anderson, S.K., & Kitchener, K.S. (1998). Nonsexual posttherapy relationships: A conceptual framework to assess ethical risks. Professional Psychology: Research and Practice, 29 (1), 91-99.

Appelbaum, P.S., & Jorgenson, L. (1991). Psychotherapist-patient sexual contact after termination of treatment: An analysis and a proposal. American Journal of Psychiatry, 148, 1466 - 1473.

Association of State and Provincial Psychology Boards. (1991). ASPPB code of conduct.

Bartell, P.A., & Rubin, L.J. (1990). Dangerous liaisons: Sexual intimacies in supervision. Professional Psychology: Research and Practice, 21, 442- 450.

Benjamin, J.B. (1994). Commentary on papers by Tansey, Davies and, Hirsch. Psychoanalytic Dialogues, 4 (2), 193-201.

Benowitz, M. (1994). Comparing the experiences of women clients sexually exploited by female versus male psychotherapists. In J.C. Gonsiorek (Ed.), Breach of trust: Sexual exploitation by health care professionals and clergy (pp.231-233). London: Sage Publications.

Bernsen, A., Tabachnick, B.G., & Pope, K. S. (1994). National survey of social workers' sexual attraction to their clients: Results, implications, and comparison to psychologists. Ethics & Behavior, 4 (4), 369 - 388.

Blanchard, C.A., & Lichtenberg, J.W. (1998). Counseling psychologists' training to deal with their sexual feelings in therapy. The Counseling Psychologist, 26 (4), 624-639.

Book, H.E. (1995). The "Erotic Transference": Some technical and countertransferential difficulties. American Journal of Psychotherapy, 49 (4), 504 - 513.

Borys, D.S., & Pope, K.S. (1989). Dual relationships between therapist and client: A national study of psychologists, psychiatrists and social workers. Professional Psychology: Research and Practice, 20 (5), 283-293.

Bouhoutsos, J., Holroyd, J., Lerman, H., Forer, B.R., & Greenberg, M. (1983). Sexual intimacy between psychotherapists and patients. Professional Psychology: Research and Practice, 14 (2), 185 - 196.

Bridges, N.A. (1994). Meaning and management of attraction: Neglected areas of psychotherapy training and practice. Psychotherapy, 31, 424-433.

Brown, L.S. (1988). Harmful effects of postermination sexual and romantic relationships between therapists and their former clients. Psychotherapy, 25 (2), 249-255.

Brown, L.S. (1994). Boundaries in feminist therapy: A conceptual formulation. In N.K. Gartrell (Ed.), Bringing ethics alive: Feminist ethics in psychotherapy practice (pp.29-38). New York: Harrington Park Press.

Canadian Psychological Association. (1991). Canadian code of ethics for psychologists. Ottawa: Author.

Canter, M.B., Bennett, B.E., Jones, S.E., & Nagy, T.F. (1994). Ethics for psychologists: A commentary on the APA ethics code. Washington, DC: American Psychological Association.

Celenza, A. (1991). The misuse of countertransference love in sexual intimacies between therapists and patients. Psychoanalytic Psychology, 8 (4), 501-509.

Celenza, A. (1995). Love and hate in the countertransference: Supervisory concerns. Psychotherapy, 32 (2), 301-307.

Chaplin, J. (1970). Dictionary of Psychology. New York: Dell Publishing Company.

Cummings, N.A. & Sobel, S.B. (1985). Malpractice insurance: Update on sex claims. Psychotherapy, 22 (2), 186–188.

Durana, C. (1998). The use of touch in psychotherapy: Ethical and clinical guidelines. Psychotherapy, 35 (2), 269-280.

Dyck, M.J. (1993). Unethical developments in moral reasoning. Australian Psychologist, 28, 60.

Edelwich, J.E. & Brodsky, A. (1982). Sexual dilemmas for the helping professional. New York: Brunner/Mazel.

Epstein, R.S. (1994). Keeping boundaries: Maintaining safety and integrity in the therapeutic process. Washington, DC: American Psychiatric Press.

Feldman-Summers, S. (1989). Sexual contact in fiduciary relationships. In G.O. Gabbard, (Ed.), Sexual exploitation in professional relationships (pp. 193-209). Washington, DC: American Psychiatric Press.

Feldman-Summers, S., & Jones, G. (1984). Psychological impacts of sexual contact between therapists or other health care professionals and their clients. Journal of Consulting and Clinical Psychology, 52, 1054-1061.

Fitzpatrick, K. (1999). Terms of endearment in clinical analysis. Psychoanalytic Quarterly, LXVIII, 119-125.

Folman, R.Z. (1991). Therapist-patient sex: Attraction and boundary problems. Psychotherapy, 28 (1), 168-173.

Freedman, N., & Lavender, J. (1997). On receiving the patient's transference: The symbolising and desymbolising countertransference. Journal of the American Psychoanalytic Association, 45 (1), 79-103.

Gabbard, G.O. (1994a) Commentary on papers by Tansey, Hirsch, and Davies. Psychoanalytic Dialogues, 4 (2) 203-213.

Gabbard, G.O. (1994b). Psychotherapists who transgress sexual boundaries with patients. Bulletin of the Menninger Clinic, 58 (1), 121-135.

Gabbard, G. O. (1994c). Reconsidering the American Psychological Association's policy on sex with former patients: Is it justifiable? Professional Psychology: Research and Practice, 25 (4), 329-335.

Gabbard, G.O. (1994d). Sexual excitement and countertransference love in the analyst. Journal of the American Psychoanalytic Association, 42 (4), 1083-1106.

Gabbard, G.O. (1995). Countertransference: The emerging common ground. International Journal of Psychoanalysis, 76 (3), 475-485.

Gabbard, G.O., & Pope, K.S. (1989). Sexual intimacies after termination: Clinical, ethical, and legal aspects. In G.O. Gabbard, (Ed.), Sexual exploitation in professional relationships (pp. 115-127). Washington, DC: American Psychiatric Press.

Garrett, T., & Davis, J. (1994). Epidemiology in the U.K. In D. Jehu (Ed.), Patients as victims: Sexual abuse in psychotherapy and counselling (pp. 37-57). Chichester: John Wiley & Sons.

Gartrell, N.K., Herman, J., Olarte, S., Feldstein, M., & Localio, R. (1986). Psychiatrist-patient sexual contact: Results of a national survey, I: Prevalence. American Journal of Psychiatry, 143 (9), 1126-1131.

Gartrell, N.K., Milliken, N., Goodson, W.H., Thieman, S., & Lo, B. (1995). Physician-patient sexual contact: Prevalence and problems. In J.C. Gonsiorek, (Ed.), Breach of trust: Sexual exploitation by health care professionals and clergy (pp. 18-28). London: Sage Publications.

Gechtman, L. (1989). Sexual contact between social workers and their clients. In G.O. Gabbard (Ed.), Sexual exploitation in professional relationships (pp. 27-38). Washington, DC: American Psychiatric Press.

Glaser, R.D., & Thorpe, J.S. (1986). Unethical intimacy: A survey of sexual contact and advances between psychology educators and female graduate students. American Psychologist, 41 (1), 43-51.

Gottlieb, M.C. (1993). Avoiding exploitative dual relationships: A decision-making model. Psychotherapy, 30 (1), 41-48.

Gutheil, T.G., & Gabbard, G.O. (1993). The concept of boundaries in clinical practice: Theoretical and risk-management dimensions. American Journal of Psychiatry, 150 (2), 188-196.

Hall, J.E. (1987). Gender-related ethical dilemmas and ethics education. Professional Psychology: Research and Practice, 18 (6), 573-579.

Hamilton, J.C., & Spruil, J. (1999). Identifying and reducing risk factors related to trainee-client sexual misconduct. Professional Psychology: Research and Practice, 30 (3), 318-327.

Haspel, K.C., Jorgenson, L.M., Wincze, J.P., & Parsons, J.P. (1997). Legislative intervention regarding therapist sexual misconduct: An overview. Professional Psychology: Research and Practice, 28 (1), 63–72.

Herman, J.L., Gartrell, N., Olarte, S., Feldstein, M., & Localio, R. (1987). Psychiatrist-patient sexual contact: Results of a national survey II: Psychiatrists' attitudes. American Journal of Psychiatry, 144 (2), 164-169.

Hirsch, I. (1994). Countertransference love and theoretical model. Psychoanalytic Dialogues, 4 (2), 171-192.

Holroyd, J. & Bouhoutsos, J.C. (1985). Biased reporting of therapist-patient sexual intimacy. Professional Psychology: Research and Practice, 16 (5), 701-709.

Holroyd, J.C., & Brodsky, A.M. (1977). Psychologists' attitudes and practices regarding erotic and nonerotic physical contact with patients. American Psychologist, 32, 843-849.

Horton, J.A., Clance, P.R., Sterk-Elifson, C., & Emshoff, J. (1995). Touch in psychotherapy: A survey of patients' experiences. Psychotherapy, 32 (3), 443-457.

Hotelling, K. (1988). Ethical, legal, and administrative options to address sexual relationships between counselor and client. Journal of Counseling and Development, 67, 233–237.

Housman, L.M., & Stake, J.E. (1999). The current state of sexual ethics training in clinical psychology: Issues of quantity, quality, and effectiveness. Professional Psychology: Research and Practice, 30 (3), 302-311.

Jehu, D. (1994). Patients as victims: Sexual abuse in psychotherapy and counselling. Chichester: John Wiley & Sons.

Kardener, S.H. (1974). Sex and the physician-patient relationship. American Journal of Psychiatry, 131 (10), 1134-1136.

Kardener, S.H., Fuller, M., & Mensch, I.N. (1973). A survey of physicians' attitudes and practices regarding erotic and non-erotic contact with patients. American Journal of Psychiatry, 133, 1324-1325.

Kerlinger, F.N. (1986). Foundations of Behavioural Research. (3rd ed.). New York: CBS Publishing.

Kernberg, O.F. (1994). Love in the analytic setting. Journal of the Psychoanalytic Association, 42 (4), 1137-1157.

Lamb, D.H. & Catanzaro, S.J. (1998). Sexual and nonsexual boundary violations involving psychologists, clients, supervisees, and students: Implications for professional practice. Professional Psychology: Research and Practice, 29 (5), 498–503.

Layman, M.J., & McNamara, J.R. (1997). Remediation for ethics violations: Focus on psychotherapists' sexual contact with clients. Professional Psychology: Research and Practice, 28 (3), 281–292.

Lazarus, J.A. (1992). Sex with former patients almost always unethical. American Journal of Psychiatry, 149 (7), 855–857.

Louw, J. (1997a). Regulating professional conduct. Part I: Codes of ethics of national associations in South Africa. South African Journal of Psychology, 27 (3), 183-188.

Louw, J. (1997b). Regulating professional conduct. Part II: The Professional Board for Psychology in South Africa. South African Journal of Psychology, 27 (3), 189-195.

Lyn, L. (1995). Lesbian, gay, and bisexual therapists' social and sexual interactions with clients. In J.C. Gonsiorek, (Ed.), Breach of trust: Sexual exploitation by health care professionals and

clergy (pp. 193-212). London: Sage Publications.

Martin, S. (1999). Revision of ethics code calls for stronger former client sex rule. APA Monitor, July/August, 44.

Netherlands Institute for Psychology. (1998). Netherlands Code of Ethics. Netherlands Institute for Psychology: Author.

Parten, M. (1950). Survey, polls, and samples: Practical procedures. New York: Harper & Brothers.

Pope, K.S. (1988). How clients are harmed by sexual contact with mental health professionals: The syndrome and its prevalence. Journal of Counseling and Development, 67, 222-226.

Pope, K.S. (1990a). Therapist-patient sex as sex abuse: Six scientific, professional, and practical dilemmas in addressing victimization and rehabilitation. Professional Psychology: Research and Practice, 21 (4), 227-239.

Pope, K.S. (1990b). Therapist-patient sexual involvement: A review of the research. Clinical Psychology Review, 10, 477-490.

Pope, K.S. (1993). Licensing disciplinary actions for psychologists who have been sexually involved with a client: Some information about offenders. Professional Psychology: Research and Practice, 24 (3), 374–377.

Pope, K.S. (1994). Sexual involvement with therapists: Patient assessment, subsequent therapy, forensics. Washington, DC: American Psychological Association.

Pope, K.S., & Bouhoutsos, J.C. (1986). Sexual Intimacy between therapists and patients. New York: Praeger.

Pope, K.S., Keith-Spiegel, P. & Tabachnick, B. (1986). Sexual Attraction to clients: The human therapist and the (sometimes) inhuman training system. American Psychologist, 41, (2), 147-158.

Pope, K.S., Levenson, H., & Schover, L.R. (1979). Sexual intimacy in psychology training: Results and implications of a national survey. American Psychologist, 34 (8), 682-689.

Pope, K.S., Sonne, J. L., & Holroyd, J. (1997). Sexual feelings in psychotherapy: Explorations for therapists and therapists in training. Washington, DC: American Psychological Association.

Pope, K.S., Tabachnick, B., & Keith-Spiegel, P. (1987). Ethics of practice: The beliefs and behaviors of psychologists as therapists. American Psychologist, 42 (11), 993-1006.

Pope, K.S., & Tabachnick, B.G. (1993). Therapists' anger, hate, fear, and sexual feelings: National survey of therapist responses, client characteristics, critical events, formal complaints, and training. Professional Psychology: Research and Practice, 24 (2), 142-152.

Pope, K.S. & Vetter, V.A. (1991). Prior therapist-patient involvement among patients seen by psychologists. Psychotherapy, 28, 429-438.

Psy Talk (1999). Code of Conduct, 4, 3.

Rodolfa, E., Hall, T., Holms, V., Davena, A., Komantz, D., Antunez, M., & Hall, A. (1994). The management of sexual feelings in psychotherapy. Professional Psychology: Research and Practice, 25 (2), 168-172.

Rodolfa, E. R., Kitzrow, M., Vohra, S., & Wilson, B. (1990). Training interns to respond to sexual dilemmas. Professional Psychology: Research and Practice, 21 (4), 313-315.

Runyon, R.P. (1977). Nonparametric Statistics: A contemporary approach. Reading, Massachusetts: Addison-Wesley Publishing Company.

Russ, H. (1993). Erotic transference through countertransference: The female therapist and the

male patient. Psychoanalytic Psychology, 10 (3), 393-406.

Rutter, P.R. (1989). Sex in the forbidden zone: When men in power – Therapists, doctors, clergy, teachers, and others – Betray women's trust. New York: Fawcett Crest.

Samuel, S.E., & Gorton, G.E. (1998). National survey of psychology internship directors regarding education for prevention of psychologist-patient sexual exploitation. Professional Psychology: Research and Practice, 29 (1), 86-90.

Schoener, G.R. (1995). Historical overview. In J.C. Gonsiorek, (Ed.), Breach of trust: Sexual exploitation by health care professionals and clergy (pp. 3-17). London: Sage Publications.

Sehl, M.R. (1998). Erotic countertransfrence and clinical social work practice: A national survey of psychotherapists' sexual feelings, attitudes, and responses. Journal of Analytic Social Work, 5 (4), 39-55.

Sell, J.M, Gottlieb, M.C., & Schoenfeld, L. (1986). Ethical considerations of social/romantic relationships with present and former clients. Professional Psychology: Research and Practice, 17 (6), 504-508.

Simon, R.I. (1991). Psychological injury caused by boundary violation precursors to therapist-patient sex. Psychiatric Annals, 21 (10), 614-619.

Slack, C.M., & Wassenaar, D.R. (1999). Ethical dilemmas of South African clinical psychologists: International Comparisons. European Psychologist, 4 (3), 165-178.

Slife, B.D., & Williams, R.N. (1995). What's behind the research? Discovering hidden assumptions in the behavioural sciences. London: Sage Publications.

Slimp, P.A., & Burian, B.K (1994). Multiple role relationships during internship: Consequences and recommendations. Professional Psychology: Research and Practice, 25, 39-45

Smith, D., & Fitzpatrick, M. (1995). Patient-therapist boundary issues: An integrative review of

theory and research. Professional Psychology: Research and Practice, 26 (5), 499-506.

Sonne, J.L. (1994). Multiple relationships: Does the new ethics code answer the right questions? Professional Psychology: Research and Practice, 25 (4), 336-343.

Sonne, J.L., & Pope, K.S. (1991). Treating victims of therapist-patient sexual involvement. Psychotherapy, 28 (1), 174-187.

South African Medical and Dental Council: The Professional Board for Psychology. (1992). Code of professional conduct of the South African Medical and Dental Council and the Professional Board for Psychology in respect of psychology. Pretoria: Author.

South African Medical and Dental Council (1994). Rules specifying the acts or omissions in respect of which disciplinary steps may be taken by the Professional Board for Psychology. Government Gazette, R1379, 1-7.

South African Medical and Dental Council: The Professional Board for Psychology. (1998). Information sheet: Rights of users of psychological services. Pretoria: Author.

Stake, J.E., & Oliver, J. (1991). Sexual contact and touching between therapist and client: A survey of psychologists' attitudes and behavior. Professional Psychology: Research and Practice, 22 (4), 297-307.

Strasburger, L.H., Jorgenson, L., & Sutherland, J.D. (1992). The prevention of psychotherapist sexual misconduct: Avoiding the slippery slope. American Journal of Psychotherapy, XLVI (4), 544-555.

Strean, H.S. (1993). Therapists who have sex with their patients: Treatment and Recovery. New York: Brunner/Mazel Publishers.

Steere, J. (1984). Ethics in clinical psychology. Cape Town: Oxford University Press.

Steere, J., & Wassenaar, D.R. (1985). Ethical principles of clinical psychologists. Stellenbosch:

Universiteits-Uitgewers.

Stolorow, R.D. (1992). Closing the gap between theory and practice with better psychoanalytic theory. Psychotherapy, 29, 159-166.

Strohm Kitchener, K. (1988). Dual role relationships: What makes them so problematic? Journal of Counseling and Development, 67, 217-221.

Tansey, M.J. (1994). Sexual attraction and phobic dread in the countertransference. Psychoanalytic Dialogue, 4 (2), 139-152.

Taylor, S.E. (1990). Health Psychology: The science and the field. American Psychologist, 45 (1), 40-50.

Thoreson, R.W., Shaughnessy, P., Heppner, P. P., & Cook, S.W. (1993). Sexual contact during and after the professional relationship: Attitudes and practices of male counselors. Journal of Counseling & Development, 71, 429-434.

Thoreson, R.W., Shaughnessy, P., & Frazier, P.A. (1995). Sexual contact during and after professional relationships: Practices and attitudes of female counsellors. Journal of Counseling & Development, 74, 84-89.

Thorn, B.E., Shealy, R.C., & Briggs, S.D. (1993). Sexual misconduct in psychotherapy: Reactions to a consumer-oriented brochure. Professional Psychology: Research and Practice, 24 (1), 75-82.

Trent, C., & Collings, S.J. (1997, September). Clinical psychologists' attitudes towards and practices regarding erotic and non-erotic physical contact with clients. (Paper presented at the Third Annual Congress of the Psychological Society of South Africa, Durban, Republic of South Africa).

Twemlow, S.W., & Gabbard, G.O. (1989). The lovesick therapist. In G.O. Gabbard (Ed.), Sexual exploitation in professional relationships (pp.71-87). Washington, DC: American

Psychiatric Press.

Vasquez, M.J.T. (1988). Counselor-client sexual contact: Implications for ethics training. Journal of Counseling and Development, 67, 238-241.

Vasquez, M.J.T & Eldridge, N.S. (1994). Bringing ethics alive: Training practitioners about gender, ethnicity, and sexual orientation issues. In N.K. Gartrell (Ed.), Bringing ethics alive: feminist ethics in psychotherapy practice (pp.1-16). New York: Harrington Park Press.

Vasquez, M.J.T., & Strohm Kitchener, K.S. (1988). Introduction to special feature. Journal of Counseling and Development, 67, 214-216.

Wassenaar, D.R. (1998). A history of ethical codes in South African psychology: An insider's view. South African Journal of Psychology, 28 (3), 135-145.

Wassenaar, D.R., & Slack, C.M. (1999). Ethical dilemmas in psychology in South Africa: Implications for change. (Paper presented at the 6th European Congress of Psychology, Rome, Italy).

White, W.L. (1995). A systems perspective on sexual exploitation of clients by professional helpers. In J.C. Gonsiorek, (Ed.), Breach of trust: Sexual exploitation by health care professionals and clergy (pp. 176-192). London: Sage Publications.

Williams, M.H. (1992). Exploitation and inference: Mapping the damage from therapist-patient sexual involvement. American Psychologist, 47 (3), 412-421.

Wincze, J.P., Richards, J., Parsons, J., & Bailey, S. (1996). A comparative survey of therapists sexual misconduct between an American state and an Australian State. Professional Psychology: Research and Practice, 27 (3), 289-294.

Zelen, S.L. (1985). Sexualization of therapeutic relationships: The dual vulnerability of patient and therapist. Psychotherapy, 22 (2), 178-185.

7 APPENDICES

APPENDIX A - COVERING LETTER

30 June 1999

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AN INVESTIGATION OF PSYCHOLOGISTS' EXPERIENCE OF SEXUAL ATTRACTION TO CLIENTS.

In partial fulfillment of a Masters degree in Clinical Psychology at the University of Natal, Pietermaritzburg, I am completing a thesis which aims to gather information to assist and support clinical psychologists in their striving to maintain ethical practices in the profession.

In order to do so, the study examines how clinical psychologists experience, respond to, and evaluate their training with regard to their sexual attraction to clients. The questionnaire follows a tick response format and should take no longer than about 20 minutes to complete.

I assure you that all information obtained in this study will be treated as totally confidential and will remain anonymous. All data will be analyzed on a sample, and not an individual basis, and will in no way reflect on you as a professional. No identifying details are required on the questionnaire.

I look forward to your participation as this research aims to provide valuable insights and information to guide and inform training of future therapists and to enable those practicing to be aware of, anticipate and avoid potential risks.

Should you require any further information pertaining to the study, please feel free to contact me on 031-7657699.

Thank you

Yours sincerely

RENE STEVENSON
Clinical Psychology M2 Student

Today's date.....

SECTION 1:

1. Please give your sex (Tick one box) ☐ MALE ☐ FEMALE

2. Please give your age .....YEARS

3. Are you (Tick as many boxes as apply)
   - ☐ SINGLE
   - ☐ IN A STABLE RELATIONSHIP
   - ☐ MARRIED
   - ☐ SEPARATED/DIVORCED
   - ☐ WIDOWED

4. How would you identify your sexual orientation?
   - ☐ HETEROSEXUAL
   - ☐ HOMOSEXUAL
   - ☐ BISEXUAL

5. In *total,* how many years have you practiced as a Clinical Psychologist since qualifying? .....YEARS

6. How would you describe your therapeutic orientation? (Please indicate the 3 orientations which most influence your practice where 1 = most influence, 2 = moderate influence, 3 = least influence, by numbering 3 boxes).
   - ☐ BEHAVIORAL
   - ☐ COGNITIVE
   - ☐ PSYCHODYNAMIC/ANALYTIC
   - ☐ SYSTEMIC
   - ☐ HUMANISTIC
   - ☐ ECLECTIC
   - ☐ OTHER (Please specify).....

7. What is your *main* area of professional work? (If more than one, please indicate by ranking where 1 = main focus, 2 = next, etc)
   - ☐ ADULTS
   - ☐ CHILDREN & YOUNG PEOPLE
   - ☐ LEARNING DIFFICULTIES
   - ☐ ELDERLY
   - ☐ PHYSICAL HEALTH
   - ☐ NEUROPSYCHOLOGY
   - ☐ OTHER (Please specify).....

8. With what proportion of your clients do you have *long term* therapeutic contact? (i.e more than 50 sessions) .....%

9. With what proportion of your clients do you have *brief* therapeutic contact? (i.e less than 20 sessions) .....%

10. What is your *main* work setting? (If more than one, please indicate by ranking where 1 = most time spent 2 = next most time, etc.)
    - ☐ HEALTH SERVICES
    - ☐ PRIVATE PRACTICE
    - ☐ SOCIAL SERVICES
    - ☐ VOLUNTARY AGENCY
    - ☐ UNIVERSITY
    - ☐ OTHER (Please specify.....

11. Have you in the past undertaken, or are you currently undertaking personal therapy? (Tick one box) ☐ YES ☐ NO

12. What is your highest qualification? .....

13. When was your first year of registration as a Clinical Psychologist? 19.....

14. At which university did you undertake your post-graduate training? .....

15. Do you currently attend supervision? ☐ YES ☐ NO

SECTION 2:

1. Have you ever felt sexually attracted to one of your clients? (Tick one box) ☐ YES ☐ NO

   If you answered YES to the above question, go to question 2 below.
   If you answered NO to the above question, go to ***SECTION 3*** on page 4.

2. How often have you been sexually attracted to one of your *male* clients? (Tick one box)
   - ☐ RARELY (ONCE OR TWICE)
   - ☐ OCCASIONALLY (3-10 TIMES)
   - ☐ FREQUENTLY (MORE THAN 10 TIMES)

3. How often have you been sexually attracted to one of your *female* clients? (Tick one box)
   - ☐ RARELY (ONCE OR TWICE)
   - ☐ OCCASIONALLY (3-10 TIMES)
   - ☐ FREQUENTLY (MORE THAN 10 TIMES)

4. In instances when you were sexually attracted to a client was the client aware of it? ☐ YES ☐ NO ☐ NOT SURE

5. In instances when you were sexually attracted to a client, was the client also attracted to you? ☐ YES ☐ NO ☐ NOT SURE

6. When you are sexually attracted to a client, does it tend to make you feel uncomfortable, guilty or anxious? ☐ YES ☐ NO

7. Do you believe that your sexual attraction to a client has ever been *beneficial* to the therapy process?
☐ NO
☐ RARELY (ONCE OR TWICE)
☐ OCCASIONALLY (3-10 TIMES)
☐ FREQUENTLY (MORE THAN 10 TIMES)

8. Do you believe that your sexual attraction to a client has ever been *harmful or an impediment* to the therapy process?
☐ NO
☐ RARELY (ONCE OR TWICE)
☐ OCCASIONALLY (3-10 TIMES)
☐ FREQUENTLY (MORE THAN 10 TIMES)

Note: For the purposes of this study *'sexual involvement'* is defined as *"contact which was intended to arouse or satisfy sexual desire in the patient, therapist or both"*.

9. Have you ever seriously considered sexual involvement with a client?
☐ NO
☐ RARELY (ONCE OR TWICE)
☐ OCCASIONALLY (3-10 TIMES)
☐ FREQUENTLY (MORE THAN 10 TIMES)

10. While engaging in sexual activity with someone other than a client, have you ever had sexual fantasies about someone who was or is a client?
☐ NO
☐ RARELY (ONCE OR TWICE)
☐ OCCASIONALLY (3-10 TIMES)
☐ FREQUENTLY (MORE THAN 10 TIMES)

11. Have you ever been sexually involved with one of your clients?
☐ NO
☐ RARELY (ONCE OR TWICE)
☐ OCCASIONALLY (3-10 TIMES)
☐ FREQUENTLY (MORE THAN 10 TIMES)

12. In those situations in which you have felt sexually attracted to a client, what have you done? (Please tick as many boxes as apply)

☐ TOLD CLIENT ABOUT THE FEELINGS, BUT *DID NOT* ACT ON THEM
☐ TOLD CLIENT ABOUT THE FEELINGS, AND *DID* ACT ON THEM
☐ SOUGHT SUPERVISION
☐ DISCUSSED FEELINGS WITH OWN THERAPIST
☐ REFERRED CLIENT TO ANOTHER THERAPIST
☐ SOUGHT PEER CONSULTATION
☐ WORKED THROUGH FEELINGS BY ONESELF
☐ OTHER (Please specify).....

were sexually attracted to a client, and did not become sexually involved with the client why did you refrain from involvement? (If more than one reason, please rank in order of priority, where 1 = primary reason, 2 = next most important reason, etc)

☐ COUNTERTHERAPEUTIC/EXPLOITATIVE
☐ UNPROFESSIONAL PRACTICE
☐ AGAINST MY PERSONAL VALUES
☐ ALREADY IN COMMITTED RELATIONSHIP
☐ DAMAGING TO ME
☐ DISRUPTS HANDLING OF TRANSFERENCE/ COUNTERTRANSFERENCE
☐ FEAR OF RETALIATION BY CLIENT
☐ ATTRACTION TOO WEAK OR SHORT LIVED
☐ FEAR OF CENSURE/LOSS OF REPUTATION
☐ SELF-CONTROL
☐ FEAR OF BEING SUED FOR DAMAGES
☐ COMMON SENSE
☐ OTHER (Please specify).....

.....

SECTION 3:

1. Did your post-graduate training/internship provide courses or other structured education about therapists' *sexual attraction* to clients? (Please to tick one box)
☐ NO SUCH EDUCATION
☐ VERY LITTLE EDUCATION
☐ SOME EDUCATION
☐ ADEQUATE EDUCATION

2. Did your post-graduate training/internship provide courses or other structured education about the ethics of *sexual involvement* between therapist and client, or former client? (Please tick one box)
☐ NO SUCH EDUCATION
☐ VERY LITTLE EDUCATION
☐ SOME EDUCATION
☐ ADEQUATE EDUCATION

3. Was your training useful in assisting you to make informed decisions about sexual involvement with clients? ☐ YES ☐ NO

4. If you believe your training was inadequate in addressing sexual issues in therapy, what do you believe would constitute appropriate training? .....

5. Do you believe education about therapists' sexual attraction to, and sexual involvement with, clients or former clients should be a required part of the training curriculum for Clinical Psychologists? ☐ YES ☐ NO

6. What ethical code/s or guidelines do you practice? (Please provide reference/s) .....

SECTION 4:

1. Please rate each of the following behaviours between therapist and client by numbering each box on a scale of 1-5 where:
   1 = NEVER ETHICAL
   2 = RARELY ETHICAL
   3 = OCCASIONALLY ETHICAL
   4 = FREQUENTLY ETHICAL
   5 = ALWAYS ETHICAL

   ☐ HANDSHAKE
   ☐ PATTING ON ARM
   ☐ HOLDING HANDS
   ☐ TOUCHING ARM/SHOULDER ETC
   ☐ HUGGING
   ☐ KISSING
   ☐ SEXUAL INVOLVEMENT WITH A FORMER CLIENT
   ☐ SEXUAL INVOLVEMENT WITH A CURRENT CLIENT

2. Please rate each of the following behaviours between therapist and client by numbering each box on a scale of 1-5 where:
   1 = ALWAYS HARMFUL
   2 = FREQUENTLY HARMFUL
   3 = OCCASIONALLY HARMFUL
   4 = RARELY HARMFUL
   5 = NEVER HARMFUL

   ☐ HANDSHAKE
   ☐ PATTING ON ARM
   ☐ HOLDING HANDS
   ☐ TOUCHING ARM/SHOULDER ETC
   ☐ HUGGING
   ☐ KISSING
   ☐ SEXUAL INVOLVEMENT WITH A FORMER CLIENT
   ☐ SEXUAL INVOLVEMENT WITH A CURRENT CLIENT

3. Under which, if any, of the following circumstances do you believe sexual involvement with clients may be appropriate? (Tick as many boxes as apply)

   ☐ ENHANCEMENT OF CLIENT'S SELF ESTEEM
   ☐ SEXUAL DYSFUNCTION
   ☐ CORRECTIVE EMOTIONAL EXPERIENCE
   ☐ TO CHANGE SEXUAL ORIENTATION
   ☐ SHORTEN GRIEF REACTION
   ☐ THERAPIST IN LOVE WITH CLIENT
   ☐ UNDER NO CIRCUMSTANCES
   ☐ OTHER (please specify).....

   .....

4. What factors do you regard to be important in determining the ethicality of sexual involvement between therapist and *former* clients? (Please tick as many boxes as apply)

   ☐ TIME SINCE TERMINATION
   ☐ TRANSFERENCE ISSUES
   ☐ LENGTH OF THERAPY
   ☐ NATURE OF THERAPY
   ☐ NATURE OF TERMINATION
   ☐ FREEDOM OF CHOICE
   ☐ WHETHER EXPLOITATION OCCURRED
   ☐ MENTAL HEALTH OF CLIENT
   ☐ WHETHER THERAPY WILL BE REACTIVATED
   ☐ RECIPROCITY
   ☐ WHETHER THERE IS HARM TO THE CLIENT
   ☐ NEVER ETHICAL
   ☐ OTHER (Please specify.....

   .....

5. What, if any, do you regard to be an appropriate time interval between termination of therapy and sexual involvement between therapist and client? (Please tick one box)

   ☐ NEVER APPROPRIATE
   ☐ LONGER THAN FIVE YEARS
   ☐ LONGER THAN TWO YEARS
   ☐ 1-2 YEARS
   ☐ 6-12 MONTHS
   ☐ 1-6 MONTHS
   ☐ IMMEDIATELY
   ☐ OTHER (Please specify).....

   .....

SECTION 5:

Are there any further comments/suggestions you would like to make?

.....

.....

.....

.....

APPENDIX C - QUALITATIVE DATA

Section 2, Question 12.

"In those situations in which you have felt sexually attracted to a client, what have you done?" Responses volunteered in the 'other' category:

- Suppressed the feelings
- The question implies a pathological response needing working through. Sexuality is part of the process and requires constant attention in the work unless it is the therapist's issue. In that case, supervision and therapy.
- Made an appropriate interpretation
- Just acknowledged the feelings and didn't work through it ... there's nothing to work through.
- Discussed feelings with husband
- Did not tell client – this information is not beneficial for client therapeutically
- Examined my countertransference experience
- Brought feelings into the relationship

Section 3, Question 4.

If respondents deemed their training to be inadequate in addressing sexual issues in therapy, they were asked to indicate, in an open-ended question what they believe would constitute appropriate training. The following qualitative data was elicited. Where the same suggestion was made by more than one subject, the numbers are indicated in parentheses.

- Self-control
- Personal focus and clarity
- Formalised, Structured education/course on ethics (x8)
- Addressing it as part of course on ethical codes, directly
- What does the attraction mean – exploration of meaning
- Awareness of the importance of boundaries in the therapeutic relationship (x4)
- Make the implicit assumptions explicit
- Raise issues more, especially re: subtle dimensions
- Supervision (x6)
- Handling of transference/countertransference issues (x4)
- Course on the desire of the therapist
- Workshops (x3)
- One good lecture on the subject at MA level
- Include such matters in learning material
- Raising of issue for discussion (x5)
- Case study examples and discussion (x3)
- Role plays (x2)
- That includes such education
- Videos
- Groupwork
- Raising awareness through SAMDC guidelines and Allan's book "The law and the Psychotherapist"

- Prepare therapists!
- Uncertain

Section 3, Question 6.

'What ethical codes/guidelines do you practice? (Please provide reference/s)

- remain in professional state of mind with clients
- ethical rules for psychologists
- human, moral, ethical and professional, in summary a patient has come to me for help not abuse; they are not required to meet and to minister to my needs, I am required to understand, meet and minister to theirs as much as I am personally capable of doing
- keep the distance, keep to the business
- ethical sense based on protection of clients best interests
- law
- ethics as applicable to all professionals
- no sexual relationships with past or present clients – not sure what references apply – ethical code for psychologists?
- common sense
- N/A
- My own moral code (x2)

Section 4, Question 1.

Rating of other forms of touch. Comments volunteered by subjects:

- Indicated different rating for adult and child for all behaviours
- Very difficult to rate out of context
- Hugging (rated 3) – 'In very specific context! e.g. grieving'. Sexual involvement with former client (rated 2) 'personally, never. In bigger picture, after 2 years post-termination'.
- These 'physical acts' are seriously context dependent
- Holding hands- 'depends on who – for e.g. elderly person OK'.
- Kissing – 'what kind? Sexual =never ethical, or non-sexual as with European style greeting is occasionally ethical.'
- Hugging (rated 3). 'As a parting gesture or when on occasion it seems appropriate to ending relationship.'
- Holding hands (rated 3) with same sex client
- Holding hands, touching arm/shoulder and hugging. 'Am aware that these behaviours are not considered ethical, however at times patients need consoling e.g. death of spouse.'
- Don't these depend on cultural background as well?
- Hugging – 'OK in group work. Context? Patting on arm – 'can be unethical with incest survivors in initial stages of therapy'. Sexual involvement with current client – 'I am open to this being ethical in certain circumstances'.
- Hugging (rated 3) 'Greeting/time of loss/bereavement'. Handshake and kissing – 'as a way of greeting'.
- Patting on arm and holding hands (rated 3) – with children

- Holding hands – rated 1 for adults, 3 for children. Hugging – 'different with adults and children. Sometimes children just launch themselves at you in expression of fondness. However, I would not initiate a hug.'
- Who initiates behaviour?
- Holding hands – 'depends on motive.'
- Holding hands – 'never ethical except during supportive work, during groupwork'.
- I think slightly different rules apply around more innocuous contact (e.g. handshake, touching arm) depending on nature of therapy and age of client e.g. touch is unavoidable in play therapy with young children. Not to touch would be sadistic and unnatural in this context

Section 4, Question 3.

Under which if any, of the following circumstances do you believe sexual involvement with clients may be appropriate? Responses volunteered in the 'other' category:

- maybe if client is no longer in therapy
- if therapy has been terminated for a sufficient period of time
- if patient is married to the therapist
- possible only after appropriate termination and renegotiating of new relationship or friendship
- only when therapy has terminated
- only after two years after ending of treatment.
- if you a radical Reichian [sic]

Section 5: Other comments.

An attempt has been made to group responses thematically for the sake of clarity.

- What is sex?
- I'd be very interested in your results as I am a lecturer in ethics and law and psychology. We do cover this topic thoroughly, but you never know.
- Please publish your findings in the SAJP.
- I think you are busy with a very relevant study. Everything of the best.
- Sterkte met jou studies.
- A controversial and neglected topic. Thank you for addressing it. Good luck.
- Study is long overdue. Please make results known.
- Interesting topic choice.
- Good luck – a very sensitive subject. What about relations between student and supervisor. I know it happens a lot.
- Good luck. Interesting study.
- Good subject for research. Good luck.
- Good luck with your work.
- Sexual involvement is an extremely sensitive issue, and could have serious implications for the future of both therapist and client. A fine line becomes evident once certain boundaries are crossed.
- A difficult issue to answer in this format – some qualitative research would be useful as

things are not easily quantified. Ethical needs to be defined – otherwise a relative term.

- I don't want too tell you how to do your research, but sexuality is a highly complex dimension of life, never mind therapy, & hence might require anonymous interviewing of therapists than just questionnaire analysis to get to the bottom of it. There is also more to sexuality in therapy than sexual involvement, or touch or the reductionism inherent in technical issues of ethics. You can have all the ethical guidelines in the world, but if you don't deal with the ordinary/legitimate dialectics of the therapist's desire in training, then ethics mean nothing.
- I find quantitative assessment of this sort not very useful. All of this depends on the therapist, client and their relationship. The hysteria surrounding sexual issues I find unhelpful.
- It is unrealistic to expect one to never feel sexually attracted to any client. What is important is what one does with these feelings.
- Overall sexual attraction is a natural occurrence. We should however, react to this in a responsible ethical way.
- I think that a clear distinction should be made between feeling/experiencing sexual attraction (and in being open to such a possibility, being able to think about and work through it) and acting upon it. The first could inform therapy, the second is unethical.
- Sexual attractiveness is often an invaluable countertransference clue to pathology/dynamics.
- There is possibly not enough emphasis on instructing young/beginning therapists as to what is appropriate behaviour towards clients. This goes beyond sexual contact and looks at self-disclosure etc. Important to focus on the issue of maintaining boundaries of all kinds AND countertransference issues. Relationships can be abusive without getting sexual.
- If this attraction leads to acting out I think is never terribly useful. Attraction often has huge CT relevance especially when the result of a projective identification process i.e. attraction isn't something to be puritanically 'extinguished', I believe.
- I have struggled to complete this – I think you are looking at literal acting out of sexual, physical relationship. What about the clinical valuing of therapist's subjectivity as a way to the patient's unconscious? I do not think physical/sexual contact with a patient is ever justified. Erotic transference, countertransference needs to be explored for patient's benefit. It is a useful source of information. It is not a bad thing to be sexually attracted to a patient, but it is a bad thing to act on it.
- There is a marked difference between fantasy and acting out of such fantasy. If fantasy is present I regard that as some useful information that can further understanding of therapeutic relationship. Projection of transference and countertransference. If one is receptive as a therapist then sexual fantasy may well enter into it as the therapeutic relationship can be one of closeness and intimacy. For me, the importance lies in always preserving the therapeutic framework and boundaries. There is no grey area in this and when I conduct supervision and training this is crucial for therapists to understand. Good luck with your research.
- I have always been very professional as I believe it is very unethical towards the client to involve oneself in therapy socially and/or sexually.
- The definition of a relationship between a client/patient and a therapist will remain as such (professional), since the need for psychology may arise even after termination of therapy for a number of months/years. Therefore that special relationship will/may change only after the clinical psychologist resigns from the profession.

- In section 4, I would rate kissing 1 if this refers to 'french kissing'. I have assumed you are referring to a light 'peck' on the cheek though.
- Individual circumstances do vary and it is difficult to make definite rules regarding individuals and their experiences.
- Firm therapeutic boundaries must be maintained at all times – for the good of the client and the therapist.
- In the therapy context it is natural that a bond develops. If the therapist is clear on boundary setting (and has clear 'internal 'boundaries' or of mind), there should be no issue. I have had clients (3 male, 1 female) attracted to me over the past six years and have always dealt with it immediately. In one case I terminated, as the client attempted to kiss me after a breakthrough session, and would not accept this as inappropriate. In the other cases, issues were raised in the first 1-3 sessions and successfully dealt with. Therapy continued as normal thereafter. I am happy to discuss any of these issues, should this be of assistance.
- If there is any sign of serious sexual attraction which cannot be resolved by discussing transference and countertransference, the patient should be referred to another therapist. This applies to social interactions as well. Boundaries in the therapeutic relationship are essential.
- Have you thought about transference, countertransference, projective identification as helpful in understanding patients and therapists?
- Have often experienced intense (non-erectile) sexual arousal in the sense of empathy with clients energy re-orientation (lower chakra openings, but I could not call this sexual attraction.
- Some of the psychologists do end up in relationship with clients or their relatives. It is dangerous to engage in therapy when single because the biological needs are not easy to meet.
- I happen to be happily married and have an ethical commitment to my family. My marriage and family are far more important to me in terms of my values than any client will ever be.
- Obviously whether the therapist and/or client is married or not also plays another major role.
- I think sexual issues and the handling thereof in training are largely subsumed under general training and ethics.
- Addressing it as part of course on ethical codes, directly.
- Therapists should be competent enough to know that they cannot have dual relationships with clients. It is the most disreputable thing to do as a therapist.
- Issues which should be addressed in this context; "What if therapist takes fully committed initiative leading to permanent relationship (e.g. manage) - should that be okayed at any point during/after therapy? I believe if the therapist is committed to love the client in a developing equal and permanent relationship and proves this intentionality by various forms of emotional, practical and material commitment, who can say nay? On the other hand casual sex even many years later after termination is almost certainly not good. But 2 years might still be a reasonable. I'm not sure.
- I do not think M1/M2 training is a good measure of sexual involvement potential.
- There are too many important aspects to be covered in training. Sexual attraction to clients should be addressed but 'within limits' regarding time allowed to it – there are just too many important issues to address other than this.
- Some of your questions are leading Q12. See comments. Also Q7. I cannot know my

clients' experience unless I ask them.

- I want to write an article dealing with this issue. I thought a neat title would be "Embracing the therapeutic mind-fuck and avoiding the professional cluster-fuck" It is important that we find spaces to open up this issue and speak about it sensibly without calling in countertransference. I think it's more appropriate to speak of 'normal human horniness' and how to deal with that in appropriate ways in the therapeutic setting. How about eliciting a number of narratives and working with those? I have a couple, but want to use them in the planned article. Look out in something like "New Therapist".
- I have never been placed in this predicament as I deal mostly with children. I have therefore used my imagination.
- My views and experience may not be a true reflection of what a therapist experiences in her typical duties. The reason for this is that I have practised mainly in an industrial setting where the scope for clinical work is rather limited.
- Recommend therapy for couple before deciding on a relationship – to protect the client