University of Alberta

Female Therapists' Experience of Client Sexual Advances

By

Marion Patricia Stewart

A thesis submitted to the Faculty of Graduate Studies and Research

in partial fulfillment of the requirements for the degree of

Master of Education

in

Counselling Psychology

Department of Educational Psychology

©Marion Patricia Stewart

Spring 2010

Edmonton, Alberta

Permission is hereby granted to the University of Alberta Libraries to reproduce single copies of this thesis and to lend or sell such copies for private, scholarly or scientific research purposes only. Where the thesis is converted to, or otherwise made available in digital form, the University of Alberta will advise potential users of the thesis of these terms.

The author reserves all other publication and other rights in association with the copyright in the thesis and, except as herein before provided, neither the thesis nor any substantial portion thereof may be printed or otherwise reproduced in any material form whatsoever without the author's prior written permission.

Examining Committee

Derek Truscott, Educational Psychology

George Buck, Educational Psychology

Jean Clandinin, Elementary Education

Dedication

This thesis is dedicated to my colleagues who were as curious as I was about this topic and particularly the one whose pointed question, “So, what do I do?” provided inspiration and focus for my writing. I would also like to dedicate this to the participants who seemed as curious as the rest of us, while willingly sharing their own experiences and advice. I have the utmost respect and admiration for each of you and appreciate the eagerness with which you contributed to this project. I have attempted to be as true to your voice as another person can be.

Abstract

Client sexual advances may be a common occurrence in therapy, yet there is little information available with strategies for managing them. In hope of initiating a dialogue, five female therapists' experiences were examined for possible insights. Informal semi-structured interviews provided data for a qualitative thematic analysis. Questions focussed on therapists' accounts of incidents, how they were managed, impact on therapy, and speculations on potential differences between female and male therapists' experiences. Discussing the topic with colleagues or supervisors and adequacy of training were also explored. Six overarching themes were derived; (1) sexual advances, (2) special relationships, (3) impact on therapist, (4) maintaining boundaries, (5) taboo topic and, (6) being female. Implications for counsellor training, supervision, and future research were discussed.

Acknowledgements

When I was in my twenties, I served on a jury. It was the first time I became truly aware of the brutality that many women endure from the men in their lives. Thus began my journey to understand why.

From this experience, my interest in exploring feminist issues arose and later evolved into the broader context of our world. There is a need to develop peaceful individuals, communities, and societies with aspirations toward a peaceful world. I learned that it is difficult to envision peace in the world without experiencing it within ourselves and our own relationships. When that is possible, it is easier to extend compassion and acceptance to others so they may experience it also. My interest in becoming a counsellor was developed from this belief. My way of contributing to the world would be one person at a time.

It has taken many years of life and experience to get here and there are numerous people to thank. First, I would like to thank Bob for our 27 years together and more recently for inspiring me with his passion for peace, his generosity, and his compassion. You have been the rock that allowed me to go out and explore my interests and discover myself in the process. I am also grateful to my wonderful children. You were my world for so long and you continue to amaze me with your talents, achievements, and the courage with which you face the challenges of young adulthood.

From the University of Calgary, I would like to acknowledge and thank Shelly Russell-Mayhew for appreciating my abilities, providing the opportunity for research experience, and being the kind of supervisor any undergrad could want. I would also like to thank Corrine Borbridge who provided a wonderful example of what counselling should look like in her class. Without support from both of you, I may not have had the experience I have enjoyed at the University of Alberta. I will be forever grateful.

It has been a privilege and a pleasure to be a student in the Department of Counselling Psychology. There are too many people to acknowledge individually. Thanks go to my instructors, supervisors, fellow students, clients, and support staff who all contributed to a positive experience. A particular thanks to my thesis advisor, Derek Truscott, whose love of writing is contagious. In spite of the prolonged process experienced with my thesis, I have incorporated some of your enthusiasm and insights that will continue to contribute to writing projects that (I hope) are in my future. Special thanks also to Jean Clandinin. I appreciate the opportunity to have worked with you, to witness compassionate leadership first-hand, and to experience the warm and creative learning environment you have nurtured at the Centre. I wish I could have spent more time there.

And then there is the group-of-seven; Tania, Carla, Tatiana, Sean, Mike, and Deb. There was amazing chemistry in this incredible mix of ages and personalities. The most wonderful part was that at the heart of our experience, there was compassion instead of competition. I appreciate your good hearts and keen minds. You are family and will always be a welcome sight whether I see you tomorrow or twenty years from now. Deb, you have become my closest friend. I cannot thank you enough for sharing and caring they way you have.

Finally, I would like to acknowledge and thank Reinhard. I appreciate the love, laughter, music, and joy in the simple things when we are together. You listened, never pressured me, judged me, or said “Just do it!” as I struggled to complete this project. Thank you. I am very grateful for having you in my life.

Table of Contents

List of Tables....................vii

Chapter One: Introduction....................1

Background.....................1

Researcher Interest....................4

Statement of Purpose....................5

Significance of the Study....................6

Terms Used....................9

Chapter Two: Literature Review....................12

Chapter Three: Method....................19

Statement of Purpose....................19

Rationale for a Qualitative Thematic Analysis....................19

Researcher Orientation to Qualitative Research....................21

Methodological Framework....................22

Participants....................25

Participant Descriptions and Their Respective Clients....................26

The Interviews....................29

Procedures....................30

Chapter Four: Findings....................35

Summary of Findings....................35

Theme 1: Sexual Advances....................37

- *Sub-Theme 1.1: Direct Approach: Overt Statements or Actions*....................37

- *Sub-Theme 1.2: Obvious Attraction: Intuitively Understood*......................39
- *Sub-Theme 1.3: Indirect Approach: Alluding to the Potential for a More Personal Relationship*..40
- *Sub-Theme 1.4: No Clue: A Third Person Enlightened Me*........................41
- *Sub-Theme 1.5: Special Populations: Sexual Advances Are Anticipated*....41

Theme 2: Special Relationship..43

- *Sub-Theme 2.1: Intimacy and Trust*...44
- *Sub-Theme 2.2: Positive Therapeutic Experience*......................................45
- *Sub-Theme 2.3: Acceptance: Not Rejection*...46
- *Sub-Theme 2.4: Vulnerability of Clients*..47

Theme 3: Impact on Therapist...48

- *Sub-Theme 3.1: Suspicion and Self-Doubt*..49
- *Sub-Theme 3.2: Dress and Behaviour*...50
- *Sub-Theme 3.3: Self-Disclosure*..51
- *Sub-Theme 3.4: The Elephant In the Room*...53
- *Sub-Theme 3.5: Dilemma—Confront or Ignore*..54

Theme 4: Maintaining Professional Boundaries..57

- *Sub-Theme 4.1: Intuition in a Grey Area*..59
- *Sub-Theme 4.2: Benefits of Client Sexual Attraction*..................................60
- *Sub-Theme 4.3: Cues and Clues*..62

Theme 5: Taboo Topic..64

- *Sub-Theme 5.1: Embarrassment and Avoidance*...65
- *Sub-Theme 5.2: Supervisors and Colleagues*..65

- *Sub-Theme 5.3: Training and Experience*..68

Theme 6: Being Female...70

- *Sub-Theme 6.1: Blaming the Victim: Fears of Not Being Believed, Judgement Questioned, Being Judged*..71
- *Sub-Theme 6.2: Male/Female Seduction Styles*..72

Summary of Findings...73

Chapter Five: Discussion...75

Sexual Advances...75

Special Relationship..76

Impact on Therapist...78

Maintaining Professional Boundaries..80

Taboo Topic...85

Being Female...88

Contributions of the Study..90

Implications for Therapists..93

Recommendations and Considerations for Future Research.......................94

Conclusion..100

References...102

Appendix A: Information Letter to Participants 108

Appendix B: Consent Form 111

Appendix C: Interview Guide..113

Appendix D: Research Consultant Confidentiality Agreement...................115

List of Tables

Table I: Themes and Sub-Themes..36

Chapter One: Introduction

Background

> [The analyst] . . . must recognize that the patient's falling in love is induced by the analytic situation and is not to be ascribed to the charms of his person, that he has no reason whatsoever to be proud of such a "conquest" as it would be called outside analysis. (Freud, 1915/1953, p. 379)

This quote from Freud illustrates that the phenomenon of client attraction to therapists in the context of psychotherapeutic practice was recognized even as the "talking cure" was being established. Freud differentiated patients' transference as a clinical phenomenon separate from non-clinical "falling in love" following the bizarre circumstances of his mentor Josef Breuer with his patient Bertha Pappenheim (also known as Anna O). Breuer met with the attractive and intelligent young Bertha twice a day, several times a week, sometimes in her bedroom. The sessions themselves gradually extended to several hours at a time. Breuer began to note an erotic tone to the sessions during the second year of therapy and seeing that his patient had taken tremendous strides towards recovery, decided to terminate therapy. Bertha relapsed and, behaving as though she were giving birth, was taken to hospital. Breuer went to see her at the hospital, where she told him that she was pregnant with his child. Breuer, shocked and surprised, rushed home to his wife and they promptly left the country for a vacation. The pregnancy turned out to be "hysterical". Bertha was not pregnant. She suffered for several more years. Upon recovery, she became a social worker, a political organizer and a scholar, translating Mary Wollstonecraft's treatise on women's rights (Pope, Sonne, & Holroyd, 2002; Kimball, 2000).

Breuer's experience motivated Freud to begin to consider the therapeutic relationship as far deeper and more complex than conventional views of the doctor-patient relationship. He began a life-long mission to understand the unique client-therapist relationship and how it could best be managed (Kahn, 1996). Rather than focus on the particular characteristics of the therapist, Freud construed the patients' feelings as a natural response of a female patient to a male therapist and began to develop the concept of transference (Pope, Sonne, & Holroyd, 2002).

Freud had emphasized that sexual attraction was an important aspect of psychotherapy because it occurred frequently. He attributed it to the therapeutic situation and not the charms of the therapist (Freud, 1915/1953). Psychodynamic literature provides a way to talk about attraction in therapy as a form of transference or countertransference. As a result, psychoanalysts have a set of constructs that may allow sexual feelings between clients and therapists to be construed as normal, predictable, and perhaps inevitable. Other theoretical orientations do not provide a theoretical basis for discussing sexual attractions in therapy (Hamilton & Spruill, 1999). Consequently, if such discussions are not taking place, practitioners may not be aware of specific vulnerabilities that might make clients and/or therapists more vulnerable to developing sexual relationships. Somer and Saadon (1999) argued that, "[t]herapists will be more effective practitioners when they understand the factors that contribute to sexual boundary violations" (p. 504). While it is not within the purview of this study to examine client-therapist sexual relationships, the topic should also not be ignored

completely. Therapists who believe they are not vulnerable to sexual liaisons with their clients may also be unaware of the personal and situational risk factors that may lead to sexual misconduct (Hamilton & Spruill, 1999; Pope & Tabachnick, 1993). Hamilton and Spruill (1999) provided a series of trainee characteristics, training factors, theoretical considerations, and systemic issues, which may contribute to the particular vulnerability of therapists-in-training. However, a study of social workers performed by Bernsen, Tabachnick, and Pope (1994) showed no significant differences between younger and older therapists in who considered sexual involvement with clients. Therefore, older therapists appear to be as vulnerable as younger therapists, perhaps for different reasons. However, even if the risks of sexual misconduct were not present, the frequency with which sexual attraction is likely to occur has implications for everyday psychotherapeutic practice (Pope, Tabachnick, & Keith-Spiegel, 2006). Because client sexual attraction may be a relatively common phenomenon, it is likely that therapists often must manage such situations. For this reason, therapist experiences of client sexual advances and how they managed those situations became the focus for this investigation. My hope and intention for this study was that it would contribute to the literature and to the counselling profession by opening up the topic for discussion and exploration. Examining the experiences of a few therapists could provide a starting point for discussing the phenomenon of client sexual advances as a more typical aspect of psychotherapeutic practice. On a practical level, ideas for detecting, managing, and serving clients' best interests in these situations could provide useful strategies for practice.

Researcher Interest

Interest in researching therapist experiences with client sexual advances evolved from a personal experience which occurred during my counselling practicum as a Master's student. After experiencing client sexual advances, I became curious and did a brief canvas within a small circle of colleagues. I found that several others had also experienced client sexual advances. It appeared that client sexual advances might be quite common and yet, until I brought it up, it had not been openly discussed within my cohort. This topic appeared to be unlike other issues in therapy which my colleagues were often eager to consult about. There appeared to be a hesitation to discuss client sexual advances. When it was time to consider the topic that I would like to research as a thesis project, this became a particularly intriguing option. I quickly discovered that there was some information about therapist sexual attraction to clients in therapy but I was unable to find information that addressed cases of client sexual attraction toward the therapist. The limited information that did exist relied on large surveys, thus there were no rich explorations of individual experiences (e.g. Harris & Harriger, 2009; Harris, 2001). Outside of psychodynamic literature related to transference, there was very little, if anything, of any depth related to client sexual advances. As a result, I was unable to locate information to suggest how client sexual advances could be managed. There appeared to be a gap between what I and some of my colleagues had experienced and documentation to suggest how to manage such situations. I decided to focus on women's experiences for simplicity because I believed there might be significant differences between the experiences of female

and male therapists. As a woman myself, I also felt that I might find it easier to understand and relate to female experiences. Additionally, women’s experiences are generally underrepresented in what has been a historically male-dominated profession.

Statement of Purpose

The purpose of this inquiry was to explore female therapists’ experiences of client sexual advances. The reason for investigating these experiences arose from my curiosity about the events mentioned in the previous section. I believed that if I and my colleagues were curious about ways to manage incidents involving client sexual advances, it was a question worth pursuing. It seemed prudent to begin by investigating the particular types of experiences therapists were having with client sexual advances. Further questions related to what impact client sexual advances might have in therapy, how therapists were managing client sexual advances, and what therapists might speculate to be different for female rather than male therapists faced with client sexual advances. I also wanted to explore whether therapists had encountered any difficulties discussing client sexual advances with clients, colleagues, or supervisors and whether they felt that their training had adequately prepared them to respond to client sexual advances. Ultimately, I hoped that this exploration might encourage open dialogue related to client sexual advances, given that sexual advances may be experienced by many therapists at some time during their practice. Exploring first-hand accounts could be a significant step toward developing strategies for responding to incidents sensitively, in ways that enhance the therapeutic relationship, and which are mindful of the emotional safety of clients and therapists alike.

Significance of the Study

Due to the possibility of serious emotional harm to clients, there are strong ethical prohibitions against therapist-client sexual relationships in professional codes of conduct (Truscott & Crook, 2004). The Canadian Psychological Association's (CPA) Code of Ethics explicitly prohibits sexual relationships due to the assumption of an inherent power relationship. Power is assumed to derive from the fact that the client enlists the services of a psychologist trusting that he or she has knowledge and expertise to help them and may reveal personal information that they might not normally reveal. Harm from sexual relationships involving female clients and male therapists has been extensively addressed (e.g., Bouhoutsos, Holroyd, Lerman, Forer, & Greenberg, 1983; Peterson, 1992). Bouhoutsos et al. (1983) went as far as to describe a therapist-patient sex syndrome bearing a resemblance to aspects of borderline and histrionic personality disorders. Other studies also reported that sexual involvement with therapists harmed clients (e.g., Feldman-Summers & Jones, 1984; Peterson, 1992; Pope, 1994; Pope & Bouhoutsos, 1986).

Maintaining professional boundaries is said to be critical to providing a safe environment for the client. An ability to manage situations in the best interest of the client requires thoughtful consideration. Several studies have attempted to explore incidence rates of therapist attraction to clients (e.g., Pope, Keith-Spiegel, & Tabachnick, 1986; Pope, Sonne, & Holroyd, 1993; Pope, Tabachnick, & Keith-Spiegel, 2006). However, there does not appear to have been previous research of any depth into therapists' experiences of client sexual advances or client sexual

attraction. A survey of 575 psychotherapists performed by Pope, Tabachnick, and Keith-Spiegel (2006) revealed that 87% (95% of men and 76% of women) were sexually attracted to clients on at least one occasion. It is likely that clients also experience sexual attraction toward therapists quite frequently, although there have been no large-scale surveys of clients to confirm this assumption. It appears that there have been few or no prior investigations of any depth into therapists' experiences of client sexual advances where the therapists avoided sexual involvement and were able to effectively manage the situations. Consequently, there is little knowledge to provide to graduate programs, supervisors, and other professionals, for use in training or consultation that is based on actual experience in practice.

Female practitioners particularly do not appear to have been adequately represented in the literature surrounding sexual boundary issues. In relation to sexual violations, only four percent of female therapists reported having sexual relations with former clients compared to 14% of males in one study by Akamatsu (1988). A more recent study that addressed statistics of sexual involvement with clients was performed by Bernsen, Tabachnick, and Pope (1994). Their survey of 453 social workers reported that only 3.6% of males and 0.5% of females reported sex with a client. While there has been a significant decline for both sexes, a gender difference still exists. Aside from statistics like these which suggest that there are male/female differences in the frequency of sexual violations, female therapists' experiences do not appear to have been adequately explored. This gap in the research seems unfathomable given the importance of the issue to ethical

practice and considering the increased number of female therapists in recent decades (Snyder, McDermott, Leibowitz, & Cheavens, 2000). I believed that the best way to begin to pursue this gap in knowledge was to interview female therapists to find out what their experiences were and how they have managed them. This was an exploratory study intended to capture several incidents occurring in practice with some depth. I also hoped to bring the topic to light and initiate a discussion of female therapists' experiences within the profession of psychology. There is no doubt that client sexual advances present a unique challenge to therapy and that counsellors would benefit from open discussion of the phenomenon. Great potential exists for the discovery and documentation of new or currently existing strategies and techniques for managing client sexual advances from situations faced in clinical practice.

Since therapists are likely to encounter client sexual advances in therapy, or at times may be vulnerable themselves to engaging in sexual liaisons with clients, developing knowledge in this area would be beneficial to the counselling profession. As a minimum, it is essential to ensure that there is adequate knowledge and training to prevent unprofessional and potentially harmful relationships from developing. Because of their sensitive nature, it is likely that the incidents that are reported through complaints to professional boards are only the tip of the iceberg. Many therapists must successfully manage such situations and remain effective in their relations with their clients. If that is the case, we could benefit from finding out what they are doing so that this knowledge can be shared with existing practitioners and transmitted to new ones. Documenting what

happens when these situations are not effectively dealt with is equally important. Education about events, good or bad, that actually occur in practice can inform practice for others and education for new practitioners. Therapists who can effectively deal with these situations not only protect their clients from emotional harm, it is likely that they could turn an awkward situation into a powerful learning experience. It would be useful to gain some idea of the impact of client sexual advances on therapeutic practice and look for models of effective strategies. It may be that client sexual advances or sexual attraction in therapy is an unacknowledged and highly significant factor that should be considered in studies of the therapeutic relationship which is so critical to outcomes.

Terms Used

For convenience and brevity, the term *therapist* is used throughout this paper to refer to professionals who provide mental health, clinical, or similar services. They may generally include psychiatrists, psychologists, counsellors, behaviourists, those who conduct forensic or other assessments, etc. The participants were comprised of female therapists, some accredited and others in training. They have been referred to as therapists or participants interchangeably.

The terms *attraction* or *sexual attraction* are complex and well utilized constructs in psychology. For example, attraction may be utilized in social psychology in relation to different types of relationships including romantic relationships, friendships, family relationships, etc. Evolutionary psychology speaks of attraction related to factors involved in mate selection. It was important to distinguish attraction and sexual attraction from sexual advances for the

purpose of this study. It was not my intention to explore the construct of attraction. How an attraction may have evolved or even if it existed would have required therapists to speculate about their clients' inner worlds or intentions. In some cases, therapists' perceptions of the existence of client sexual attraction were considered a sexual advance. The focal interest of this research related to how they managed the perceived sexual attraction or more overt sexual advances. Both situations could be disruptive and were considered sexual advances for the purpose of this investigation. Throughout this paper, including within participant quotes, attraction and sexual attraction were used interchangeably at my or the participants' discretion based on their dictionary meaning and otherwise not explored in depth. To provide a general baseline, the following definition by Reber and Reber (2001) is offered: Sexual: "relating to, in a very general way, the behavioural and affective component of sexuality" (p. 675); Attraction: "A characteristic of an object, activity or person such that it evokes approach responses from other objects or persons" (p. 64).

The term *client sexual advances* evolved from the need to distinguish the phenomenon of interest from the construct of sexual attraction for reasons stated above. It was utilized in this study to refer to incidents or situations where therapists perceived sexual attraction or sexual intention on the part of their clients. Sometimes therapists' intuitions or subjective judgements were relied upon. Other incidents involved overt statements or actions by the client. At times, therapists did engage in speculations about their clients' intentions in our discussions. This generally occurred in the context of offering an explanation for

what triggered their intuitions or when they offered insights from their own psychotherapeutic understanding of the client involved.

Intuition or *Instinct:* Participants sometimes used the word “instinct” to describe what I have interpreted as intuition. I have utilized the word ‘intuition’ throughout the document referring to therapists’ subjective experience that an environmental cue triggered their perception of client sexual advances. It was understood that intuition may not always be relied upon for the accurate assessment of situations. However, it may serve to alert us to potential threats or situations that could require our attention. Once alerted, confirming or disconfirming evidence was often sought or experienced. As will be discussed later, intuition appears to be an important ally in detecting potential client sexual attraction and deciding how to proceed with such information.

Chapter Two: Literature Review

Outside of psychodynamic theoretical orientations, little information was available that was directly related to client sexual advances or managing client sexual advances/attraction in therapy. Similarly, there appears to be a gap in the literature related to the experiences of female therapists. The information on sexual attraction that currently exists has been primarily aimed at addressing issues related to sexual violations. There is a multitude of information on sexual violations and the harm attributed to it, but it is beyond the purview of this investigation and is aptly covered in the literature related to therapist-client sexual relationships (e.g., Pope, 1994; Pope & Bouhoutsos, 1986; Pope, Sonne, & Greene, 2006; Peterson, 1992; Strean, 1993). Its relevance to this investigation is that it has raised awareness and opened the door to the difficult discussions of sexual issues in therapy. It has also been useful for educating therapists and others about client and therapist vulnerabilities and harm. It may be important to be aware of sexual issues in therapy in order to understand why the prohibitions on therapist-client sexual relationships exist. For that reason, I have summarized two key articles with statistics related to sexual violations below. Where sexual attraction in therapy was explored, it was largely related to therapist attraction to clients. Harris (2001) began to look at the phenomenon of sexual attraction whether therapists' or clients' in the context of marriage and family therapy. Harris and Harriger (2009) attempted to assess how marriage and family therapists-in-training thought that they might handle sexual attraction in therapy.

A brief synopsis of the most pertinent information from these studies has also been provided.

Holroyd and Brodsky's (1977) ground-breaking study documented evidence related to the number of therapists who had engaged in sexual relationships with clients. A survey of 1,000 psychologists with a return rate of 70% indicated that 12.1% of male therapists and 2.6% of female therapists had engaged in sexual relationships with clients. The most recent study, according to Pope (1994) was performed by Bernsen, Tabachnick, and Pope (1994). One thousand social workers (500 male, 500 female) were sent surveys with a 45% return rate. Respondents were 50.6% male and 49.4% female (N=453). Only 3.6 % of men and 0.5% of women reported having sex with a client. This represented a 10% annual decrease since 1977. The authors compared previous national studies with data from 5,148 therapists and found significantly more male than female offenders but no differences among the professions of psychology, psychiatry and social workers. It should be noted that a shortcoming of the earlier studies was that they did not include options for reporting same-sex involvements (see Williams, 1992, for a discussion of potential problems with studies and statistics of sexual involvement).

Pope and Bouhoutsos (1986) provided descriptions of ten common scenarios of therapist-patient sexual intimacy based on clinical research. For example, "role trading" where the therapist's wants and needs become the focus in the therapy room, or "It just got out of hand" where the therapist does not "treat the emotional closeness that develops in therapy with sufficient attention, care and

respect" (p. 4). "True love" describes the situation where the therapist uses rationalizations to "discount the clinical/professional nature of the relationship with its attendant responsibilities" (p. 4). By revealing these real-life scenarios, the authors hoped to inform therapists who may be treating clients or other therapists in cases where therapist-patient sexual intimacy was experienced. It also served to provide vivid examples for those who may be involved or at risk of becoming involved with clients. Pope and Bouhoutsos suggested:

> Awareness of these scenarios is important for professional organizations and educational institutions. Both providers and consumers of therapeutic services need comprehensive and continuing education about activities that lead to clearly unethical and clinically damaging sexual intimacies. (p. 3)

Bernsen, Tabachnick, and Pope's (1994) survey of social workers went beyond the statistics of sexual involvement and extended their investigation into the area of therapist sexual attraction to clients. These statistics were somewhat more pertinent to this study. They noted that therapist sexual attraction to clients had not previously been acknowledged in research or education. They reported that most therapists had experienced sexual attraction to clients (82%). Only 83 of 444 respondents (18%) reported never being attracted to any client. This contrasted greatly to the number of therapists who reported actually engaging in sexual relationships (3.6 % of men and 0.5% of women). Of those who had experienced attraction, 87% reported that they had never seriously considered sexual involvement and 98% reported that they had never acted out sexually with clients. There was a significant gender difference with male therapists more

frequently experiencing attraction. Male therapists also considered becoming sexually involved with clients significantly more often than female therapists (19% vs. 16%). The authors found that sexual attraction toward clients was often associated with guilt, anxiety, or confusion. It is clear that therapist sexual attraction toward clients happens frequently. However, those attractions rarely develop into sexual relationships.

The present investigation was unlike Bernsen et al.'s (1994) study of therapist sexual attraction to clients because therapists' feelings of attraction, if they existed, were not explored in this case. Here, I focussed on clients' sexual advances toward therapists and how therapists managed those situations. Participants were therefore engaged in managing situations involving their clients' attraction rather than their own. How therapists experience and manage situations where they are attracted to clients may be very different from how they would manage situations where clients are attracted to them. For example, the therapist managing their own feelings may do so separately from the therapy room, either alone or in consultation with colleagues. When clients are experiencing sexual attraction toward the therapist, it could be argued that it becomes the therapist's responsibility to monitor or manage the situation in the best interest of the client. How therapists respond to these two scenarios may differ significantly.

Bernsen et al.'s (1994) study acknowledged the existence of sexual attraction in the therapeutic setting and therapists' responsibility for managing it, albeit within the context of avoiding sexual relationships with clients. Relevant to this investigation, similarities may exist between Bernsen et al.'s study and the

present study due to findings suggesting the taboo nature of these discussions and the discomfort, awkwardness, and confusion therapists experienced when confronted with sexual attraction in therapy. Bernsen et al. also found that only 10% in the social workers study felt that their training had been adequate. Pope and Tabachnick (1993) had similar results in a psychology study (9%). They suggested that discomfort with the topic is probably responsible for its neglect in graduate training and as a focus for scientific and professional books.

In a study of 259 therapists-in-training for marriage and family therapy, Harris and Harriger's (2009) findings suggested that students were quite confused about how to respond to client or therapist attraction in conjoint therapy. When counselling couples rather than individuals, counsellors have the additional complication of a spouse or partner to consider when deciding how or if to address client sexual attraction. In response to a hypothetical situation involving a client's disclosure of attraction to the therapist, 53% of participants thought they would process the expressed attraction with the couple together, but 33% reported uncertainty. Most indicated that they would not meet with the attracted partner (76%) or the non-attracted partner (70%) individually. Referral to another therapist for the client's benefit was indicated by 37% who agreed or strongly agreed and 38.4% were undecided. Referring the couple to another therapist for the therapist's benefit was agreed or strongly agreed to by 32.6%, while 35.5% were undecided. The authors suggested that the confusion expressed by therapists-in-training indicated an urgent need to address issues of attraction in conjoint therapy. The authors recommended open discussion and training as ways of

normalizing experiences of sexual attraction in therapy in order to facilitate a professional environment where ethical dilemmas could be addressed.

In a previous article that utilized the same data (N=259), Harris (2001) reported that 85% of respondents indicated that they would feel cautious, 69% uncomfortable, 53% nervous, 48% flattered, 46% self-conscious, 44% respectful, 44% anxious, 22% embarrassed, 18% vulnerable, and 15% scared, if a client expressed an attraction toward them. These findings indicate a considerable range of emotions that may be experienced by therapists faced with client sexual advances. Most participants indicated that they would be willing to discuss the issue with colleagues, although 13% felt that it might somehow portray them as unethical. Harris (2001) proposed the following:

> Perhaps the biggest problem with sexual attraction in therapy is that we are unaccustomed to discussing it as something that could easily develop through the course of 'good' therapy or appropriate joining. When supervisors and therapists do not discuss attraction as it happens, it leaves the therapist in an uncomfortable position. Thoughts such as, "this shouldn't be happening," or "my supervisor will think I wanted it to happen" are common. If we, as a discipline, could normalize the fact that sexual attraction might occur between therapist and client in therapy and that attraction is different than sexual contact, we may begin addressing the ethical dilemmas more openly. When we do not discuss attraction we implicitly underscore—and maybe even reinforce—the idea that experiencing it in therapy is unethical or inappropriate. (p. 126)

Harris emphasized his belief that the clinical supervisor has the responsibility of anticipating dilemmas that therapists-in-training may face, including the possibility that sexual attraction can occur. The myriad of emotional responses that therapists-in-training may experience in response to their own feelings of sexual attraction or in response to client sexual attraction require attention. Harris suggested that space should be created to address these

experiences in supervision. In his recommendations for future research, Harris wondered if therapists had discovered effective ways of managing sexual attraction and whether gender affected the frequency of these events. He wondered if seasoned therapists might believe there is danger in situations that are poorly handled or what clients might think about sexual attraction in therapy. These wonderings were very similar to my own. This investigation was undertaken in order to begin the exploration by documenting several experiences and probing for such insights.

Chapter Three: Method

Statement of Purpose

The purpose of this exploration was to investigate the types of client sexual advances participants had experienced, the impact client sexual advances might have in therapy, how therapists managed incidents, and whether they felt there might be aspects of their experiences that could be distinct from those of male therapists. I also wished to explore whether therapists had encountered difficulties discussing client sexual advances with colleagues or supervisors and whether they felt their training had adequately prepared them to respond to client sexual advances.

Rationale for a Qualitative Thematic Analysis

A qualitative thematic design was utilized in this project because of its practicality for a novice researcher and its suitability for exploring previously under-researched areas. A thematic design facilitates a process where themes can evolve from the data in the absence of hypotheses and where the participants' views on a topic are not known (Braun & Clarke, 2006). As a result, rather than focussing only on data related to pre-existing hypotheses, the entire data set was utilized to produce a sense of the predominant themes. In this case, the data set consisted of the complete transcripts of the five participants. Since this was an exploratory investigation into therapists' experiences, an inductive approach was desirable because it allowed the data obtained in the interviews to suggest what was significant and important. Utilizing an informal semi-structured interview format allowed the flexibility for participants to offer their accounts and

perceptions of events before other questions were introduced. Prompting for more information rather than directly asking questions was often enough to elicit elaboration that offered richer and sometimes more thoughtful descriptions of their experiences. I hoped to capture what therapists thought were the most significant aspects of their experiences.

In order to avoid vague presentations of events that were more focussed on feelings than specific incidents, it was important to encourage participants to begin by providing as many details of each incident as possible. Matthews (2005) suggested this interview technique because when participants begin with descriptions of feelings, they often do not feel the same pressure to provide details of the events that triggered them and may simply provide details that justify how they felt. As a result, the researcher may be left with an incomplete picture of events from which to draw meaning. Once participants had given a full account of specific incidents, it was then possible to explore their experiences more thoroughly and include thought processes and feelings. The thoughtfulness and deeper consideration given at that point provided a richer understanding of how therapists experienced each incident. The sequence of focussing on specific incidents and then exploring them deeper helped to keep the conversation, however informal, focussed on the subject at hand and very little time was wasted in digression from the topic or tangents.

Within those parameters, I attempted to remain as open as possible to hearing whatever they might tell me and to avoid imposing any of my preconceptions. I also did not want to make assumptions about whether those

experiences were perceived as positive or negative. I wanted to hear from therapists themselves whether they regarded incidents of client sexual advances as good or harmful, growth promoting or inhibiting, whether they enhanced the therapeutic relationship or produced ruptures in the alliance, how therapy was affected, and so on. I thought that this type of investigation could lead to a better understanding of what may occur in practice as well as lead to more specific questions for future research.

Researcher's Orientation to Qualitative Research

In counselling clients, my naturally humanistic orientation has motivated me to emphasize being fully present with clients. I attempt to listen and understand each person as a unique individual. And while I acknowledge that each person may experience events differently because of their unique background, personality, and history, there are often understandings that can be usefully applied to other individuals facing similar circumstances. This is the orientation I brought to this exploration. I felt that the depth provided by listening to each individual's experience of client sexual advances could highlight areas of similarity that may be significant for others in similar situations. Details of experiences may often be different. More often, it is the way that people process their experiences that is helpful when attempting to understand complex human experiences. I believe we can gain better insight into those processes by probing more deeply into their experiences. This type of insight is often sought after surveys that alert us to a phenomenon about which we want to know more. Here, individual experiences were a beginning point because I did not have pre-existing

data on which to base a hypothesis and I did not wish to rely on speculation. Rather than supplying a questionnaire and asking therapists to fill in the blanks, I chose interviewing as a means of having participants provide information they deemed relevant and significant about their experiences with client sexual advances. I hoped that their experiences could highlight some of the patterns and issues that others could relate to and might begin to generate further thought and discussion.

Methodological Framework

Braun and Clarke (2006) suggest that qualitative methods can be divided into two camps. The first camp includes those methods stemming from a particular theoretical or epistemological position with limited variability in how the method is applied. Grounded theory (Strauss & Corbin, 1998) and discourse analysis (Potter & Wetherell, 1987) are examples of these. A recipe is provided to guide specific steps that ought to be adhered to during analysis. The second camp is comprised of “methods that are essentially independent of theory and epistemology and can be applied across a range of theoretical and epistemological approaches” (Braun & Clarke, 2006, p. 78). Thematic analysis fits within the flexible second camp. Braun and Clarke (2006) argue that thematic analysis should be considered a foundational method of qualitative analysis. They further propose that it should be the first qualitative method of analysis that researchers learn because it provides the core skills required for conducting many other forms of qualitative analysis. Also, because of its theoretical freedom, thematic analysis provides a flexible tool with potential for obtaining a rich, complex, and detailed

account of the data without the in-depth knowledge required for some other qualitative methods. I was able to maintain the advantages of a qualitative thematic analysis that somewhat resembled Glaser's (1978) constant comparative analysis without the methodological knowledge and research experience that Glaser suggested was essential for performing grounded theory research. And, unlike grounded theory, a thematic analysis does not impose an obligation to generate theory. This seemed appropriate given that the present project was exploratory in nature. Attempting to generate theory was not a purpose and would likely have been a premature prospect.

The flexibility provided because thematic analysis does not prescribe a single recipe method does not mean that there are no rules. Braun and Clarke (2006) provide six phases of analysis as guidelines for a thematic analysis. By using guidelines, they hope to strike a balance between rigid methods and "anything goes". Guidelines also recognize that the researcher can make active choices to utilize a particular form of analysis that is appropriate to the type of inquiry. They argue that methodological soundness arises from a combination of; a) a good fit between the method applied and the research objectives, and b) transparency. Transparency arises from clearly communicating the researcher's epistemological assumptions (which are present to some degree in all research) and providing a good description of what was done, why it was done, and how the analysis was conducted. A clear description of the procedures offers the reader a way to evaluate theoretical and methodological soundness. It also allows the reader to evaluate the applicability of the research to other situations, make

comparisons to other research, or replicate studies (Braun & Clarke, 2006). The guidelines for analysis suggested by Braun and Clarke (2006) formed the foundation for the analysis utilized here. I have provided a more detailed description of the analysis later in this section.

In the spirit of transparency, I would like to clarify certain epistemological assumptions that guided my analysis. First, I acknowledge that there are many factors that contribute to the ways that people make meaning of experiences, including influences of the broader social context. I believe it is crucial to be aware of this potential when reading or interpreting any human study. There are also many different ways of understanding people and events. I did not attempt to dissect transcripts to find underlying meanings as a constructionist paradigm would have warranted. Nor did I wish to explore my participants' experiences at the perceptual level required for a phenomenological study. For the purpose of this study, I felt it was appropriate to utilize the accounts provided by participants at the semantic level of meaning. The explicit or surface level meaning of participants' words were used in a straightforward way as the basis for developing themes (Braun & Clarke, 2006).

Braun and Clarke (2006) point out that accepting that language can be used to articulate meaning and experience is essentially a realist position. It can be quite appropriate as long as there is consistency and openness about how the study was carried out and the claims it makes. In this case, it seemed the most practical approach for an initial exploration into potential thematic threads that might warrant further investigation in the future. Having said that, as Braun and Clarke

(2006) suggest, it is important that the analytic process go beyond description. The findings of this study, although themselves based on semantic content organized into patterns, became the basis for interpretation and theorizing about their broader significance and implications.

Participants

Five female therapists volunteered to participate in this study. Two participants were recruited for the study by word of mouth. (A person within the university community recommended someone who also enlisted another person—snowball sampling). Two participants volunteered following a presentation I made at the university which described the study, and one participant responded to an advertisement posted on the Psychological Association of Alberta's website. Of the five participants, two were Master's students, one was a PhD student, and two were Registered Psychologists. Students' educational backgrounds included various university or college counselling programs, not always located in Edmonton (where they were situated at the time of the study). One Registered Psychologist had five years experience and the other had nine years of experience in the profession. Ages ranged from early twenties to mid forties. Two therapists were of visible minorities.

This was essentially a convenience sample. An advertisement on the Psychologists Association of Alberta website only garnered one response. The sensitive nature of the topic probably contributed to the difficulty in attracting a broader spectrum of participants. Establishing trust may have been an important factor. A personal presentation and personal contacts were attributable for attracting four of the five participants. The participants were relatively

homogeneous, given that they lived and worked in the same city, were female, and had somewhat similar educational backgrounds. The strength of this particular sample was their direct experience with the phenomenon of interest. Participants were able to provide first-hand accounts of client sexual advances. As a result, the scenarios documented here were based on actual occurrences rather than hypothetical data. The number of participants was sufficient for saturation of the data based on the criteria that no new categories were introduced in the analysis of the fifth and final interview transcript. These accounts were a fertile ground for an initial exploration into the phenomenon that could help to stimulate further investigation in a number of directions.

Participant Descriptions and Their Respective Clients

Keeping track of the therapists and their respective clients throughout this document may be comparable to tracking the players in a theatre performance. For that reason, I have provided a brief summary and description of the participants and their respective clients as a reference for the sake of clarity. Pseudonyms were used for all participants and descriptive identifiers or pseudonyms for their clients in order to ensure anonymity for all parties. Descriptions of participants and clients are short for the same reason. Therapist accounts of client sexual advances are revealed in the findings section where five types of sexual advances are described. Additional details and meaning can be found in the respective themes and sub-themes.

Stella (P1)

Stella is a Caucasian female who was in her mid-forties at the time of the interview. The incidents she described occurred in recent years while she was a Master's student in a university program. Two key incidents were discussed:

Young man: Young and immature for his age with many presenting issues. He was fragile and vulnerable at the time he came to therapy with Stella.

Mature woman: She was in a troubled lesbian relationship and working through historic trauma.

Rhonda (P2)

Rhonda is a female Caucasian woman who was in her late 20's at the time of the interview and had been a Registered Psychologist for five years. The incidents she described occurred during her internship as a PhD student at a university when she was about 23 or 24 years old. Two key client incidents were reported:

Salsa Dancer: A male client who was in his thirties made suggestive comments often related to salsa dancing.

Secret Admirer: A male client who told one of Rhonda's colleagues in the same clinic that Rhonda was so pretty that he stared at her throughout their sessions. Rhonda's colleague alerted her to the situation.

Kelly (P3)

Kelly is a female of visible ethnic minority who was in her mid-twenties at the time of the interview. She was a PhD student in a university program. The

incidents she described occurred in recent years during her practicum experience as a graduate student.

Bride-seeking father: A father-daughter family therapy situation where the father told Kelly she would be a good mother figure for his daughter and asked her out to dinner.

Fantasizing female client: A young lesbian client who graphically described her fantasies involving Kelly.

Sophia (P4)

Sophia is a female of visible ethnic minority who was in her early 30's at the time of the interview. She is a Registered Psychologist and had been practicing for over ten years, including practicum and internships. She spent a substantial time in a forensic in-patient environment and later in a specialized clinic whose clients were often young males working in remote locations.

Adrian: A young male forensic inpatient with a conviction for exhibitionism. He was immature for his age and would often masturbate in front of staff. ADHD was also a factor and therapy sessions were eventually reduced to four, fifteen minute sessions carried out throughout the day. This strategy was employed in order to avoid excessive anxiety that might lead to masturbation or other unhelpful behaviours during therapy.

Various Male Clients: Sophia sometimes referred to more recent clients at a clinic where young male oilfield workers or other young male clients were often seen.

Margot (P5)

Margot is a Caucasian female. She was in her early 20's and a Master's student at the time of the interview. The incidents described occurred during her recent practicum experience.

> Fantasizing Male: In the fifth or sixth session together, a male client revealed that he had been fantasizing about Margot. More pressing issues pushed this to the background and therapy ended before it could be addressed.
>
> Sex-Seeking Male: In their final session, a male client asked if they could have sex once in a while.

The Interviews

After an initial contact, participants had been emailed a copy of the information letter in order to clarify details of the study as well as participant and researcher obligations (see Appendix A). Their willingness to participate was confirmed either in person or by phone. Upon confirmation, interview dates were set for meetings at locations that offered privacy and were convenient for participants. I met with some participants in offices, others in homes.

Before interviews commenced, participants were asked to read the consent form. They had an opportunity to ask questions and once they had confirmed their agreement to do so, they signed the consent form (see Appendix B). A brief introduction to the study was provided as a means of opening the interview and focussing the discussion (see Appendix C, Interview Guide). Each participant was then asked to tell me about their experience with client sexual advances. This

open-ended introductory question was intended to allow participants to provide their own interpretations of events with as little input from me as possible. I would probe or prompt for more information if they seemed to require it. My goal was hear their own thoughts and conclusions about the experiences before I began to insert the other research questions as part of a semi-structured interview. I attempted to re-create the same openness with each question. This was not a linear process. It was an informal interview, although each of the questions on the list were addressed at some point in the conversation. Some of these questions were; How do you believe client sexual advances may have impacted therapy? What were the greatest lessons you took away from the experience? Did you discuss the situations with colleagues or a supervisor? If so, did you find colleagues or supervisors comfortable with the topic, knowledgeable, or helpful? What are your thoughts about whether sexual advances should be addressed or ignored in therapy? Do you feel your training prepared you? (See Appendix C, Interview Guide, for a complete list of guiding questions.)

Procedures

According to Braun and Clarke (2006), phase one and two of a six-phase guideline involves familiarizing oneself with the data and then generating the initial codes. Since this project was to be data-driven rather than theory-driven, it was important to code each transcript entirely and include everything that I felt might be significant. A theory-driven analysis might have been more selective and focussed on data that related to a particular theory. I utilized the entire data-set

(transcripts) and coded information almost indiscriminately. I coded everything that I considered potentially germane.

The process I utilized for familiarizing myself with the data and then developing the initial codes was as follows. After each interview, the voice file was immediately emailed to a transcriber. Three to five days later, I received the transcripts and then listened to the voice file while editing the transcripts for errors or omissions. The interview was still fresh in my mind making it easier to fill in blanks and do the few corrections necessary. I then copied the transcripts into a software program so excerpts could be transferred into specific categories once they were created. Categories were created as I read through the entire transcript again. The data was coded into categories as I came across anything that I felt might be potentially significant. Some excerpts were assigned to more than one category. I went through the same process for each subsequent interview. Text excerpts were added to existing categories or, if they did not fit existing categories, I would create new categories. The fifth and final interview offered no new categories and I was therefore satisfied that saturation of the data had occurred. After coding the final interview, I reread the previous four interview transcripts to ensure I captured anything that might fit into categories that were created subsequent to reading each one. I felt satisfied that I was very familiar with the data by the end of this process and that I had done a thorough job of coding the data. Approximately thirty initial categories evolved from this procedure.

The third phase of analysis involved refocusing the analysis at the broader level of themes rather that categories. The long list of codes needed to be sorted and organized into a smaller number of themes with sub-themes. I interpreted this stage as somewhat similar to Glaser and Strauss' (1967) second stage of the constant comparative method. The focus shifts from comparing incident to incident across participants to comparing incidents with properties of the category. The difference may seem subtle, but this step is intended to produce a more concise and meaningful representation of the data and how it is conceptualized. Once the categories are clearly conceptualized, the search for overarching themes can begin. Themes are intended to capture something important about the data related to the research questions. They represent patterns or meanings from frequent, dominant, or significant themes, inherent in the raw data (Thomas, 2006). The significance or "keyness" of a theme is not necessarily quantifiable and therefore does not rely on the number of times it is repeated (Braun & Clarke, 2006). In order to develop themes, I had to look at the relationship between categories and consider different levels of overarching themes and sub-themes that told a story of the data. This time-consuming process was accomplished by reading and rereading the coded text and mapping them into candidate themes and sub-themes. Several versions of a thematic map evolved for further consideration.

Phase four involved reviewing and refining the themes. The candidate themes and sub-themes were reviewed several times in order to generate a reasonably succinct representation of the most significant findings. After much

consideration, certain candidate themes were dismissed because they did not have enough data to support them. Redundant themes were also eliminated. Other candidate themes were found to be too broad and were broken into separate themes. Through this process, the objective was to organize the data so that themes would cohere meaningfully and each theme would be distinct from other themes. I reviewed all the sorted transcript extracts to ensure they contributed to a coherent pattern for each theme. This process reduced the number of candidate thematic maps still under consideration to two options. This step provided an additional opportunity to give more consideration to the content (data excerpts) that supported each theme than could be achieved in the more conceptual Phase Three. It offered an additional means of ensuring the integrity and internal consistency of themes before selecting the one candidate thematic map deemed most appropriate to tell the story of the data. At this point several months had passed since the interviews. I felt a need to confirm that my final interpretation of the data still felt reflective of the voices of the participants. I listened to each participant's voice file again. I wished to ensure that I did not miss anything previously that I now thought was important. I also wanted to hear each voice with nuances again so that I felt closer to the meaning they were trying to convey in their interviews. This final step provided me with a sense and comfort that I had indeed stayed true to the original meanings as I understood them and that the thematic map accurately reflected those meanings.

Phase five involved naming and defining the themes. The objective in this case was to provide a coherent and internally consistent account for each theme

and sub-theme. A short narrative description of each theme and sub-theme was developed and utilized as an introduction to the data excerpts which illustrated and provided evidence for each one. As well, it was intended that each theme would fit into a broader overall story of the data as it was interpreted by me as researcher. The themes and sub-themes developed from this process, their descriptive narratives, and the supporting data excerpts, constitute the findings from this research and are located in the findings section of this document. Phase six in Braun and Clarke’s (2006) six-phase guidelines involves producing a report of the findings, which is the purpose of this document.

Chapter Four: Findings

Summary of Findings

The findings of this study were derived from interviews with five female therapists who had experienced client sexual advances. Six overarching themes were derived from the interview data. Themes and sub-themes represent significant aspects of therapists' experiences based on similarity across participants and/or impact of the experience on the therapist(s). Therapists who experienced client sexual advances: (1) experienced different types of sexual advances that ranged from subtle clues of sexual attraction to very overt statements or actions (Sexual Advances); (2) worked to develop a special relationship with their clients in order to facilitate a caring environment for a positive experience of therapy to take place (Special Relationship); (3) were impacted in ways that stimulated a range of emotions from self-doubt and suspicion to discomfort and distraction, and confusion about how or if to confront an issue that felt like a tangible presence in the room (Impact on Therapist); (4) became more aware and diligent about maintaining professional boundaries and utilized their intuitions to detect and make decisions about how to respond to incidents based on a risk assessment process (Maintaining Professional Boundaries); (5) did not feel well prepared for client sexual advances and found it a challenging topic to discuss with clients or to disclose to supervisors and colleagues (Taboo Topic); (6) displayed some behaviours and concerns that may be uniquely female (Being Female). (See Table I below for a complete list of themes and sub-themes.)

The following table summarizes the themes and sub-themes which were derived from the data and are elucidated in this section.

Table I

Themes and Sub-themes

Key Themes	Sub-Themes
1. Sexual advances	1.1 Direct approach 1.2 Obvious attraction 1.3 Indirect approach 1.4 No clue 1.5 Special populations
2. Special relationship	2.1 Intimacy and trust 2.2 Positive therapeutic experience 2.3 Acceptance: not rejection 2.4 Vulnerability of clients
3. Impact on therapist	3.1 Suspicion and self-doubt 3.2 Dress and behaviour 3.3 Self-disclosure 3.4 Elephant in the room 3.5 Dilemma—confront or ignore
4. Maintaining professional boundaries	4.1 Intuition in a grey area 4.2 Benefits of client sexual attraction 4.3 Cues and clues
5. Taboo topic	5.1 Embarrassment and avoidance 5.2 Supervisors and colleagues 5.3 Training and experience
6. Being female	6.1 Blaming the victim 6.2 Male-female seduction styles

Theme 1: Sexual Advances

Based on the accounts provided by participants in this study, I distinguished five types of sexual advances. Some sexual advances were overt, while others relied on therapist intuition based on cues and clues provided by clients. These included; direct approach, obvious attraction, indirect approach, no clue, and special populations.

Sub-Theme 1.1: Direct Approach: Overt Statements or Actions

The direct approach involved incidents of client sexual advances that were very obvious or blatant and therapists felt that clients' intentions were unmistakable.

Rhonda described how she became alerted to her client's attraction:

> He would often talk about how good of a Salsa dancer he was and how he could move it, the first thing that triggered me was when he really got into detailed description of how he could move his hips and how that was so beneficial for womankind right. . . . And so then I started getting incredibly uncomfortable. . . . I'm getting a little creeped-out here about how much he talks about this and then as the counselling progressed, he started to make more suggestive comments directly, "Hey, you know after our session why don't we go out for a drink?" or "Why don't we, do you like Salsa dance?" You know, and that sort of stuff so, I mean I'm not naïve and I could see where this was going and so my anxiety just continued to go up and up and up 'cause I had no idea what to do and it was, I think it was quite embarrassing at the time for me, because I think in my mind I was going, "This is not supposed to be happening." (Rhonda, P2)

Kelly described the situation she faced with a male client involved in father-daughter family therapy. In addition to more subtle behaviours, he asked her out for dinner and told her that she would make a good mother-figure for his daughter.

> It was a father, a single dad and his daughter. . . . When I first started working with him I kind of got the sense that he was attracted to me and,

> you know, I didn't do anything about it because nothing overt had come up but I could see him kind of checking me out, you know, kind of looking at my breasts but trying to be discreet about it. And after awhile it started to get a bit more inappropriate and I was really young back then, I mean I didn't have the same boundaries that I have right now or even the confidence, so when he started making comments like oh, you know, "We should go for dinner sometime." and I would just say, "No, that's not appropriate." So I actually, no I probably did have good boundaries 'cause I said no, it's not appropriate. Ah but he kept, you know, trying and he would do it in very roundabout ways . . . and at one point he asked me if I was married and I asked him, "Well, how would my answer affect my work with you and your daughter?" And he said, "Well I'm just thinking that, you know, my daughter needs a mother figure and you would be really good." . . . Like I know when a man looks at me that way, he's not thinking of, you know, what a great personality I have. (Kelly, P3)

Kelly felt that she had developed a very good relationship with a female client who eventually confided that she had sexual fantasies involving Kelly:

> We had a very long relationship, you know, spanned at least twenty sessions minimum that I had with her, and she was great. We got along really well and at one point you know kind of in the middle, maybe session twelve or eleven she just said, "You know what, you're so pretty." And it's like, oh thank you. And she's like, "Yeah," she says, "You know, sometimes I think about you after our session and sometimes I have these thoughts, you know, with you that are probably not appropriate." And I thought, "Oh."
> . . . I know she was embarrassed just given the nature of her, you know, her sexual fantasies and such and she was actually discussing some of them very openly with me. I was a little uncomfortable but I wasn't like oh my God, I wasn't freaking out it was a little bit awkward, probably for a few weeks afterwards. (Kelly, P3)

Margot described how the first incident she had to deal with was a man who told her that he was having fantasies about her:

> The first one was closer to the beginning of my practicum, and I was working with an individual who ended up telling me in session that he was having fantasies about me. And I was kind of freaking out inside and I said to him, "You know, I appreciate what you've said to me, and I know we need to address this but I really would like to discuss with my supervisor what would be the best way to do that. And, so I would appreciate it if we could maybe talk about this next time." (Margot, P5)

Margot had another client who, in their last session quite openly stated his interests in having sex with her and his belief that she "wanted it":

> My intuition had been telling me that this one client I was working with was attracted to me. But there had never been any overt reasons for me to think that. . . . we had scheduled our last session, it was our termination session together, and he called me a couple days before and, you know, said, "I'm coming in and I just would like to know if we can talk about sex next week." . . . At that point I kind of knew. I thought, okay, there's something here, he's going to bring it up, and he came in, and I actually invited him, I said, "You said on the phone that there was something that you wanted to discuss today, and I'm just wondering if you'd like to bring that up?" And he kind of, he was embarrassed, I could tell . . . and he said, "I was just wondering if you and I could have sex once in a while?" . . . And he was saying, "Well you know, I thought you wanted it." And I said, "You know, this has always been a professional relationship to me." (Margot, P5)

Sub-Theme 1.2: Obvious Attraction: Intuitively Understood

Certain cues and clues were intuitively understood as displaying the clients' sexual attraction to the therapist. In the absence of overt statements or actions, situations that might sound ambiguous if described to someone who was not in the room, felt very obvious to the therapist. Awareness of the client's sexual attraction seemed to have effects on the therapist and situation that were often similar to those of sexual advances that were more overt.

Stella described the first of two experiences as a "crush." In fact, she was not sure if I would classify the incident as a sexual advance. However, I found the situation was suitable to include because the attraction was quite palpable and had implications that significantly affected her behaviour and strategies for working with the client.

> I was mentioning to you a little bit about my concern about this idea of sexual advances, that my experience hasn't really been about sexual advances, but it hasn't ever gone that far, but the two experiences I have

> had, the first I'll tell you about, was more the sense of a crush, but it was very clear. (Stella, P1)

Stella described how she developed a sense of the young man's crush.

> He just started to look forward to coming to counselling so much. And he told me that, and he would journal in between sessions and he would journal to me in his journal, and he would just, you know, just couldn't wait to come to counselling, and he would tell me that. And then I found that in our sessions he would want to find out more and more about me and my life . . . his body language changed and he would look at me, and you know, look me right in the eye, and I could feel him digging, you know, trying to dig inside of me as a person. And he was, at the end of sessions he was so grateful and so thankful and very often very, very, teary. The emotionality I could understand, and even the gratitude I could understand, but I could feel his, it was an attraction, I could feel him being attracted. (Stella, P1)

Sub-Theme 1.3: Indirect Approach:
Alluding to the Potential for a More Personal Relationship

Stella's second incident involved a mature female client who used indirect means to allude to something more than a therapeutic relationship when she repeatedly emphasized the unique "connection" between them and said she did not want the relationship to end.

> The work we did together was really quite advanced and very beneficial for her in the end. Which I believe was just because we were such a good match as a counsellor and client. But when she used to say that and she'd say it all the time, is you know, talk about this connection, and after a while I started to feel that she was talking about something else. . . . This client was a woman about my age and after the first several sessions, very similar to with the young man; I could feel her attraction to me. I could feel it. And at the very end she was saying, "You know I don't want to lose you in my life." She said, "You don't make a connection like that and just let that person get lost in your life." And I became quite uncomfortable then. And at that point I explained to her that ethically a therapist . . . [must stop seeing] a client, you know, she was saying, "Well can't we be friends?" And I said, "Ethically, not really." (Stella, P1)

Seven months after therapy ended, Stella's mature female client pursued her by phoning her at home and her approach became more direct (overt).

> About seven months went by when my phone rang and it was her. And she phoned me at home and was saying how she couldn't stop thinking about me and, you know, wondered how I was doing and that she'd almost phoned me so many times, and that she really wanted to see me. And I felt in a real quandary, I didn't know what to do. And so I met with her for coffee, and she started with this connection piece again but it was much, much stronger, and she actually asked me then, pretty overtly, you know, if I felt any attraction to her. And I said no, that basically I, you know, wasn't oriented that way. (Stella, P1)

Sub-Theme 1.4: No Clue: A Third Person Enlightened Me

Rhonda described being enlightened by a co-worker about a client who would stare at her in sessions:

> I thought therapy, our sessions, whatever you want to call it, they were going well and we were seeing changes, I, both myself and the client and then . . . I don't know if they approached me or how it came about but the team member said to me, "Yeah, each time he comes back from session he just keeps saying, 'Wow, she's so pretty and I just stare at her all the time when I'm in the room with her.'" (Rhonda, P2)

Sub-Theme 1.5: Special Populations: Sexual Advances are Anticipated

Sophia worked in a forensic environment with in-patient sex offenders. Sophia generally felt prepared for client sexual advances in her work. However, one client, who she referred to as Adrian, posed particular challenges that made it difficult at times for her to maintain her usual calmness and ability to focus on therapy:

> Adrian was young, he was I believe 18 or 19 at the time we got him. And his main diagnosis was exhibitionism. So he tended to masturbate in front of staff. He tended to, this would entail him just feeling himself, but there were times when he would expose himself. Or he would have, you know, a visible erection and you could be in therapy, and you might notice this and when you do, when I did before, some of the things he would do was he would stare me down, to intimidate me. (Sophia, P4)

Adrian also engaged in this type of behaviour when he was in his own room but it was evident to Sophia that he was masturbating and that he was aware that she could detect his behaviour:

> There were a number of times when I was no longer one of the good guys. And he would be mad at me, and so he would masturbate in his room . . . he could see me in our main office, and it's just a glass wall . . . all the rooms of the offenders were around it. So we can see them clearly but they can at the same time see us. . . . He'd peek from his little window on his door and he would masturbate. And we'd know he'd be masturbating because we could see the movements. (Sophia, P4)

Sophia described some of the challenges presented by Adrian's behaviour in therapy:

> And when I'm in therapy with him, there were a number of things that he might do. . . . He has vocalized that he was sexually attracted to me. And so at that time you were thinking, "Should I even be his therapist?" But he's attracted to everybody who's young and I'm the psychologist assigned to that unit . . . and also we were a little short staffed, so I had to deal with that patient. . . . He did a number of little things actually. He tried to expose himself, feel himself, masturbate in front of me, trying to come close to me. When I stand, you know, at the end of the therapy session, you stand up, he stands up, and the proximity is quite um, there's short distance between me and him. (Sophia, P4)

Sophia was no longer in a forensic institution at the time of the interview. However, at the specialized clinic where she was working, her clients often consisted of young men. Some of them had been away working in the oilfields. At times, she had to address their behaviour:

> Some of them are young. I mean we've had some 18 year olds . . . like you work at McDonalds or they're out in the rigs in the oilfields, they see me and sometimes I can look quite young and so you know, they start flirting with me. . . . And, and you try to manage that as gently as possible . . . I remind myself he's not a forensic patient. So I do it more gently and sometimes I don't even go there. I mean some of them are really flirty and it's not affecting therapy, you know, I'm not losing my credibility. They still know that, you know, I'm giving them solid advice. I've had one patient ask me for a date. And I think I just said, "Are you serious?" (Sophia, P4)

At times, Sophia has had to explain that the counselling centre is not a place to look for dates:

> They've been away from home for a long time. They come here, they see a lot of pretty girls because we hire a number of young therapists. And some of them will say to me, "I like that Julie girl," in session. So I would say, "Hey, Julie's married, you know. You can look but you can't touch. Remember they're your therapists." So I would just remind them in a more casual way. They say, "Oh I know, I know." (Sophia, P4)

A presenting concern of Margot's sex-seeking male client was related to previous issues with women, which she described as "similar to sexual harassment". However, she trusted that his intentions towards therapy were sincere until he made an overt statement in his last session:

> And he said, "You know, I was just wondering if you and I could have sex once in a while?" . . . and I had had this inkling . . . this is just something that I was wondering for a while working with him, that he may just be coming because of that. . . . Now, in retrospect, I think it [was] for sure. . . . I felt very threatened again, and this is for a different reason, because he has had accusations of being a sexual, I wouldn't say predator, but kind of sexual harassment and things like that. So that definitely felt, and I guess because it was this explicit violation of boundaries, that I just didn't figure it would ever be that overt, and, so it was a little bit scary to me. (Margot, P5)

Theme 2: Special Relationship

The therapeutic context seemed to provide unique conditions that may be related to the development of sexual attraction and client sexual advances. Therapists in this study described caring therapeutic styles intended to help clients feel comfortable sharing personal thoughts and feelings. More than a professional duty, therapists often described genuine caring and a sense of personal responsibility for clients' positive experiences of therapy. Once established, maintaining the special relationship became of primary importance which may

also have contributed to therapists' hesitation to discuss client sexual advances with clients. Sub-themes included; intimacy and trust, positive therapeutic experience, acceptance: not rejection, and vulnerability of clients.

> I'm a fairly warm and very empathic counsellor. And I really worked to draw him out and make him feel safe, and as I did, and he started to feel safe, and he started to relax, and began to relate to me, he just started to look forward to coming to counselling so much. (Stella, P1)

> I think he felt very comfortable with me, and we had formed a good rapport. . . . He told me that he felt that way and that he could tell me things that he hadn't ever told other people before. (Margot, P5)

Sub-Theme 2.1: Intimacy and Trust

Intimacy (the ability to share deep personal thoughts and feelings) and the trust necessary for clients to feel comfortable with intimate disclosure seemed to be important aspects of the relationship. It contributed to the sense of a special bond between client and therapist.

> Because counselling can sometimes feel like a very unique personal relationship [like] you have with your partner in terms of how much you disclose on a personal level, how much you share your innermost thoughts and feelings, yet it is still different. (Rhonda, P2)

> Because we are getting to know our clients at a very intimate level that probably a lot of people don't know them at . . . that there would naturally be some kind of attraction to their therapist because the therapist hopefully possesses qualities that they admire and maybe they want to emulate. (Kelly, P3)

> This client had been through incredible trauma in her life. And yet it was very, very interesting that when she came to me, she and I connected immediately very, very well. And she also just started to open up and trust, and we really did some just amazing work together. . . . And one of the things that she would always say to me is, "We have such an amazing connection." She said, "I've rarely felt this kind of connection with anybody in my life." And I too felt there was an amazing connection between us. It was almost, almost a psychic connection, you know, we really understood each other. (Stella, P1)

Perhaps it may have been difficult for Sophia to feel such a warm connection to Adrian as some other clients. However, she attempted to provide a facilitative relationship that emphasized trust. She considered it an important part of a helpful therapeutic experience in spite of some of the challenges he presented.

> There was one time when a correctional officer touched him just to make sure, you know, he has cold hands [and has not been fondling himself]. But I mean those kinds of things can ruin therapeutic relationship because it's telling him I don't trust him. (Sophia, P4)
>
> If he violates the trust, a number of things can happen . . . my trust in him might not be there anymore, so in some ways he needs to establish that. And if I violate his trust, you know . . . so boundary issues were talked about at the get-go. Trust issues were talked about and the dos and don'ts of therapy in terms of I'm your psychologist so when you're coming to see me I expect that you would respect me. And so one of the things I would ask him to do is for his hands to be on the table . . . there was a bit of a struggle there . . . so you set up consequences for that. What I would tend to do is I would say to him, "Once I see your hands in your pockets and I think you are touching yourself or you're masturbating, the logical thing for me to do is to end the session, or I would get up and leave the room until you can in some ways show to me that you can tolerate 10 minutes of therapy." (Sophia, P4)

Sub-Theme 2.2: Positive Therapeutic Experience

Providing a positive therapeutic experience for the client appeared to be an important goal for therapists. They may have avoided immediately confronting client sexual advances because of the perceived risks of discomfort, awkwardness, embarrassment, that seems to accompany the topic. They did not want to risk a rupture in the relationship or that the client might terminate therapy prematurely.

> I think it really depends on the therapists' own boundaries, their own level of comfort with this kind of thing and how much they're willing to risk therapeutically in addressing this with their client. . . . There is a risk you know. The risk is—they don't come back . . . or he may [feel that he's been wronged.] Nobody likes to be wronged. At least most people

> don't in my experiences. And to be kind of way off the mark in this kind of situation is kind of embarrassing. (Kelly, P3)

> I thought you know, if I react to this it's going to do more harm than good. At this point he trusted me and trusted the relationship, and absolutely adores me, it's so obvious, and if I do anything to jeopardize that, other than you know, keep telling him that I started very, very early on the termination you know, starting to help him take responsibility for the fact that our therapy was going to end. (Stella, P1)

> It's gonna be really uncomfortable and if the presenting issues are genuine and I bring this up and it's so uncomfortable that he cuts it off then there's work that could have been done and we miss out on it because of this elephant in the room and because of my desire to call a spade a spade and say look, I think this is what's going on. (Rhonda, P2)

> The risk of embarrassment would have been a bigger one I think, to both of us. I was worried about risking that, and then that not have being true. And then, that would be, seemed irreparable to me, in terms of the therapeutic relationship. And I was also conscious of the fact that he had attempted counselling in the past and had never stuck with it. (Margot, P5)

Sub-Theme 2.3: Acceptance: Not Rejection

Acceptance was an important part of developing rapport with clients. Conversely, therapists seemed to be cautious about saying or doing anything that might be associated with rejection. Looking deeper, the threat of a client feeling rejected may have, at times, been associated with a perception that they might have felt rejected as a suitor. This is possibly another factor underlying avoidance of confronting client sexual advances.

> He would've stopped coming if I had made it uncomfortable for him or if he didn't feel like I was accepting him. (Margot, P5)

> At the end of it all, this young man, on our last session, gave me this gigantic box of Callebaut chocolates that must have cost him an arm and a leg, and I just about died. But I thought again, you know, this young man needs me to accept this, and I can't make a big issue out of it, that we have done some very important work together, and even if he had a crush on me I needed to accept whatever it was that he was feeling, and allow him to move forward. (Stella, P1)

> Looking back he probably felt rejected . . . even though I made it very clear that, you know, this stays in the therapeutic context. (Kelly, P3)

> I was really trying to focus on him and his issues and manage my own reactions which were wild, across the bar like, oh my gosh, this is disgusting, I'm getting a little creeped-out here about how much he talks about this. (Rhonda, P2)

Sub-Theme 2.4: Vulnerability of Clients

Therapists were often mindful that clients may have had particular vulnerabilities that contributed to the development of sexual attraction within the therapeutic context. Therapists speculated about what may have contributed to their clients' vulnerability to develop a crush, attraction, and/or to engage in more overt sexual advances. A sense of client vulnerability may have also contributed to the difficulty approaching the subject of client sexual advances with clients.

> He was very immature for 21, very immature . . . and I think he may not have known how to relate to men. He was afraid of men, and he was quite a submissive young man himself. . . . Actually he hadn't learned social relations very well at all with anybody . . . he had very low self-esteem and, he had a lot of issues. . . . I don't know what it was in the relationship with me, except that I was so empathic, and I think it was the first time he'd ever been to a counsellor, and it was the first time he ever felt understood. And he really felt understood, he just, yeah, he would cry and cry and cry. . . . I think that just left him in awe that I could sense him so clearly. (Stella, P1)

> Him having a crush on me, I was afraid would hurt him in the end somehow. You know, I didn't know because I was fairly novice you know, how does that pan out in this kind of situation and, you know, when a client is so vulnerable they fall in love with their therapist, how does that leave them? (Stella, P1)

> And at first I felt, not threatened, I felt frightened because; a) she was struggling with her relationship partner and I didn't want to somehow be a factor in her mind in complicating that. (Stella, P1)

> And the fact that she said that she thought about me so many times, she'd almost phoned me so many times . . . so I thought, meet with her and sit down and talk to her again. And also I obviously had to deal with this

> crush thing. . . . And so then I had to stop being so gentle, and I had to stand up for my privacy and my ethical rights. And that's very, very hard to do when you care so much about a client, and you've done very important work with them . . . and it broke my heart to have to say that to her, and it frightened me because I know how, again, vulnerable she is, and yet I felt forced. . . . And I haven't heard from her since and that was quite a while ago, and that frightens me. And now I'm like, oh God, you know, how is she doing, is she all right, what has she done? (Stella, P1)

Sophia suggested that Adrian, as a mandated client in an institution, didn't have much choice about who his therapist would be and he suffered from comorbid disorders and other complex issues that contributed to his vulnerability as a client.

> But I only got to see him once, one hour every three days or so. So during the rest of the time he was not with me he was getting into other kinds of trouble and of course, whenever I got him we made some progress but it was a closed environment and there wasn't a lot for him to do. He was also diagnosed with ADHD. At the time he was bored and he was using sexual advances as an intimidation factor. . . . He would continue to come back. He was abused by a male guardian, so he does not like males to begin with and he's developed enough relationship with me that he knows me. I've been consistent in providing him service. (Sophia, P4)

Theme 3: Impact on Therapist

Client sexual advances impacted the therapists in several ways. Sometimes there was confusion and anxiety about what, if anything, to do about them. Awareness of client sexual advances sometimes became an "elephant in the room". It became a presence that was challenging to ignore and challenging to address. Whether or not client sexual advances were directly discussed, there was often awkwardness or discomfort that could be distracting. Therapists' behaviour, interactions, and perhaps the relationship itself could be altered. Therapists often seemed to develop a heightened awareness toward maintaining professional

boundaries which led them to be more guarded. Sub-themes included; suspicion and self-doubt, dress and behaviour, self-disclosure, and the elephant in the room.

> Oh, definitely, yeah. I felt really guarded going into the sessions, you know, and I would try to focus on the daughter more than him. And it wasn't very comfortable because, you know, I had my supervisor's voice in the back of my head saying you know it's all in your head. And then you know I have to, you know, deal with seeing him because he just, he was just creepy to begin with. . . . Yeah, I felt that I couldn't really be myself as a therapist because usually my personality comes through with therapy and with that particular family I felt like it was being stifled. (Kelly, P3)

> I think I had to catch myself, because I wanted to be a lot more challenging with him than with some of my other clients. Part of that was he had a lot of resistance just anywhere that we went and so I was feeling frustrated by that resistance, but I also think, especially in retrospect that, I think it probably bugged me that I sensed [the attraction] and was trying to kind of put up a defence against that. (Margot, P5)

Sophia had to adjust session times in an attempt to avoid Adrian's lapses into deviant sexual behaviours.

> Oh it interfered with therapy sometimes. Because to begin with, the therapy was helping him manage his sexual behaviour. Like his, you know, his inappropriate sexual behaviours. . . . One hour long therapy does not work for this guy. So I would truncate it into 15 minute sessions. Because if it was one hour long he'd glaze over. . . . And that was effective because then he does not have a chance to get into a, you know, a sexual mode where he's sitting there for 15 minutes, he glazes over, he starts and, and I've seen this a number of times. Unconsciously his hands would go down. . . . He has a complicating diagnosis of ADHD. And at that time he was not medicated because he refused medication. And that's his right. . . . And there were a couple of times I broke up therapy with him because his sexual attraction was getting to the point it was, it was not helpful anymore. (Sophia, P4)

Sub-Theme 3.1: Suspicion and Self-Doubt

When sexual advances became part of the dynamic in therapy, it sometimes led to therapist self-doubt and/or created suspicion about clients' motives for coming to therapy and if their efforts in therapy were sincere.

Beginner therapists doing their best to monitor interactions would question their prior perceptions of what had occurred in therapy which included suspicions such as whether the client was motivated by wanting to spend time with them or feigned progress to please them.

> And one of my first thoughts was, okay, so now is he just coming to stare at me. Does this just completely invalidate all what we've been doing? . . . I didn't want to be wasting time in terms of, well there might be somebody else if he's just coming here to sit and stare then maybe there's somebody else who could be using this spot. . . . I really started to question the progress that's being made maybe the issues weren't as big as he presented and so I started to doubting the client which is a horrible place for myself to go. I really, really don't like doing that. I think it erodes the trust and the relationship and the rapport. (Rhonda, P2)

> And that coupled with a bunch of other things that were happening with my other clients, I was very anxious for a long time when I first started . . . and questioning the decisions I made, everything I did, going back and looking at it and saying I didn't do this right, I wrecked everything . . . yeah, in general, and I think that was just another straw on the camel's back I think . . . because it was very vivid . . . a lot of times [it would be] the first thing I would think about when I thought about the stressors I had. (Margot, P5)

> I think, because it wasn't overt, I didn't want to make it overt. . . . The thought that he might be coming only because he was attracted to me [made me feel vulnerable]. . . . I was wondering for a while working with him that he might just be coming because of that . . . now in retrospect, I think it for sure was. (Margot, P5)

Sub-Theme 3.2: Dress and Behaviour

Therapists described adjusting the way they dressed and behaved with clients when they became aware of client sexual attraction or experienced more overt sexual advances. Personal safety was also a consideration.

> I was very careful the way I dressed in sessions with him . . . very careful if I used my hands or anything you know, touching or anything with him. I didn't do anything that could lead him to think anything but professional relationship. And so the effect it had on me was to be extra vigilant about those fine details, at a time when I was learning to be a therapist and I was

> trying so hard to focus sort of on, sort of the broad techniques of just helping this young man generally. (Stella, P1)

> I felt professional [in how I dressed] and I know that's how I was perceived by my colleagues and my supervisor, but at the same time I felt like an added protection, if I started wearing pants instead when he was around. Just to make sure there weren't any cues, unintended cues, right. (Margot, P5)

> I regularly wear skirts now that I'm not doing forensic work, but it's still pretty, you know, below the knee and I never face my patients like this (knees facing forward). I would go like this (knees facing sideways). I'm still facing them, face to face but it's more of a side view . . . you kind of learn to, you know, make sure that nothing is being exposed or because if you uncross your legs you're uncrossing like this and you're wearing a skirt, you know, there could be opportunities for, I don't know so. (Sophia, P4)

> I have a number of long jackets, you know . . . almost like a spring coat. And I would wear them, because I don't have a doctor's coat, so I would wear them, you know sometimes as a shirt that you're wearing inside. Just so at least, you know, I'm preventing any other fantasizing or anything like that. (Sophia, P4)

> This kind of lighting is a consideration. Usually if it's a male patient, I tend not to do this kind of [soft] lighting right away. (Sophia, P4)

> As a female if you have a patient who's really quite intent on practicing these sexual advances, what is unique is you have to consider, you know, safety issues given your height, given your weight, your physique. That's why I usually position myself by the door. . . . We go through dress codes . . . actually this is frowned upon, this shoe because it's quite fragile and they'll say well if you have to run away from an offender you won't be running away far. (Sophia, P4)

Sub-Theme 3.3: Self-Disclosure

Most therapists expressed increased vigilance and experienced a particular discomfort with self-disclosure in response to client sexual advances. They seemed to become particularly sensitive when these clients probed for personal information. Therapists wanted clients to be able to discuss their most intimate thoughts and feelings, but therapist disclosure was generally intended to be

strategic. It was offered when it might benefit the client or contribute to the therapeutic relationship. Diffusing the effects of power differentials and keeping the personal quality of the relationship were objectives that encouraged self-disclosure making it difficult to avoid altogether.

> I found that in our sessions, he would want to find out more and more about me and my life. And I would usually steer fairly clear of that unless there was something that I felt, you know, a personal disclosure that was directly going to help him, that was absolutely relevant to his situation. (Stella, P1)

> I really didn't have a good guideline at that point about self-disclosure in counselling either and so, yeah, it became very palpable in the session and was distracting. (Rhonda, P2)

> I think self-disclosure is a really . . . nice way of connecting a person, reducing the power differential and helping the client feel more comfortable and sometimes normalizing some of their experiences as well. So yeah, I do see it as a useful tool . . . and I do emphasize tool because you know like if that keeps me in touch of thinking why am I using this personal disclosure like it's, I'm just not running off the mouth. I am doing this for a purpose. (Rhonda, P2)

> I can see though that the amount of personal disclosure, it's a double edged sword because for me I think . . . I'd be concerned about coming across as very aloof and, and like a psychoanalytic [analyst/therapist]. . . . You know, I'm a blank slate . . . but the other side is that it could be confused as something, a friendship, something other than being in a counselling relationship. . . . I'm just thinking about some clients in particular who after personal disclosures, maybe not immediately after but, I've had it where they come back to a session and further sessions where they start asking, they start soliciting a personal disclosure . . . so it starts to become a pattern. My flag goes up and I tend to start using examples about other clients, in their situation. And I start taking the focus away from me or even amalgamating a bunch of clients. (Rhonda, P2)

> But in the therapy, boundary violations was one of the first things I talked to him about. . . . You know, my role as a psychologist is this one and it's not exactly a two-way street in which I could ask him personal questions but he could ask me similar questions. So at the get-go we established the ground rules. (Sophia, P4)

Sub-Theme 3.4: The Elephant in the Room

In conversations, it became apparent that most participants were describing something tangible when they were discussing how it was to be in the room with a client when client sexual advances were involved. Whether or not it had been openly discussed, client sexual advances became an "elephant in the room" and nearly impossible to ignore. This sometimes led to therapist discomfort and distraction, diverting energy and attention away from the therapy itself. Monitoring the situation, trying to ignore it, or the awkwardness that existed after it was addressed, provided challenges while therapists attempted to focus on maintaining the therapeutic relationship and the work of helping clients. The situation also prompted a dilemma about whether or not client sexual advances should be confronted.

> That's exactly what it felt like. It was very, very present, very palpable. And yet I didn't feel I could address it. (Stella, P1)

> And I'm starting to feel quite uncomfortable with this person in the room. And I really . . . minimized or attempted to minimize my reactions in the session and sort of that gut instinct that's, you know, red flag, red flag. (Rhonda, P2)

> Because I wonder okay, am I right or am I just putting my own stuff into this. . . . I also felt vulnerable around that issue. I think, because it wasn't overt, I didn't want to make it overt. The thought that he might be coming only because he was attracted to me, bothered me. (Margot, P5)

> And then there is this crush taking on a life of its own that sort of, not even, I mean in a way I think it helped therapy for him. And in a way I think it detracted from therapy for me because it caused me to have to deflect some of my energies.
> QUESTION: And you might have been more natural with him. . . .
> Yeah. Yeah if I didn't have to sort of half way through our time together start to just sort of be very, very careful and cautious. (Stella, P1)

> I felt really guarded going into the sessions, you know, and I would try to focus on the daughter more than him. I felt that I couldn't really be myself as a therapist because usually my personality comes through with therapy and with that particular family I felt like it was being stifled. (Kelly, P3)

Sub-Theme 3.5: Dilemma—Confront or Ignore

Therapists were faced with a dilemma about whether to confront or ignore client sexual advances. The elephant in the room created an added pressure to manage the situation. They described weighing a desire to openly address the issue against concerns related to discomfort, embarrassment, risks, benefits, avoidance, timing, tact, etc. I wondered if there may be something like a tipping point where certain behaviours may be tolerated to a point and beyond that point therapists would feel compelled to make a conscious decision to confront the issue directly or to disregard it. Therapists' accounts of thoughts and events that led to their decisions to either confront or ignore client sexual advances reflected processes that were quite drawn-out, elaborate, and sometimes difficult.

> I sort of weighed, really weighed the pros and cons, oh my goodness, do I, don't I, you know. Things seem to be going okay, maybe if I don't bring it up that you know, that we'll just finish off, we're gonna end anyhow you know and he would go on his merry way and that's a secret I guess that I'll just keep with myself . . . the downside to that was I really, I guess calling a spade a spade is pretty important . . . and I didn't want to be wasting time in terms of well . . . if he's just coming here to sit and stare then maybe there's somebody else who could be using this spot. I really started to question the progress that's being made maybe the issues weren't as big as he presented and so I started to doubt the client which is a horrible place for myself to go. . . . I think it erodes the trust . . . but the con side was that, oh I'm gonna embarrass him [if] I bring it up. It's gonna be really uncomfortable and if the presenting issues are genuine and I bring this up and it's so uncomfortable that he cuts it off then there's work that could have been done and we miss out on it because of this elephant in the room . . . and so that took me about 3 or 4 sessions to kind of mull over. . . . I eventually did and it was embarrassing on both our ends. It was uncomfortable and when I did finally address it with the client and acknowledged what was going on and my reactions and we really came to a, not a standstill but a point where we really had to look at whether this,

the actual counselling, was being helpful or if he was just coming to talk to a pretty girl. (Rhonda, P2)

I didn't have a clue how to handle it. And I just had to handle it. You know, the thing that I kept thinking was, what's in the best interests of this young man? What's going to help him the most? And I just kept that front and centre, and thought okay, you know, he's not hurting me . . . and maybe that sounds very caretaking and condescending, but I really believe that he was coming into therapy at that point so incredibly vulnerable, and then even in experiencing the crush becoming even more vulnerable, almost. . . . But as I say I don't really think it would have helped anything if I had confronted him with it and made it into a great big issue. . . . I was afraid to do anything that would cause him to feel, well humiliation's a very good word 'cause I think he'd been humiliated a lot in his life. (Stella, P1)

Initially no, I kind of just brushed it off because with my supervisor saying, oh it's all in your head. I'm like okay, maybe it is my insecurities . . . I would either ignore it or I would just change the subject right away . . . but, you know, when he was talking about you know going out for dinner and me being a mother figure for his daughter, I just said, "You know what, like we need to talk about whether or not this therapy is in fact helpful for you and your daughter." . . . In the end . . . they had kind of ended up firing me so, because I wasn't receptive to his advances in my opinion, that's kind of what was the reason. . . . He said he wanted a different therapist because he felt that we didn't have a good relationship. (Kelly, P3)

I mean it's so hard with clients because I just think sometimes maybe they're not attracted to us and, you know, for whatever reason we're picking up those cues and they're thinking oh my God my therapist thinks like I want her or, you know, and that's not the case you know I just, yeah. . . . I'm just thinking about right now with some of my male adolescent clients, you know, they're at that age where they're curious and they're seeing women differently and, you know, they've got a very high sex drive and I see them sometimes looking me, you know, once-over. But I don't say anything because it's not in a disrespectful way. You know if they were doing it disrespectfully I would say, "You know what, that's not appropriate, right?" But we're all humans and we're all going to look, and you know, why would I be any different than some other woman they see on the street. (Kelly, P3)

I think the openness will get better with time if you're a therapist who hasn't . . . been in these situations a lot. I remembered when I was asking the suicide question, or even like sexual orientation and it's a high-functioning client. I stammered my way through it. It didn't feel natural. So I practiced in front of a mirror. . . . And initially yeah, I skirted the

> issue, I'd say something like, "Are there times when you wished things would just be better if you were not in this world?" It's so poetic and their face is like, huh? And so they can say no and they could be thinking of killing themselves but because you ask it in that way, you might not get the correct answer or you might not get the answer you're looking for. The same with [client sexual advances] . . . there's finesse in it. Then you don't threaten the relations, you don't feel that you're threatening the therapeutic relationship. (Sophia, P4)

Sophia would be straightforward when addressing Adrian's behaviour.

> There's no wishy-wash[y] about it. He won't get any, you know, sort of like indirect suggestions . . . it has to be right at the get-go. I reviewed his file, I knew exhibitionism, so I knew coming in what to expect. (Sophia, P4)

Kelly was pleased that she had faced the issue directly with the female client who disclosed that she had sexual fantasies involving Kelly.

> I'm actually very happy with the way I handled it . . . there's some, you know, uncomfortable feelings of course and you know it's normal, I mean I'm human too. But I think just taking that step and actually addressing it with her was really brave on my part. I mean looking back I was like, whoa, I was able to do that back then? Like, yeah, but I'm glad I did. I kinda faced my fear and I thought well, you know, if we expect clients to be open and honest then you know why aren't we doing the same thing? You know if we're not open and honest I think we're being very hypocritical as practitioners. (Kelly, P3)

With non-forensic patients, Sophia would be more subtle in her approach. She provided suggestions drawn from her own experience of pointing out behaviour that concerned her or that could interfere with therapy.

> I just come from forensics. This looks harmless but it needs to be addressed. So I just said, "Hey, are you like this when you're out and about and you're with a woman whom you consider classy? It kind of looks like flirting to me eh?" . . . I would approach it in that way. And then he has an opportunity to say, "No, no, no. I'm just being my funny self." You know, or if it's something that hinders therapy, I'm going to address it . . . and sometimes my patient . . . they compliment me and they say, "Oh I never thought I would get a beautiful therapist," or something like, or, "I would get a young one," or "I would get," you know. . . . I mean some of them may not know what kinds of things to say at the get-go. They've never seen a psychologist before. They don't know about

> boundaries that, and these are some of things that we usually don't go into. I'm your therapist you're my patient. You know that kind of thing and that's my line. But some of them would compliment you and some of them don't mean anything by it. (Sophia, P4)

Theme 4: Maintaining Professional Boundaries

Therapists who encountered client sexual advances often became cautious and more vigilant about maintaining professional boundaries. Some discussed the difficulty demarcating the boundary, especially in the area of self-disclosure. Most therapists did not have a lot of experience when these events occurred which may have also played a part. Sub-themes included; benefits of client attraction, intuition in a grey area, cues and clues. (See sub-themes; Dress and Behaviour, and Self-Disclosure, within theme "Impact on Therapist" for therapists' discussion of adjustments to behaviour related to those sub-themes.)

> [The boundary] wasn't clear to me all the time. You know, sometimes when he would ask about my personal life and things I thought well, you know, maybe I should tell him I have a boyfriend and you know, maybe I should tell him these things. And then I thought you know, the more you do that the more he draws you in to disclosing about my personal life and it creates sort of even more of an intimacy that isn't relevant to helping him. And I did get sort of confused in there at a certain point as to what's relevant to helping him, and where am I trying to just sort of protect myself from this young man's crush? (Stella, P1)

Agreeing to longer sessions with the young man was a decision that Stella later regretted.

> I was naïve enough and inexperienced enough that I agreed to do that. And I shouldn't have. I should have stuck to the one-hour session. I think that it would have kept the sessions, you know, very strictly professional. It wouldn't have allowed him to start to slide into asking the more personal questions and digging into my personal life. It would have kept the sessions more focused. It was exhausting. (Stella, P1)

Stella felt forced to re-establish boundaries with the mature female after she began contacting Stella at home.

> It got to a point where I realized that I was not going to be left alone, and she was making it pretty clear that she had very strong feelings, and it was just going in a bad direction. But I almost felt like I had to counsel her again . . . I thought well maybe if I just see her a couple of times, you know, I can help her move beyond this. . . . I should have just been very, very cut and dried, and just said you know, "I'm sorry but I told you when we completed our sessions together that these were the boundaries, and I need to have them respected, and I'm sorry but I cannot speak with you. . . . because by trying to be gentle it just prolonged it and added fuel to the fire. It allowed it to get worse. And so there's a point you know, that you have to be cruel to be kind. (Stella, P1)

Sophia was generally comfortable in a forensic environment but found it challenging to maintain boundaries with Adrian. Adrian would often test the limits of acceptable behaviour.

> And there were a number of times when he challenged me, he would say, "Yeah, watch." you know. "You think I'm masturbating I'm not." . . . and to begin with he actually has cold hands because, there was one time when he said, "if you want you can touch my hands and see how cold they are," you know . . . "I can't . . . 'cause I don't know where your hands have been prior to coming to my session." . . . and because of course any touching can be perceived by him as a special thing. (Sophia, P4).

Sophia suggested that the issue is sometimes a matter of educating the patient about the potential for attraction to develop in the client-therapist relationship.

> I would address it in such a way that, "You know how sometimes because you work in a one-to-one setting and you might start to like me, not just as your therapist. But you know or sometimes this can happen between patients and therapists, and if you find it is, it's happening with you it's alright to bring it out in session so we can address it." And so, I would even say something like, "You know, this I might be assuming a lot, I'm not saying I'm the prettiest girl in the world or anything like that." But you know, it kind of just gives them a chance especially because they're community patients. They're not sex offenders. (Sophia, P4)
>
> I usually don't do that with all my patients. I do it when I start having the inclination that they are starting to become attracted, it's getting in the way. I might not be as gentle if, you know, it's very overt and I'm saying,

> "Okay look at, you know. Therapist. Patient. It's a good relationship but it doesn't involve all these kinds of things." . . . but initially because I'm fishing and I'm not sure what's going on with the patient, maybe it's just his personality 'cause some people are really flirty. Nothing to do with me. It's just that, you know, that's their approach, so I need more information. (Sophia, P4)

Sub-Theme 4.1: Intuition in a Grey Area

Therapists did not believe that there could or should be a set formula for dealing with client sexual advances. Sexual advances themselves appear to be unique in their manifestation and the degree of effect on therapy or therapist. Therapists often considered many variables before deciding how to approach each situation according to their distinct understanding of individual clients and circumstances. They often relied on their intuitions to detect client sexual advances and to make decisions about confronting or ignoring incidents. Ethical guidelines and ethical problem solving provided an additional means for evaluating decisions.

> It's such a unfortunately grey area. I think one of the things that I do say when I'm talking to students is to listen to your gut, to pay attention to your reactions. I don't think there's necessarily a formula to suggest when it might be interfering but counselling is so much about the relationship you have with the individual and if you start to feel creeped-out or if you start to feel like it is interfering, it's a good time to bring it up in discussion with myself or with your client. (Rhonda, P2)

> There is no right or wrong answer in my opinion. I think for example a code of ethics would be a good start in terms of the ethical decision making model as to what the therapist could do. . . . I find that in this profession we're too much at the extremes you know. You don't have sex like you said and if you're in the States you wait two years because that's what the APA code says so . . . or then you know the, the other side of that is like well you do good work and there is no sexual attraction and I just think that this grey or that the middle ground is not covered. (Kelly, P3)

> I feel like I did the best I could at the time, and I still question whether I should have brought up the part about boundaries before it [be]came so

> overt with the second individual. You know, part of me says yes and part of me says that would have again damaged the therapeutic relationship, and so, I'm not sure. (Margot, P5)

Therapists described intuiting or sensing client sexual attraction in spite of the absence of direct comments or overt actions on the part of the client.

> His body language changed and he would look at me, and you know, look me right in the eye, and I could feel him digging, you know, trying to dig inside of me as a person. . . . It was an attraction; I could feel him being attracted. (Stella, P1)

> After the first several sessions, very similar to with the young man, I could feel her attraction to me. . . . I could just see it in her eyes and, and I could just see it in her. (Stella, P1)

> The first thing that triggered me was when he really got into detailed description of how he could move his hips and how that was so beneficial for womankind right. (Rhonda, P2)

> When I first started working with him I kind of got the sense that he was attracted to me and, you know, I didn't do anything about it because nothing overt had come up but I could see him kind of checking me out, you know, kind of looking at my breasts but trying to be discreet about it. (Kelly, P3)

Sub-Theme 4.2: Benefits of Client Sexual Attraction

Some participants mentioned that there may be positive benefits of client sexual attraction. This was generally related to motivating the client to enter or maintain therapy. Therapists suggested that there might be benefits from acknowledging client sexual advances, especially as in a learning experience for the client. In other instances, it was suggested that it might be better not to acknowledge it because of the potential negative consequences. Instead it was ignored or used; such as when it was assumed to be a "hook" for getting a client to enter therapy or maintain it when they may otherwise have not. Once in therapy, therapists hoped to provide a positive counselling experience that would

allow clients to benefit from therapy. Seen as potentially beneficial, the decision to confront or ignore client sexual advances might contribute to the sense of it as a grey area without a clear prescription for management.

Stella believed there were some positive benefits of the young male client's crush.

> I think because he was so fond of me he trusted the sessions completely. And I think that he looked forward to them, and in trusting and looking forward to them therapy, his first experience of therapy was a very positive thing. And he disclosed in a way that I think he's never disclosed in his life. (Stella, P1)

Margot hoped that her client's attraction to her would be positively motivating so he would continue to come to therapy. She and others considered it the 'hook' that helped these clients maintain a commitment to therapy.

> And I was also conscious of the fact that he had attempted counselling in the past and had never stuck with it. And so a part of me thought well even if that is the only reason he's coming, can I use that? I mean he's coming . . . and as long as it's not overt, I'm comfortable with it enough that I'll try to use it any way I can. (Margot, P5)

> I don't want this to be an issue about why you're coming . . . but then you know sometimes I think well maybe if I can use it as a hook to bring them [in], you know a foot in the door and we can move past it whether it be addressed or not, then . . . get them in when otherwise they might not. (Rhonda, P2)

> I would even say to the therapists, "Your patient really likes you because you're young and you're good looking, so use that in some ways. I'm not saying though you would use it in a negative way. It can be a positive way. And you can acknowledge that." (Sophia, P4)

> He would've stopped coming if I had made it uncomfortable for him or if he didn't feel like I was accepting him. . . . But I also think that he thought, "Oh that girl was hot, I'm gonna go back." (Margot, P5)

Sub-Theme 4.3: Cues and Clues

There were often cues or clues that stimulated or confirmed therapists' intuitions of sexual attraction or intentions. Probing questions, gifts, body language and dress, and compliments, provided some of the clues. Contrarily, sometimes therapists did not perceive cues at all and were taken by surprise.

> She questioned me a number of times, very subtly about my sexual orientation, men, and having children, and things. (Stella, P1).
>
> And at one point he asked me if I was married and I asked him, "Well, how would my answer affect my work with you and your daughter?" (Kelly, P3)
>
> Usually it's a question about my status. "You have kids yet?" kind of thing, or they're complimenting something, or they're asking about, "So, like you know, what are you doing Friday night?" That kind of thing, or, "Do you like the Oilers' game?" (Sophia, P4)

Body language, dressing more attractively, and other related behaviours seemed to have played a part in stimulating an intuition of client attraction or sexual intentions.

> The cues are the look in her eye, yeah more than anything. The look in her eye, sometimes the tone in her voice when she'd address me. . . . Yeah, at first it was sort of crushy, and I also noticed that when she first came to see me she looked liked an absolute wreck. . . . And then she started to look really very nice when she came to see me. And I commented on that to her a couple of times, and she was just, she would say, "Yeah well, you know I feel so much better when I come to see you and everything." You know, typical counsellor stuff you know, you would expect that. But there's something about, there's a, a tone of voice, there's a look in an eye. It's hard to say exactly what it is, but you know when somebody's attracted to you. You know, you feel it. (Stella, P1)
>
> Like I know when a man looks at me that way, he's not thinking of, you know, what a great personality I have. (Kelly, P3)

Compliments could seem quite innocuous in some situations, but in other cases they could stimulate the therapist to be alert and cautious.

> We got along really well and at one point you know, kind of in the middle, maybe session 12 or 11, she just said, "You know what? You're so pretty." (Kelly, P3)
>
> And sometimes my patient says, "Oh, and you're young." Like they compliment me and they say, "Oh I never thought I would get a beautiful therapist," or something like or, "I would get a young one," or, "I would get," you know, they're not exactly as bad as Adrian's sexual advance but in some ways that's going away from the, you know, it's a boundary issue. (Sophia, P4)
>
> One of my sex offender patients commented on my shoes. I mean it could be considered neutral. He said, "I like your shoes. Where did you get it?" And so I'm thinking, "I wonder why he's asking me this." (Sophia, P4)

Sometimes cues or clues, if they existed at all, were not perceived. Rhonda and Kelly were not aware of their clients' attraction until it became overt. Margot had an intuition that sexual attraction existed but did not anticipate the client's direct proposition.

> It was really only [when] my team member commented [that the client had] said, "I'm staring at her the whole time in session," that it was, aw darn it. (Rhonda, P2)
>
> I knew she was a lesbian but I, you know, would never, I never thought that she was attracted to me. . . . I just, I didn't pick up any cues from her, I didn't pick up, you know, [that] there might be some kind of tension. (Kelly, P3)
>
> And he said, "I was just wondering if you and I could have sex once in a while?" . . . and I guess because it was this explicit violation of boundaries, that I just, to me, I just didn't figure it would ever be that overt, and, so it was a little bit scary to me. (Margot, P5)

Theme 5: Taboo Topic

It seemed very clear that there was a hesitancy to discuss client sexual advances with clients, supervisors, and colleagues. It may have been related to discomfort, shyness, embarrassment, and risks they associated with discussing the topic. Some mentioned concerns that disclosing client sexual advances made them vulnerable to potential judgements of their behaviour, competence, character, or integrity. Some were afraid that others might think their assumptions were based on beliefs about their own attractiveness, or that they were misreading cues. With clients, therapists were often concerned about embarrassing the client or their own embarrassment, particularly if they were wrong and had misinterpreted cues. Sub-themes included; embarrassment and avoidance, supervisors and colleagues, and training.

> I think even just talking about this does raise a little bit of discomfort in me because it's not a very, ah it's not something that we talk about you know in case conferences for example or maybe even supervision with some people. So I do sense a little bit of discomfort in myself you know and it's nothing to do with you at all it's just the nature of the topic you know. It's still kind of taboo in a sense. . . . I haven't told anyone except you. (Kelly, P3)

> I think the therapist would need a lot of tact in, you know, choosing the right words in bringing this up. I mean you can't just say, you know, I think you want me and, you know, because I'm your therapist I just can't sleep with you. I mean nobody would say that. At least I hope not. But you know there are certain ways of bringing it up that would maybe lessen the client's defensiveness or embarrassment or guilt or shame whatever they're feeling. (Kelly, P3)

> The fact that there was a natural ending built in, meant that okay, why exacerbate something and take the risk of causing harm if I didn't have to . . . and you know, no real harm was being caused, so let it go its natural course and come to the conclusion, move him on into the areas he had to go, and let that defuse out naturally . . . so that he doesn't walk away with some big stigma in his mind. (Stella, P1)

Sub-Theme 5.1: Embarrassment and Avoidance

Embarrassment appeared to be associated with discussing client sexual advances, along with associated feelings such as discomfort, awkwardness, shame, humiliation, etc. Therapists were often concerned about stimulating those types of feelings in clients and sometimes they were concerned about feeling embarrassed themselves. This was often a consideration when contemplating whether to confront or avoid the topic of client sexual advances.

> I was afraid to do anything that would cause him to feel, well humiliation's a very good word 'cause I think he'd been humiliated a lot in his life. And I didn't want to add to that, and so I thought I just need to walk very, very carefully with this young man. (Stella, P1)

> At the beginning . . . I think I was embarrassed. . . . I didn't have a measuring stick for myself or my experiences with other clients to know if this was regular, everyday thing that happened. Yeah so . . . the uncomfortableness went on for quite some time I think. (Rhonda, P2)

> The con side was that, oh I'm gonna embarrass him if I bring it up. It's gonna be really uncomfortable and, and if he, if the presenting issues are genuine and I bring this up and it's so uncomfortable that he cuts it off then there's work that could have been done and we miss out on it because of this elephant in the room and because of my desire to call a spade a spade . . . and I eventually did and it was embarrassing on both our ends. (Rhonda, P2)

> We only had maybe one or two more sessions left and it came to an end so it ended okay but I remember there was 20 minutes there that were painfully uncomfortable. I think we were both red. (Rhonda, P2)

> I just remember at that moment being very shocked, feeling like my face was warm, although I don't think it, it was outwardly, just very flushed, um and nervous. And I remember thinking about it a lot afterward. (Margot, P5)

Sub-Theme 5.2: Supervisors and Colleagues

With supervisors or colleagues, some therapists were concerned about their competency, character, or actions being judged. They were afraid that

supervisors or others might believe that they liked the attention and/or engaged in behaviour that encouraged it. Some alluded to a worry that their version of events might not be believed without concrete evidence or that others might think that they were conceited about their looks and either misconstrued events or were bragging about their appeal in an indirect way? All of this, on top of the taboo nature of the topic, made it a difficult topic to raise with supervisors or colleagues. It was often avoided unless they felt quite secure in their relationship with a supervisor/colleague and trusted they would be believed and not blamed.

> I think, people's perceptions of us will change regardless of the outcome. You know whenever you bring sex into the picture you're introducing a vulnerability . . . and you know we're in the position of power in this relationship . . . and maybe a colleague that I might disclose to here may not agree with what I had done. . . . You know there's an element of being judged and I think we do that enough as it is to each other, there's no need to kind of bring this up as well. (Kelly, P3)

> I know definitely in my case she [my supervisor] did question my competency. . . . But I think, yeah, there would maybe be some questioning of not just competence but maybe ego. You know like, you know, do you really think you're so hot that you would think that all your clients would want you and want to sleep with you. . . . I'm just thinking well no I'll refrain from saying that. (Kelly, P3)

> I think in the context of my second occurrence. . . I felt capable of handling it but I also didn't bring it up to my supervisor because I think I didn't want to come across as looking like I have a swelled head or I'm over confident about my looks, or that yeah, of course this is going to happen you know . . . the allegation could reflect as much on the person making the allegation [as it does on the perpetrator]. You know it has a lot to do with perception. (Rhonda, P2)

Kelly's first supervisor provided an experience that confirmed many of her apprehensions about discussing client sexual advances. The supervisor's response contributed to Kelly feeling unsupported. Without support and strategies to help

her, she attempted to ignore the situation and it affected her confidence and how she approached therapy with the bride-seeking father and his daughter.

> She just said I'm reading too much into it, she said, "Because you're new to the profession . . . you might be taking things a little bit too [seriously] so maybe it's just your insecurity coming out, like you know, he's probably not attracted to you, I mean you're so much younger than him, he probably wants somebody his own age." I felt like she didn't believe me. Like not so much that I had a big ego but just, you know, I don't believe you, you're new, you're new to the profession, you're probably already a little bit insecure as it is, and this is just one way in which your insecurity is coming out. You know, you think that this man is attracted to you and, yeah . . . with that particular family I felt like it was being stifled. . . . It's [the advances] kind of being ignored, because obviously it didn't exist. It's all in my head. . . . Kind of truck on and do what it is that I need to do and, you know, get them out of there in whatever the minimum number of sessions was. (Kelly, P3)

Kelly found support from a colleague who she confided in and who had had experience with the bride-seeking father herself.

> I told her and she's like, "Oh yeah you know, he did the same thing to me." And you know, actually bought her a present, I can't remember what it was but it was something inappropriate. Like it was too extravagant and my colleague didn't accept it, she said no, like this is not suitable, it's not appropriate. . . . That was really helpful talking to her about it because she had experienced it too, so I'm, okay, it's not in my head, you know, and my supervisor is just way off. (Kelly, P3)

Kelly's supervisor for the second incident with the female client was much more supportive than her prior supervisor. It was a very different experience for Kelly.

> I mean she was fantastic and she was always encouraging and she trusted my judgement. I mean I had some cases that were really tough, you know, for my level of development back then and she said, "No you're doing the right things and I trust you, I trust your judgements." You know, "This is why I'm here. I'm here to support you and if I ever feel that you're doing something inappropriate or we could take a different course of action I will let you know, but so far that hasn't come up yet." She actually observed me working with this client a couple of times in a reflecting team. So she, she knew her. You know she wasn't just, you know, some file. (Kelly, P3)

Sophia suggested that it is a good idea to talk about client sexual advances with colleagues in spite of reservations one may have.

> It’s better that more people know about it so they can help you monitor it, rather than you feeling ashamed about it and not wanting to share it. And even if you get mad at, you know, mad about your reactions it’s still better to actually acknowledge your feelings rather than keeping it to yourself and saying I can deal with this because the potential for, you know secrets, the potential for you sliding, and your colleagues might not know what’s going on with you is, is higher if you keep it to yourself. (Sophia, P4)

Sub-Theme 5.3: Training and Experience

Most therapists told of events that occurred early in their practice. They generally felt unprepared for the experience and inexperience seemed to have left them more vulnerable to discomfort and awkwardness with the situations and difficulties managing them.

> Man, I did not feel prepared for that at all. Well you know . . . I can’t totally say none because it is covered in ethics but it’s the extreme end that’s covered in ethics. It’s the sleeping with your client, thou shall not sleep with the client, we know that line right and that one gets drilled in very easily and I felt that was the extent of the training. Ah, in terms of the slippery slope of how to address you know, sexual advances in session, whoa, I was totally unprepared. (Rhonda, P2)

> I didn’t have a clue how to handle it. And I just had to handle it. You know, the thing that I kept thinking was what’s in the best interests of this young man? What’s going to help him the most? And I just kept that front and centre, and thought okay, you know, he’s not hurting me . . . but maybe I didn’t have enough knowledge to know if it was harming the client or not. I don’t know. (Stella, P1)

> At the beginning I didn’t, like I say, I think I was embarrassed, I wasn’t sure, I didn’t have a measuring stick for myself or my experiences with other clients to know if this was regular, everyday thing that happened so because everything was new at that point in my career, I just, I chalked it up to well it’s new and I’m uncomfortable and I’m generally uncomfortable with clients at this point because I’m starting out in the profession. (Rhonda, P2)

> I guess I just felt like it was more likely to happen because I was young, than it would have been had I been maybe middle-aged or a bit older. I'm not exactly sure why but I just, I kind of feel maybe in a sense they feel more able to give those sexual advances because I seem less experienced with them, and wouldn't be as threatened by them, or something like that . . . so I think that kind of took me aback again, about my age, and that coupled with a bunch of other things that were happening with my other clients, I was very anxious for a very long time when I first started. Um, and questioning the decisions I made, everything I did, going back and looking at it and saying I didn't do this right, I wrecked everything. . . . I think my vulnerability came from the fact that I realized, it was another thing that made me realize how much experience I don't have. (Margot, P5)

With experience, most therapists seemed to be more comfortable talking about it with colleagues or supervisors.

> Now I don't have an issue . . . or if I do [it's] much less of an issue. I'll even mention to colleagues you know, this yeah I'm getting a sense that this person is just coming to see me or see another of our interns 'cause yeah they're hot. So, I actually am quite more open with the students that I supervise. (Rhonda, P2)

> And sometimes I think I'll break the ice a little bit with my students in going, "Yeah, do you ever get the sense that he's staring at your chest not your eyes?" or, "she's staring at your chest or your ah you know." (Rhonda, P2)

> I've been very blessed, my supervisors encouraged examining our feelings as a therapist as part of supervision. So for the most part they're pretty open to it. I don't have any problem. Although I've never really been attracted to a client. I don't know if personally I would say that to my supervisor unless it's something like for example if a client is cute you'd say he's kind of cute so I have to make sure, you know, I'm not paying more special attention to him. I don't think I would have a problem saying that to my supervisor. . . . But if it's a really deep attraction, I might not say anything. But thank god it has not happened, I have a fiancé so. (Sophia, P4)

> Don't not talk about it, you have to debrief and, you know I think it's a pretty common experience, to different levels of overtness, for women, so you know, many women therapists have to deal with it at some point, and so talking about it can only make it [easier] to deal with it I think. (Margot, P5)

Theme 6: Being Female

When asked directly, most therapists resisted making assumptions about how experiences related to client sexual advances might be different for female versus male counsellors. They acknowledged that male therapists also experience client sexual advances and were hesitant to rely on gender stereotypes for speculating on differences. During the course of our conversations however, some potential differences were suggested or came up in response to other questions such as; how client advances affected therapy, therapist behaviour, and safety. Sub-themes included blaming the victim and male-female seduction styles.

> As a woman, I am interested in these sorts of topics because when I heard what your study was about I thought, oh, excellent you know. I think there are differences between women and men counsellors, not that I can articulate them too well right now, but I think there are some unique aspects about being a woman and being a woman counsellor. (Rhonda, P2)

> I do have a sense in general and I know you get into trouble when you start stereotyping based on gender but in my experience I guess I should say even with personal and professionally women tend to be in my life more aware of perception, more aware of how they may be coming across, and so may engage more in, more impression management than men. (Rhonda, P2)

> I can't imagine men thinking, "Oh I need to change myself." Right. Because they're already at that position of power just by being male, and if they're white that's even more so. I can't imagine them saying, "Oh, I have to change my demeanour," or "I have to maybe engage in less frequent eye contact because that might be off-putting to some of my female clients," or whatever. (Kelly, P3)

> I think of course they [male therapists] would be questioning themselves. They'd be questioning perhaps, you know, what's going on in the therapeutic relationship that is maybe making them more attracted to me? Is it some kind of transference issue, whatever the case may be? But I don't think, I'm generalizing here, that male therapists would be as bothered by it as female therapists. I think it's just kind of the cultural and social messages we get that . . . it must be your fault 'cause you're a

> woman and you probably did something to bring it on. . . . And you know given the fact that it's not really talked about in the profession, that's all the more reason to blame yourself and say that you must have done something or were giving off the signs and he kind of took the bait. (Kelly, P3)

> You know because I was very young you know and I thought I was reasonably attractive. Is this how they're gonna see me? You know like, instead of concentrating on the therapy are they just gonna think of other stuff? (Kelly, P3)

> So, are they gonna take me seriously you know, was another one because I'm young, right? And I find that right now sometimes when I work with older male clients that I have to, yeah I have to kind of prove that I'm not this, you know, young pretty little thing that doesn't really know what she's doing. (Kelly, P3)

> One of the disadvantages of my approach [compared to male therapists] is that the offender or the patient might think it's not serious enough. I tend to become serious after the next, you know, if there's another boundary violation. (Sophia, P4)

Sub-Theme 6.1: Blaming the Victim:
Fears of Not Being Believed, Judgement Questioned, Being Judged

I could not help but think of similarities between the difficulties female victims of sexual harassment or sexual assault have when they consider bringing the allegations forward and the difficulties therapists described. There appeared to be fears that people would question the therapists'(victims') perception of events or think that therapists (victims) might somehow be responsible for leading the perpetrator on, having contributed to their own situation (victimization). The therapists (victims) also sometimes questioned themselves in hindsight.

> I just thought that maybe there's something in my demeanour that is suggesting that I'm interested. Maybe I'm too friendly or I smile too much or this and that, but I thought, no I don't behave differently with him than I do with my other male clients so why should I even be thinking this? . . . With my supervisor saying, "Oh it's all in your head." I'm like okay, maybe it is my insecurities 'cause I am new to the field and didn't really have any experience prior to that. (Kelly, P3)

> One; I didn’t want it to be an issue right, and two; I didn’t want to be perceived by anybody who I might bring it up to that oh, she’s so full of herself, of course she’s going to think everybody thinks she’s pretty and everybody’s going to be attracted to her. . . . I guess I was trying to do some impression management. (Rhonda, P2)

> Yeah. I know definitely in my case she did question my competency. . . . But I think yeah there would maybe be some questioning of not just competence but maybe ego. You know like, “Do you really think you’re so hot that you would think that all your clients would want you and want to sleep with you?” (Kelly, P3)

> The allegation . . . could reflect as much on the person making the allegation (as it does on the perpetrator). You know, it has a lot to do with perception and so it, like in my first example, it took me a while to figure it out and when the comments became more and more direct I’m going, okay this is obviously what’s going on, you know. It doesn’t take a rocket scientist to figure this one out. So yeah, it was very, very clear, but if it hadn’t have been and I brought it up to my girlfriend or a supervisor yeah, certainly there would have been, I would have been concerned about you know oh, well she’s, she’s just arrogant about her looks right or like what, where’s the evidence, how can you, how can you prove that you know this person is attracted and it’s interfering in the relationship. (Rhonda, P2)

> Maybe a colleague that I might disclose to here may not agree with what I had done. . . . “Oh gees, you know, you’ve got really poor boundaries.” Or “I can’t believe you brought that up with her. I would never have done that.” I’m like, “Well okay fine but don’t judge me for it.” You know there’s an element of being judged and I think we do that enough as it is to each other, there’s no need to kind of bring this up as well. (Kelly, P3)

Sub-Theme 6.2: Male/Female Seduction Styles

Acknowledging a heterosexual bias and that male/female stereotypes were being utilized, some suggestions were provided that indicated there may be differences in how sexual overtures might typically play-out toward female versus male therapists.

> I don’t know like how females would approach like, you know, an overture toward a male therapist, probably similar questions but perhaps more subtle. Like I’ve had male colleagues before tell me like of the kinds of advances that their patients have made towards them. . . . For example

> leaning forward that kind of thing to show cleavage, crossing their legs, wanting to stay more, longer in session, and start asking personal questions. If it were a male, I don't' really see them leaning forward or, you know, it's more like, it's different . . . the proximity, they might sit closer to me . . . but it's like, more of a show me kind of way. With the female the stereotypical I think would be like, you know, you lean forward across the desk. Play with your hair. Yeah. I haven't seen that in males. Usually it's a question about my status. "You have kids yet?" Kind of thing, or they're complimenting something, or they're asking about, "so like you know, what are you doing Friday night?" That kind of thing, or, "Do you like the Oilers' game?" (Sophia, P4)

> I think also, male clients toward a female would be more overt about it, and I think if it was a male therapist working with a female, it's funny, I was thinking about this because I think in general females would tend to have more emotional responses, so you know, "I'm in love with you," or something like that. And that would feel far less threatening to me, than somebody saying, "I want to have sex with you." (Margot, P5)

> I think for a lot of male clients, they come to only feel intimacy in a sexual way, especially the ones that we see. And, so, it becomes then that the only way they can feel intimacy with a woman is through that sexuality. And that's why that would come out on the therapist I think. Whereas, I mean that's certainly true for some female clients as well, but I think less so, that intimacy doesn't always need to be a sexual thing. And, they can go the emotional route and feel the intimacy that way, and not kind of sublimate it with the idea of being sexual. (Margot, P5)

Summary of Findings

Six overarching themes were derived from interview data. Themes and sub-themes represent significant aspects of therapists' experiences based on similarity across participants and/or impact of the experience on the therapist(s). Therapists who experienced client sexual advances: experienced different types of sexual advances that ranged from subtle clues of sexual attraction to very overt statements or actions; worked to develop a special relationship with their clients in order to facilitate a caring environment for a positive experience of therapy to take place; were impacted in ways that stimulated a range of emotions from self-

doubt and suspicion to discomfort, distraction, and confusion about how or if to confront an issue that felt like a tangible presence in the room; became more aware and diligent about maintaining professional boundaries and utilized their intuitions to detect and make decisions about how to respond to incidents based on a risk assessment process; did not feel well prepared for client sexual advances and found it a challenging topic to discuss with clients or to disclose to supervisors and colleagues; and displayed some behaviours and concerns that may be uniquely female.

Chapter Five: Discussion

This purpose of this exploration was to explore female therapists' experiences of client sexual advances, how they may have impacted therapy, how therapists managed incidents, whether they discussed the incidents with supervisors or colleagues, whether their training had adequately prepared them, and if they thought that female therapists' experiences might be distinctly different from those of male therapists. Six overarching themes were identified. The themes were; sexual advances, special relationship, impact on therapist, maintaining professional boundaries, taboo topic, and being female. Sub-themes were also identified. In this section, the themes are examined in order to highlight insights they may offer and relationships to existing literature.

Theme 1: Sexual Advances

Therapists brought stories of incidents of client sexual advances as they defined them. I had not provided a clear definition for them and yet, in most cases they seemed confident that the experiences they conveyed were client sexual advances. These included; direct approach, obvious attraction, indirect approach, no clue, and special populations. The common underlying features of client sexual advances consisted of therapists recognition of clients' sexual attraction (either intuited or through overt behaviour) and that therapists felt client sexual attraction or behaviour was significant enough to warrant monitoring, managing inconspicuously (such as paying extra attention to boundary issues) or confronting directly. Therapists were often alerted to the existence of client sexual attraction through intuition before there were overt actions by the client. In other cases,

clients did not make overt or direct statements and therapists relied solely on their intuition as a means of detecting client sexual advances. Rhonda provided an idiosyncratic account of being taken by surprise when she was told by a colleague about the secret admirer who found her so pretty that all he could do was stare at her in sessions. Until then, she had no clue or suspicion of the attraction and there were no overt actions by the secret admirer. Sophia anticipated client sexual advances in her work with special populations, including sex offenders. However, she was surprised by the degree of provocation she faced with Adrian. It proved to be a significant challenge to work with him. The situations faced by therapists were varied. They ranged from the subtle (Stella detecting sexual attraction in the form of a crush) to the brash (Margot being asked if she would like to have sex once in a while). The incidents described by therapists are not likely to have captured the range of experiences possible and therefore this is not intended to be a complete list. These are simply the experiences of these five women. Others might have very different stories to tell. These accounts provide real-life scenarios which illustrate different types of client sexual advances that people might encounter and which could be useful for discussion, training, and to stimulate future research.

Theme 2: Special Relationship

Therapists in this study gave priority to the therapeutic relationship in their work with clients. The special relationships they developed often emphasized intimacy and trust, acceptance, providing a positive therapeutic experience, and caring about the vulnerability of clients. This suggested a strongly humanistic

component to their therapeutic styles. Therapists attempted to provide an environment conducive to client disclosure of a deeply personal nature. They were fervent in protecting the relationship and were hesitant to take risks that might rupture the alliance they worked so hard to build. Harris and Harriger (2009) proposed that the processes involved in developing a therapeutic alliance are similar to processes involved in mate selection. Mate selection factors of proximity, shared values and goals, physical attraction and social/cultural expectations may all be involved. The therapist's job is to show empathy and convey a sense of caring that is supposed to lead to trust and may involve warm feelings (Harris, 2001). While I am not suggesting that client sexual advances are limited to humanistically oriented therapists, the therapist accounts provided here demonstrated an emphasis on the therapeutic relationship that resembled Rogers' (1957/1992) client-centred approach which has become integral to any discussion of the role of relationship in change principles (e.g., Goldfried & Davila, 2005).

The values of humanistic orientations were developed in the 1960s and 1970s when there was a radical shift from previous conservative styles that supported the power position of the therapist. The tearing down of boundaries was encouraged. It may be more challenging for humanistically oriented therapists to maintain boundaries while they attempt to maintain a healthy middle ground with their clients (Williams, 1997). Seasoned practitioners may feel more comfortable with this whereas beginner therapists might struggle with developing a perfect balance between closeness to their client and professional distance. I certainly sensed this struggle in their stories. They were very concerned about maintaining

the therapeutic alliance and providing a positive experience of therapy for clients. They tried to avoid saying or doing anything that might put the relationship at risk. Stella's approach with the young man provided good evidence of such a commitment. She was very protective of the young man who she saw as very vulnerable. She believed that she had made critical inroads with him because of the trust and intimacy that allowed him to disclose in ways he had not previously experienced. She did not feel she should jeopardize the relationship and his progress by bringing up his crush, although it was quite distracting and uncomfortable at times. On the other hand, Sophia was very aware that she had to maintain professional distance in her relationship with Adrian because of his sexual misconduct and how he might be misconstrue any displays of affection. There was no question about where to draw the boundary in Adrian's case and therefore the boundary was not nearly so grey as other situations therapists encountered. Developing the therapeutic relationship in order to facilitate intimate disclosure for clients was the first challenge. Maintaining that relationship in the face of client sexual advances presented a new challenge that often caught inexperienced therapists off-guard.

Theme 3: Impact on Therapist

Client sexual advances impacted therapists in several different ways. Therapists often felt unprepared or surprised by client sexual advances and would then question their perceptions in hindsight. This sometimes stimulated suspicion and self-doubt. Rhonda began to wonder if the secret admirer's work in therapy was sincere or if he was simply coming to spend time with her. She began to

question the progress that she believed had been made in therapy as evidenced by her statement, “Does this just completely invalidate all what we’ve been doing?” (Rhonda, P2). She became suspicious and began to doubt the client. She worried that he might have been exaggerating the issues he presented in order to continue therapy and spend time with her. Margot also felt insecure and questioned her own decisions after being faced with client sexual advances. She had suspected that the sex-seeking male client was coming to therapy because he was sexually attracted to her but she never considered that he might make a direct proposition for a sexual relationship. Insecure as a beginner therapist already, the incident left her questioning her own decisions and judgement in hindsight.

Therapists often described awareness of client sexual advances in therapy as a palpable presence or an elephant in the room. The resulting discomfort and distraction interfered with their ability to be fully focussed on the work of therapy and could affect their behaviour and interactions with the client. Stella was vigilant with the young man to make sure that he did not get any unintended cues that might lead him to think his feelings were reciprocated. Kelly was unable to ‘be herself’ with the bride-seeking father and felt that she was being stifled. Margot caught herself being more challenging when she sensed her client’s attraction and later felt that she was putting up a defence.

Faced with the palpable presence client sexual advances produced, therapists struggled with the decision of confronting or ignoring client sexual advances. They did not see it as a black and white issue with a straightforward response. They often underwent a complex deliberation that involved a

risk/rewards assessment due to the potential for embarrassment (to therapist or client) and worrying that the client might terminate therapy. Because therapists often seemed willing to tolerate certain levels of client sexual advances or flirtatious behaviour, I began to consider the idea of a tipping point. Perhaps the decision to confront clients about their sexual attraction or more overt behaviours depends, in part, on therapists' personal level of tolerance. How much awkwardness, discomfort, anxiety, confusion, etc. could they tolerate before they needed to address the issue directly? There seemed to be a tendency to avoid confronting the client unless therapists felt it interfered too much with their, or the client's, ability to focus on therapy. Rhonda "weighed the pros and cons" of confronting the secret admirer and was eventually swayed to speak to him when she began "doubting the client" which she felt might erode trust and therefore harm the relationship which was seen as vital to therapy.

Theme 4: Maintaining Professional Boundaries

Therapists who encountered client sexual advances seemed to intuitively respond by becoming more vigilant about maintaining professional boundaries. Participants were often surprised by their first encounters with client sexual advances and confused about what to do. They were often highly focussed on applying their newly acquired knowledge with clients in therapy (Skovholt & Ronnestad, 2003) and were not expecting clients to make sexual overtures. In their heightened state of focus on techniques, they may not have noticed or paid much attention to cues and clues that more experienced therapists might recognize. When they became aware, client sexual advances became a distraction

as they considered whether to confront the client or not, often at the same time as they were going through a range of reactions and emotions of their own. They generally responded by falling back on their ethical training and became vigilant about maintaining professional boundaries while attempting to focus on what was in the best interest of the client.

There is strong support for maintaining professional boundaries in psychotherapy across theoretical disciplines. Pope (1994) stated, “Establishing safe, reliable, and useful boundaries is one of the most fundamental responsibilities of the therapist. The boundaries must create a context in which therapist and patient can do the work of therapy” (p. 70). Simon (1991) provided a warning regarding boundary violations that might have sexual undertones or are in the direction of sexual misconduct. He argued that they do not have to necessarily get as far as sexual involvement to be harmful. “The boundary violation precursors of therapist-patient sex can be as psychologically damaging as the actual sexual involvement itself” (Simon, 1991, p. 614). Attention to boundary maintenance appeared to provide a strategy for managing the relationship and adjusting their own behaviours when therapists were somewhat uncertain about what else to do.

Intuition, possibly stimulated by subtle (and sometimes not so subtle) cues and clues often provided the stimulus for therapists to focus on boundary maintenance. Self-disclosure became a particularly significant area to monitor. Client probes for personal information were an important cue. They sometimes triggered an intuition of client sexual attraction or at least concern that things

might be headed in a wrong direction. Stella described her experience with the young male client, "I found that in our sessions, he would want to find out more and more about me and my life." As a result, Stella began to monitor self-disclosure closely. Rhonda described self-disclosure as a double-edged sword. Her statement highlights the challenge many therapists may face on a regular basis:

> I think self-disclosure . . . can be a really nice way of connecting a person, reducing the power differential and helping the client feel more comfortable and sometimes normalizing some of their experiences as well. . . . But the other side is that it could be confused as something, a friendship, something other than being in a counselling relationship. (Rhonda, P2)

The focus on relationship and equalizing the power in the relationship may be particularly challenging for therapists whose theoretical orientations emphasize those values. Self-disclosure appears to be a conspicuous realm for distinguishing professional from personal relationship.

Intuition became an important ally in detecting, monitoring, and deciding when or if to respond to client sexual advances. Smith-Pickard (2009, p. 29) provided a description of an embodied experience that seems to mirror therapists' attempts to describe intuited events, "I am particularly interested in embodied relational experiences that lie beyond the exchange of factual information. These experiences are not easily expressed through language because they belong to the non-verbal, affective dimension of our lives." This might help to explain the uncertainty therapists sometimes displayed when they considered disclosing situations to others that they could not provide any concrete evidence for. Intuition is a word that describes an experience that may seem as difficult to

describe or define as the concept of "love." How do you explain awareness of sexual attraction in any better terms than, "I could feel him being attracted," as Stella described? Rhonda explained that she advises students she supervises to "listen to your gut." Intuition is most likely an important ally in perceiving much of what is perceived in therapy, including client sexual attraction. Trusting that you have perceived something allows the therapist to consider what to do next. Kelly's experience with the supportive supervisor who trusted her (intuited) assessment of the situation with the fantasizing female client contributed to her confidence to manage the situation. Sophia mentioned that in more ambivalent situations she needs more information to support her intuition in order to respond appropriately if a response is necessary at all. That sounds prudent given the potential risks therapists have named.

Intuition seemed to play a critical role in boundary maintenance by first stimulating awareness of cues and clues signalling the possibility of client sexual attraction. It then helped guide therapists' responses based on the unique circumstances involved in each situation. Intuition also seemed to be utilized in drawing an invisible line or limit of tolerance for relevant behaviours which were either accepted and overlooked or stimulated anxiety and action if deemed necessary. This was the basis for the concept of a tipping point where, in some cases, therapists felt it was necessary to address client sexual advances in some way. They could no longer overlook or ignore the situation. Intuition itself is simply a "feeling" that something may be so. In the case of client sexual

advances, it is an important ally in becoming aware of a situation that may have potential to interfere with a client's experience of therapy.

The decision to address client sexual advances was sometimes complicated by the notion that a client may have been attracted to therapy because they were attracted to the therapist. This was considered a potential positive benefit of client sexual attraction. In some cases, therapists felt that certain clients might not have otherwise maintained a commitment to therapy and therefore would not have received the help they strove to provide. Stella described benefits of the young man's crush, "He was so fond of me he trusted the sessions completely . . . his first experience of therapy was a very positive thing . . . he disclosed in a way that I think he's never disclosed in his life." Margot described how client sexual attraction may have been positively motivating with one client, "And I was also conscious of the fact that he had attempted counselling in the past and had never stuck with it. And so a part of me thought well even if that is the only reason he's coming, can I use that?" I wondered if using it as a hook might also contribute to the awkwardness of addressing client sexual advances. Perhaps a therapist might feel uncomfortable acknowledging that they were aware of the sexual attraction and "used it" in some way? And what if the client senses that the therapist is aware, or senses a therapist's nervousness? Perhaps the client might attribute the nervousness to an affective response suggesting her reciprocal attraction. Maybe that was the case for Margot's client who said that he "thought she wanted it [sex]." Clearly some therapists believed that in some cases sexual attraction could be beneficial. The possible consequences of not acknowledging it,

if and when its presence may be significant, were not explored with the same tenacity as the dangers of addressing it.

What was seen as a significant risk from addressing client sexual advances directly was the potential for damaging the therapeutic relationship or at least a lingering awkwardness between them. On the other hand, not addressing the elephant in the room might seem antithetical to the openness that has evolved as part of the special relationship. Kelly suggested, “We’re kind of modeling the behaviour that you want them to take up in their own lives.” Keeping silent when something feels very salient in the room may not be the model for communication that therapists hope to provide. There appears to be no right or wrong way to manage the situation due to the many variables involved. Unfortunately, therapists often did not feel comfortable enough to discuss their reasoning with supervisors or peers. When sensitive and validating supervision or consultation was available, it was helpful in alleviating therapists’ anxiety and discomfort.

Theme 5: Taboo Topic

Conversations with participants indicate that client sexual advances or sexual attraction in the context of therapy continues to be a taboo topic in psychology training, supervision, and among colleagues and peers. Raising awareness of sexual issues in therapy would be a significant step forward. Pope and Bouhoutsos (1986) pointed out the necessity of being aware of vulnerabilities and the harm that can result from sexual transgressions in therapy for clients, therapists, and the profession generally. The authors voiced apprehension about the tragic consequences for clients, the breach of trust involved for professionals, and the profession’s neglect of the topic:

> Long a taboo topic, sexual intimacy between therapists and patients is still a painful topic for many of us. So devastating are the consequences for the patients and so deep is the betrayal of trust (let alone of laws, ethics, and professional standards) on the part of the therapist, that we tend to avert our eyes and act as if it never or rarely occurred. We engage in denial and discounting. We develop a habit of "selective inattention." (p. 1)

The lack of discussion and resources on sexual issues in therapy for the purposes of education and awareness has probably contributed to the taboo nature of the topic (Pope & Tabachnick 1993). Therapists who experience client sexual advances may be hesitant to discuss their situations in part because of this neglect. Client sexual advances themselves do not constitute any wrong-doing on the part of the therapist. Yet, therapists experienced a hesitancy to discuss client sexual advances with clients, supervisors, and colleagues. It is important to distinguish between sexual attraction in therapy and sexual violations. They are not the same. Sexual attraction is a quite natural human phenomenon that is bound to occur in the intimate context of therapy. Harris (2001) pointed out the need to normalize the process of being attracted to another person in order to facilitate open discussions and promote ethical practices.

The risk of embarrassment (whether client's or therapist's) was a strong motivator to avoid discussions of client sexual advances. Stella did not want to humiliate the young man who she believed had suffered enough humiliation in his life. Rhonda hoped to avoid risking the therapeutic relationship with the secret admirer but she eventually decided she had to address it. She described it as embarrassing for both of them. Some personal issues, and particularly sexual issues, may have more potential for awkwardness and embarrassment. Pope, Sonne, and Greene (2006) provided a list of taboo topics and questions for

therapists and therapists-in-training to ask themselves. This allows them to purposefully explore topics that receive only superficial treatment in the literature and can provoke anxiety, discomfort, and confusion. They pointed out the risk of these topics becoming “invisible” to therapists because of a tendency to avoid, mask, or minimize them. It is helpful to remain aware of those risks and ask ourselves “why” when we find ourselves attempting to avoid a difficult topic.

Training for students and supervisors should include the need to develop an alliance capable of allowing the open discussion of client sexual advances, therapist attraction to clients, and even therapist contemplation of a sexual relationship if it comes to that. Humans are susceptible to human emotions and rationalizing why their circumstances are special or different from others (Pope & Bouhoutsos, 1986). Therapists in such situations need a safe and empathetic place to diffuse strong emotions and make decisions that include consideration of the potential impact on the client involved as well as the therapist.

With supervisors, therapists not only risked embarrassment, they feared greater risks of judgements of their competence and character. Kelly pointed out what may be the heart of the problem, “I think people’s perceptions of us will change regardless of the outcome. You know, you bring sex into the picture and you’re introducing a vulnerability.” Because of the taboo around sexual issues and the association of sexual attraction with sexual misconduct, therapists were often afraid to talk about them.

Supervision and training could play a critical role in normalizing experiences of client sexual advances and helping students feel confident in their

ability to manage them. Kelly's first supervisor insinuated that Kelly was imagining that the bride-seeking client was attracted to her. Kelly's next supervisor was encouraging and supportive. She clearly indicated her belief in Kelly's interpretation of events and her ability to manage them. The gift Kelly's supportive supervisor gave her was to trust her, validate her experience with the fantasizing female client as legitimate, and show a belief in her abilities to manage the situation. As West and Clark (2004) suggested, a healthy supervisory alliance should be able to handle the question, "Are there things about your practice you shy away from discussing in supervision?" (p. 25). They also suggested that supervisors model sharing difficult moments with their supervisees as a way to reinforce the message that it is not only okay, but a safe place to talk about difficult situations with their clients. Smith-Pickard (2009) spoke more specifically about sexuality and argued that, "Sex in the consulting room would transgress an ethical boundary but sexuality is always present in an encounter." Smith-Pickard suggested that the supervisory relationship provided a place where the concept of sexuality could be explored. "This type of encounter is an experiential collaboration where the inevitable presence of sexuality is acknowledged and can provide an initiatory understanding of what happens relationally in the therapeutic space" (Smith-Pickard, 2009, p. 29).

Theme 6: Being Female

Male therapists have consistently outnumbered female therapists in reports of therapist-client sexual involvement. This led Pope (1994) to suggest that, "A clear, comprehensive, and useful understanding of the nature, meaning, and

effects of therapist-patient sex and of ways to help exploited patients cannot emerge from denial of this obvious, marked gender imbalance and the context that it creates" (p. 19). In a study involving 189 marriage and family therapists, Nickell, Hecker, Ray, and Bercik (1995) found that in the previous two years, males were more likely than females to have engaged in sexual fantasies involving clients "rarely" or "sometimes" (62% versus 36%). The authors speculated that gender role socialization likely plays a part in such findings. It would be helpful to understand gender differences better. Female therapists' experiences related to sexual issues in therapy have not been explored in depth. This investigation strove to uncover some hints that might lead to ideas for further investigation.

Therapists adjusting their behaviour and dress in light of client sexual advances may not seem surprising. However, if we feel that way, we might benefit from asking ourselves, "Why?" and, "What are the consequences of such thinking?" It may be partly because of a tendency to acknowledge certain behavioural differences between men and women as typical within the culture and to generally accept male/female stereotypes as valid. When we concede that certain behaviours are characteristic, it is possible that we may overlook their potential significance and possible deeper implications. What does it mean when female therapists change their appearance and behaviour as a reaction to client sexual advances? When they are hesitant to discuss sexual issues with supervisors and colleagues because they believe their own integrity and behaviour will be scrutinized, what does that imply? When female therapists understand the power

of sexual attraction as a lure to motivate clients to come to therapy, what is that telling us? Gilbert (1987) offered a treatise on the role of female and male emotional dependency issues and sex role socialization in the therapeutic setting and how they may be implicated in the eroticism of the therapeutic relationship. I believe there is a need to explore issues like these further if we want to understand and respond to client sexual advances better. The young women in the present study did not seem to have previously considered how therapist-client interactions and client sexual advances might be influenced by gender-role socialization. They were hesitant at first to speculate about gender differences at all. It seems that it is not politically correct in the current climate where young women may feel that, because there have been advances in gender equality, feminist issues are not an issue any more. I hope others will disagree and explore these issues further—not in a way that exaggerates the differences between men and women—but in a way that is sensitive to a patriarchal heritage that still influences our intrapsychic worlds, including the beliefs, desires, and values that influence our behaviours.

Contributions of the Study

This study seems to be unique because it has offered a different perspective from the mainstream literature. The focus was not on therapist sexual feelings or sexual violations. Instead, the aim of this study was to explore client sexual advances and therapists' experiences of managing them. In addition, I attempted to look specifically at female therapists' experiences. Female therapists' experience with client sexual advances (or generally) have not specifically been explored with any depth in the literature.

The findings suggest that client sexual advances and sexual feelings in therapy are generally experienced as difficult, awkward, and even threatening to discuss. This is especially true with supervisors and colleagues where the stakes of being judged unfairly may be high. Client sexual advances may also have potential to affect the quality of the therapeutic relationship. Therapists, and presumably at least some of the clients, experienced awareness of client sexual advances as a tangible presence in the room. Even when it was acknowledged, there could be lingering awkwardness. How embarrassment or avoidance of the issue may have impacted the relationship was not examined specifically and might benefit from a deeper look from both therapist and client perspectives. Additionally, this investigation provided some specific incidents of client sexual advances which could be utilized as real-life scenarios for discussions in training and supervision.

We also learned something about the challenges therapists may face when confronted with sexual advances including; how it may impact their trust and feelings towards the client or stimulate self-doubt; that it may cause them to alter their behaviour; and that they may face the dilemma of whether to address the issue openly or not. The special relationships therapists developed with their clients and caring attitudes were admirable. But it also highlighted the unique challenge of trying to manage such a close relationship and maintain some professional distance. Maintaining professional boundaries became a significant focus and a factor in managing the relationship appropriately. Maintaining awareness of those boundaries meant paying attention to issues of self-disclosure,

cues and clues of client sexual attraction, and utilizing intuition when making complex decisions about whether to confront client sexual advances or not.

Managing client sexual advances appears to be a grey area that requires therapist judgement based on gut-feelings or intuition. Intuition was often relied on for deciphering the meaning of cues and clues and deciding when or whether to test those hypotheses by seeking more information or through open discussion. Sometimes intuition also suggested that consulting with supervisors or colleagues could be risky. The underlying fears seemed to project from concerns that they might be judged harshly and wrongly and that they may not have any way to defend themselves. From that, we became aware of a particular need for safety within the supervisory alliance. The ability to discuss experiences in therapy with supervisors allowed therapists to openly evaluate their intuitions, as well as develop awareness and confidence in their own ability to intuit and respond appropriately to situations they encountered.

Findings also alerted us to some particular ways that females may experience sexual advances differently from male therapists. That foray provided several unanswered gender-related questions to ponder. Primarily, I am left wondering what, if anything, may be the impact of gender-role socialization on therapy and client-therapist dyads. Another important aspect of this study was that the taboo nature of the topic highlighted the desirability of normalizing client sexual advances. This could help to facilitate the discussion of sexual feelings in general with supervisors, colleagues, and clients (when it is appropriate to do so).

Implications for Therapists

The possibility that therapists might experience client sexual advances and therefore have to manage them in some way was of major significance in deciding to do a qualitative investigation into the phenomenon. Like Harris (2001), I wondered if therapists had discovered effective ways of managing client sexual advances, whether gender affected these events, and whether therapists could provide insight into potential dangers from poorly handled incidents. This investigation began the exploration into these types of themes. We were able to glimpse some of the challenges that therapists, especially beginner therapists, often struggled with on their own. Through their willingness to share their experiences, therapists were able to highlight some important issues. It is possible to see how it could be beneficial to provide broad awareness of the somewhat hidden phenomenon of client sexual advances, especially since they may occur with some regularity.

Client sexual advances, and sexual feelings in therapy generally, require a safe environment for discussion. As a result, the quality of the supervisory alliance takes on special significance. We may wish to train the trainers to talk about difficult issues and to provide an environment that allows their supervisees the freedom from judgement that could make disclosures more likely. It could be beneficial to acknowledge client sexual advances and sexual feelings in therapy as a common and natural possibility that is not necessarily related to sexual violations—unless we do not pay attention to them. It may also be fitting to acknowledge, understand, and disseminate information about therapist and client

vulnerabilities that could lead to sexual relationships. This would help to reinforce the message that it is important to avoid sexually inappropriate relationships due to the significant harm some clients have experienced from therapist-client sexual relationships and the breach of trust (Pope, 1994). Therapists in this study were aware of the prohibitions, but may not have had a thorough understanding of the potential consequences of sexual relationships. Perhaps that level of understanding would have impacted or reinforced the decisions they made or will make in the future regarding how to respond to client sexual advances. Broadly speaking, therapists' knowledge and awareness of the potential for client sexual advances, vulnerabilities that can lead to sexual violations and sexual issues generally, should be fostered. Therapists would then be better equipped to make informed and ethical choices that are in the best interest of the client, the profession, and for themselves. Previous studies and this investigation suggest that the kind of training and awareness necessary does not always happen. When therapists are not informed, they may be more vulnerable to sexual relationships (Pope, Sonne, & Greene, 2006). At the very least, the therapeutic relationship may be compromised in ways that currently are not well understood. The situation may be made worse if they are afraid to access help and cannot find information because the topic is avoided and good information is not readily available.

Recommendations and Considerations for Future Research

This preliminary examination of the experiences of five female therapists provided an in-depth look at a number of incidents that they encountered. The participants consisted of a small, local, and mostly homogenous group that may

not be indicative of the broader population of female therapists. Further studies that incorporate more diversity in relation to age, experience, cultural, and other factors could provide valuable contributions over and above the insights provided here. The voices of more mature and experienced female therapists would be particularly helpful. The question of how to manage client sexual advances is a valid one that was barely touched on. Participants in this study were relatively young and/or inexperienced, and the two who had several years experience could only provide insight from a limited number of incidents. The perspectives provided here offered a good glimpse into early experiences by therapists-in-training. Additional studies may also bring a number of new issues to the table.

From the insights gathered in this investigation, I believe it would be beneficial for the profession to acknowledge and begin to produce broader information about sexual feelings in therapy. It may also be helpful to produce research that focuses in a new direction when it comes to sexual issues in therapy. Client sexual advances and sexual issues generally could be explored and understood as a naturally occurring phenomenon that can occur in therapy, rather than simply in relation to sexual violations or misconduct. Filling this gap in knowledge in such a way could help normalize these types of experiences. It could also help to ensure that information is more easily accessible to graduate programs, students, supervisors, and anyone who may be faced with dilemmas around sexual issues in therapy.

The topic of client sexual advances appears to be taboo. Therapists often found it difficult, awkward, and embarrassing to approach with clients,

supervisors, and colleagues. Research is also challenged by the taboo nature of sexual issues in therapy. Researchers must consider whether the questions they wish to pursue may be better suited to anonymous surveys rather than personal interviews. Recruiting participants for this study relied on personal contact and a sense of safety for participants to disclosure of their experiences with client sexual advances. It may have been more difficult to recruit participants if they had been required to disclose attraction toward clients, sexual feelings, flirtatious behaviour, sexual advances toward clients, etc.

In training, supervision, and consultation, it would be advantageous to encourage openness and discussion of sexual issues. Students and others may then feel safe to explore their experiences and feelings without fearing negative judgments or repercussions. New ways of discussing sexual issues in therapy that are not threatening could contribute to this end. Perhaps it would be helpful to discuss them in terms related to theoretical orientations, or develop new constructs or language with the intention of normalizing and explaining the experiences rather than making them more complex. The part that gender-role influences might play in understanding behaviours could provide some useful intelligence.

Therapists would not only benefit from more information on the phenomenon but also concrete strategies for managing specific situations. Therapists not only struggled with how to manage client sexual advances, sometimes they felt vulnerable or threatened. Margot very quickly felt “threatened” by the client’s background of sexual harassment once he violated the

civility barrier and told her he would like to have sex with her. If she had been a sole practitioner without a support staff close by, how much more threatened might she have felt? The issue of personal safety was only raised by Sophia when she worked with potentially violent offenders. How much of a concern should this be for other therapists? And might female therapists be more vulnerable, as Sophia suggested? These are questions that could be explored in more depth.

Sophia and Rhonda offered practical advice that they provide to students but more research is needed. It would be helpful to hear from a number of seasoned practitioners who have successfully managed situations, as well as those who may have had negative experiences. This represents a very practical direction that could provide information for training and/or immediate relief in highly stressful situations when therapists may find themselves struggling with client sexual advances or other sexual issues in therapy. Findings from this study indicate that it may be difficult or impossible to produce specific solutions to every conceivable situation. It is a delicate area that requires some tact on the part of the therapist, perhaps similar, in a sense, to discussing suicide as Sophia suggested. Assuming that many therapists must manage such situations, their experiences could point to strategies that might provide growth promoting and positive outcomes. We may also learn how to minimize difficult, challenging, or potentially harmful situations.

The sexual nature of the topic appears to contribute to the difficulty discussing client sexual advances. How individuals experience and think about sexual issues is probably quite personal to the individual. Pope, Sonne, and

Greene (2006) tackled issues like this in a book titled, "What therapists don't talk about and why: Understanding taboos that hurt us and our clients." They offered scenarios with questions designed to provoke awareness of the reader's personal beliefs and attitudes about each issue. This allows the reader to examine their own feelings about difficult and taboo topics like; sexual feelings, arousal, and fantasies; hatred for a patient; prayer with patients as part of therapy; sexual orientation and self-disclosure; difficult aspects of race and ethnicity; and many other difficult topics. According to Pope et al., the goal is to become more mindfully aware of "the complex, messy situations that occur in real life, of how we respond to them, and of the need for openness, honesty, courage, and constant questioning" (p. 4). The authors also scrutinized myths about psychologists that may contribute to the difficultly approaching some topics. The book might be a good resource for graduate programs and perhaps a model for a book specifically about sexual issues in therapy.

Finally, I hope that further research is undertaken that explores the unique context of female therapists. Although women's status in North America has progressed significantly, we are not beyond the influence of our patriarchal roots. Nor are we immune to local or world cultural and religious influences that impact women's (and men's) knowledge, beliefs, attitudes, and behaviour. Issues of gender, culture, and social influence are not only relevant for understanding clients, they are relevant toward a better understanding of ourselves. Female gender roles and their impact on women have been explored by feminist writers (e.g., Chodorow, 1989; Dinnerstein, 1976; Gilligan, 1982; etc.). The insight

gained has contributed to the development of feminist therapies and a better understanding of women generally. Some researchers have approached the topic of male gender role expectations and their impact on therapy (e.g., Cochran & Rabinowitz, 1996; Pederson & Vogel, 2007; Scher, 1990). Their work provides ideas and theories about how gender-role expectations contribute to men's hesitancy to seek counselling and their resistance to therapy when they are there. This information is valuable on a practical level because it suggests strategies that may help these attitudes to be overcome and perhaps provide better experiences and improve results. The role of therapist gender in therapist-client dyads is still largely unexplored. Understanding how therapist gender may affect interactions in therapy could provide useful intelligence in the therapy room.

Conclusion

Client sexual advances can be a source of anxiety and a challenge for therapists who face these situations. Raising awareness about client sexual advances and other sexual issues in therapy by studying them, teaching them, and openly discussing them could help to alleviate the taboo nature of the issue and help counsellors, especially trainees, feel more comfortable seeking assistance from supervisors and colleagues. Opening a dialogue, normalizing experiences, and considering the implications for therapists and clients within therapy are all potentially valuable goals. Professional standards and prohibitions against sexual relationships suggest the importance of developing an awareness of sexual issues in therapy that may have implications for clients, therapists, and for the profession generally. However, sexual violations appear to be a far less likely phenomenon than sexual attraction in therapy. For that reason, it might be better to shift the emphasis away from the less likely scenario to scenarios that are more likely to occur, including sexual attraction (whether clients' or therapists') and how we might manage those situations. Given the taboo nature of the topic, attempting to clearly distinguish sexual attraction from sexual violations could contribute to greater discussion in training and consultation. Accepting sexual attraction as a common and naturally occurring phenomenon in human relationships would contribute toward making it easier to acknowledge and disclose. As a result, therapists may feel more comfortable seeking advice, support, and the information they need to make informed decisions about how to manage client sexual advances or related issues. Further research on the effect of therapist-client gender

on therapists' experiences and in terms of therapist-client dyads could also provide benefit to such a dialogue and be of practical assistance to counsellors in their work with clients.

References

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.

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 & Behaviour, 4*(4), 369-388.

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

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* 77-101.

Cochran, S. V., & Rabinowitz, F.E. (1996). Men, loss, and psychotherapy. *Psychotherapy, 33*(4), 593-600.

Chodorow, N. (1989). *Feminism and psychoanalytic theory.* New Haven: Yale University Press.

Dinnerstein, D. (1976). *The mermaid and the minotaur: Sexual arrangements and human malaise.* New York: Harper & Row.

Feldman-Summers, S., & Jones, G. (1984). Psychological impacts of sexual contacts between therapists or other health care professionals and their clients. *Journal of Consulting and Clinical Psychology, 52*(6), 1054-1061.

Freud, S. (1953). Further recommendations in the technique of psychoanalysis: Observations on transference—Love. In E. Jones (Ed.) and J. Riviere

(Trans.), *Collected papers of Sigmund Freud* (Vol. 2, pp. 377-391). London: Hogarth. (Original work published 1915)

Gilbert, L, A. (1987). Female and male emotional dependency and its implication for the therapist-client relationship. *Professional Psychology: Research and Practice, 18*(6), 555-561.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development.* Cambridge: Harvard University Press.

Glaser, B. G. (1978). *Advances in the methodology of grounded theory: Theoretical sensitivity.* Mill Valley: The Sociology Press.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Chicago: Aldine.

Goldfried, M. R., & Davila, J. (2005). The role of relationship and technique in therapeutic change. *Psychotherapy: Theory, Research, Practice, Training, 42*(4), 421-430.

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

Harris, S. M. (2001). Teaching family therapists about sexual attraction in therapy. *Journal of Marital and Family Therapy, 27,* 123-128.

Harris, S. M., & Harriger, D. J. (2009). Sexual attraction in conjoint therapy. *The American Journal of Family Therapy, 37*, 209-216.

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

Kahn, M. (1996). *Between therapist and client: The new relationship.* New York: Freeman.

Kimball, M. M. (2000). From "Anna O." to Bertha Pappenheim: Transforming private pain into public action. *History of Psychology, 3,* 20-43.

Matthews, S. H. (2005). Crafting qualitative research articles on marriages and families. *Journal of Marriage and Family 67,* 799-808.

Nickell, N. J., Hecker, L. L., Ray, R. E., & Bercik, J. (1995). Marriage and family therapists' sexual attraction to clients: An exploratory study. *The American Journal of Family Therapy, 23*(4), 315-327.

Pederson, E. L., & Vogel, D. L. (2007). Male gender role conflict and willingness to seek counselling: Testing a mediation model on college-aged men. *Journal of Counseling Psychology, 54*(4), 373-384.

Peterson, M. R. (1992). *At personal risk: boundary violations in professional-client relationships.* New York: Norton.

Pope, K. S. (1994). *Sexual involvement with therapists: Patient assessment, subsequent therapy, forensics.* Washington: 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. G. (1986). Sexual attraction to clients: The human therapist and the (sometimes) inhuman training system. *American Psychologist, 41*(2), 147-158.

Pope, K. S., Sonne, J. L., & Greene, B. (2006). *What therapists don't talk about and why: Understanding taboos that hurt us and our clients.* Washington: American Psychological Association.

Pope, K. S., Sonne, J. L., & Holroyd, J. (1993). *Sexual feelings in psychotherapy: Explorations for therapists and therapists-in-training.* Washington: American Psychological Association.

Pope, K. S., Sonne, J. L., & Holroyd, J. (2000). *Sexual feelings in psychotherapy: Explorations for therapists and therapists-in-training.* Washington: American Psychological Association.

Pope, K. S., Sonne, J. L., & Holroyd, J. (2002). *Sexual feelings in psychotherapy*. Washington: American Psychological Association.

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

Pope, K. S., Tabachnick, B. G., & Keith-Spiegel, P. (2006). Sexual attraction to clients: The human therapist and the (sometimes) inhuman training system. *American Psychologist*, *41*(2), 147-158.

Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour.* London: Sage.

Reber, A. S., & Reber, E. S. (2001). *Dictionary of psychology.* London: Penguin.

Rogers, C. (1992). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting and Clinical Psychology, 60*(6), 827-832. (Original work published 1957)

Scher, M. (1990). Effect of gender role incongruities on men's experience as clients in psychotherapy. *Psychotherapy, 27*(3), 322-326.

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

Skovholt, T. M., & Ronnestad, M. H. (2003). Struggles of the novice counselor and therapist. *Journal of Career Development, 30*(1), 45-58.

Smith-Pickard, P. (2009). Sexuality in supervision. *Therapy Today, 20*(2), 28-31.

Snyder, C. R., McDermott, D. S., Leibowitz, R. Q., & Cheavens, J. (2000). In C. R. Snyder & R. E. Ingram (Eds), *Handbook of psychological change* (pp. 640-659). New York: Wiley.

Somer, E., & Saadon, M. (1999). Therapist-client sex: Clients' retrospective reports. *Professional Psychology: Research and Practice, 30*(5), 504-509.

Strauss, A. L., & Corbin, J. M. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory.* Thousand Oaks: Sage.

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

Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation, 27*(2), 237-246.

Truscott, D., & Crook, K. H. (2004). *Ethics for the practice of psychology in Canada.* Edmonton: University of Alberta Press.

West, W., & Clark, V. (2004). Learnings from a qualitative study into counselling supervision: Listening to supervisor and supervisee. *Counselling and Psychotherapy Research, 4,* 20-26.

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

Williams, M. H. (1997). Boundary violations: Do some contended standards of care fail to encompass commonplace procedures of humanistic, behavioural, and eclectic psychotherapies? *Psychotherapy, 34*(3), 238-249.

APPENDIX A

UNIVERSITY OF ALBERTA
Faculty of Graduate Studies
Department of Educational Psychology

Female Psychotherapists' Experience of Client Sexual Advances

Dear Practitioner,

My name is Marion Stewart. I am a graduate student at the University of Alberta. As my thesis project, I am interested in having conversations with psychotherapists or counsellors who have had experiences with client sexual advances toward you as the therapist. Due to the intimate nature of the therapeutic relationship, we know that client sexual advances in the context of therapy are likely to occur frequently. How psychotherapists deal with them has not been adequately examined, however. The information resulting from this exploration is expected to be useful for preparing graduate students and informing practitioners in general. It may help formulate more specific questions to guide further research. Ultimately, it is hoped that it will help us to provide better responses that can enhance the therapy experience for clients.

What will I be asked to do?

You will be asked to participate in a 1 – 2 hour semi-structured interview with the researcher.

What Type of Personal Information Will Be Collected?

You will be asked several open-ended questions about your experience with clients in therapy where you have perceived a sexual advance. This may or may not have been reciprocal. Whether or not it was openly discussed, if and how you responded, and what resulted from your response will be of particular interest. Your perceptions, ideas, or suggestions surrounding this issue will also be appreciated. Whatever you wish to share is likely to benefit other practitioners in similar situations. Questions may include items such as, "What has been your experience with client sexual advances in therapeutic practice?" "How have you handled the situations you have encountered?" "What impact do you think this had on therapy?" In addition, some demographic information will be requested.

If you decide to participant:

1) You will be given an explanation of the study and be provided with an opportunity to discuss any questions or concerns that you may have.

2) You will participate in a single interview that will be audio-taped and transcribed. The interviews will occur at the University of Alberta, Education Clinic or a mutually agreed location. They will be approximately one to two hours in duration. The interviews will be of a conversational nature and will explore your experiences involving client sexual advances toward you as the psychotherapist and potentially, your thoughts, feelings and suggestions regarding what occurred and suggestions for others in the situation.

3) All information collected (i.e., audiotapes, and transcriptions) will be sorted so that your name is not associated with it. A coding system will be devised to organize the data. This will be done to ensure your privacy, confidentiality, and anonymity. The write-up of the findings will diligently attempt to avoid including any information that can be linked directly to you or your clients. Transcripts and audiotapes will be secured in a locked filing cabinet and will be kept for at least five years following the completion of the study. Any research personnel that may be involved in this study will sign a confidentiality agreement and will comply with the University of Alberta Standards for the Protection of Human Research Participants http://www.ualberta.ca/~unisecr/policy/sec66.html.

It is expected that this research study will provide new knowledge and reveal the importance of understanding not only that sexual advances occur in therapy, but also how they may be adequately responding to or alternatively, the pitfalls that may occur so that we can learn better responses. While it is not anticipated that you will experience distress, some people find that talking about difficult situations may elicit anxiety or discomfort from revisiting these situations. Even as professionals, this may be the case. In that event, referrals to low or no cost counselling agencies in your area may be provided.

Given the importance of this research, the findings of this study may be reported in academic journals and presented at conferences. Your name and other identifying information will not be used in any presentations or publications of the study results. The plan for this study has been reviewed for its adherence to ethical guidelines and approved by the Faculty of Education, Extension and Augustana Research Ethics Board (EEA REB) at the University of Alberta. For questions regarding participant rights and ethical conduct of research, I can contact the Chair of the EEA REB at (780) 492-3751.

Your participation in this study is completely voluntary and you are free to withdraw your involvement at any time. You have every right to opt out of this study without prejudice and any collected data up until the end of the data collection period will not be included in the study.

Thank you for your interest and consideration. Please feel free to contact me with your questions or for **further** *information.* ***If you are able to help by participating in this research, please contact me at the Education Clinic (780) 492-3746 or by email, marion.stewart@ualberta.ca.*** *Your willingness to contribute to this research will be sincerely appreciated.*

Principle Researcher:

Marion Stewart

Department of Educational Psychology

University of Alberta

(780) 492-3746

Research Supervisor:

Dr. Derek Truscott

Department of Educational Psychology

University of Alberta

(780) 492-1161

Thank you for considering your participation in this study.

Sincerely,

____

Marion Stewart, BA
Master's Student, University of Alberta
Department of Educational Psychology

APPENDIX B

UNIVERSITY OF ALBERTA
Faculty of Graduate Studies
Department of Educational Psychology

Consent Form

Project Title: Female Psychotherapists' Experience of Client Sexual Advances

Principle Researcher: Marion Stewart

Research Supervisor: Dr. Derek Truscott

Thank you for your interest in participating in this study. The purpose of this study is to understand the experiences of psychotherapists where client sexual advances have occurred in therapy, their strategies and responses for dealing with it, and its perceived impact on the therapeutic process. This information could benefit other practitioners, graduate student training and further research. Ultimately, it is hoped this research will contribute to better client care as we learn from these experiences.

As previously indicated in the information letter, I understand that my participation in this study will involve the following:

1) I will be given an explanation of the study and be provided with an opportunity to discuss any questions or concerns that I may have.

2) I will participate in a single interview that will be audio-taped and transcribed. The interviews will occur at the University of Alberta, Education Clinic or a mutually agreed location. They will be approximately one to two hours in duration. The interviews will be of a conversational nature and will explore my experiences involving client sexual advances toward me as the therapist and potentially, my thoughts, feelings and suggestions regarding what occurred and suggestions for others in the situation.

3) All information collected (i.e., audiotapes, and transcriptions) will be sorted so that my name is not associated with it. A coding system will be devised to organize the data. This will be done to ensure my privacy, confidentiality, and anonymity. The write-up of the findings will diligently attempt to avoid including any information that can be linked directly to me or my clients. Transcripts and audiotapes will be secured in a locked filing cabinet and will be kept for at least five years following the completion of the study. Any research personnel that may be involved in this study will sign a confidentiality agreement and will comply with the University of Alberta Standards for the Protection of Human Research Participants http://www.ualberta.ca/~unisecr/policy/sec66.html.

It is expected that this research study will provide new knowledge and reveal the importance of understanding not only that sexual advances occur in counselling, but also how they may be adequately responding to or alternatively, the pitfalls that may occur so that we can learn better responses. While it is not anticipated that I will experience distress, some people find that talking about difficult situations may elicit anxiety or discomfort from revisiting these situations. Even as professionals, this may be the case. In that event, referrals to low or no cost counselling agencies in my area may be provided.

Given the importance of this research, the findings of this study may be reported in academic journals and presented at conferences. My name, and other identifying information will not be used in any presentations or publications of the study results. The plan for this study has been reviewed for its adherence to ethical guidelines and approved by the Faculty of Education, Extension and Augustana Research Ethics Board (EEA REB) at the University of Alberta. For questions regarding participant rights and ethical conduct of research, I can contact the Chair of the EEA REB at (780) 492-3751.

My participation in this study is completely voluntary and I am free to withdraw my involvement at any time. I have every right to opt out of this study without prejudice and any collected data up until the end of the data collection period will not be included in the study.

Having read and understood all of the above, I, ________________________
__________ agree to participate freely and voluntarily in this study.

_________________________________ _____________________________

Signature of Participant Date

_________________________________ _____________________________

Signature of Researcher as Witness Date

NB. Two signed copies of the consent form are required. One copy is to be kept by the participant, and one returned to the researcher.

Thank you for offering to participate in this study. Please feel free at any time to bring up any questions and/or concerns regarding your participation in this study. Contact information is as follows:

Principle Researcher:

Marion Stewart

Department of Educational Psychology

University of Alberta

(780) 492-3746

Research Supervisor:

Dr. Derek Truscott

Department of Educational Psychology

University of Alberta

(780) 492-1161

APPENDIX C

Female Therapists Interview Guide

Introduction:

The purpose of this study is to gain insight into the experiences of female therapists who have had experiences with client sexual advances. How the therapist managed these situations and what happened as a result is of particular interest. This information could benefit other practitioners, graduate student training, and help guide further research. Ultimately, it is hoped that this research will contribute to better client care as we learn from these experiences.

I will be asking questions about your experiences with clients who have explicitly or implicitly indicated that they were sexually attracted to you. I will also be asking you to reflect on how this affected your work as a therapist and how you feel it may have impacted therapy. Your perceptions, ideas, or suggestions that emanate from your experience are of interest and will also be appreciated. Whatever you wish to share is likely to benefit other practitioners in similar situations.

I would like to audio tape what you say so I do not miss any of it. I do not want to take the chance of relying on my notes and thereby miss something you say or inadvertently change your words. If at any time during the interview you would like to turn off the tape recorder, please feel free to do so.

Guiding Questions:

1. *Tell me about your experience with client sexual advances?*
2. *How do you believe it may have impacted therapy?*
3. *What were the greatest lessons you took away from the experience?*
4. *Would you have done anything differently in hindsight?*
5. *Did you discuss the situations with colleagues or a supervisor?*
6. *If not, what do you think held you back?*
7. *If so, what type of response did you receive?*
8. *If so, did you find colleagues/supervisors comfortable, knowledgeable, or helpful?*
9. *What do you think may make the topic difficult to discuss?*
10. *What are your thoughts about whether sexual advances should be addressed or ignored in therapy?*
11. *What would you suggest for other practitioners in similar situations?*
12. *Do you feel your training prepared you?*
13. *What would you suggest for training? That is, the type of training that would be beneficial to prepare for these situations?*
14. *In what ways do you think your experience may have been different because you are female?*

15. *How do you think the experience would be different than if it were a male therapist in that position?*
16. *Are there any other comments or information that you would like to share?*

Demographic Information:

Age:

Gender:

Consider yourself a visible minority:

Education or Professional Designation:

Years of therapeutic practice:

Specialization of practice or areas of expertise:

Population served:

Location of practice:

APPENDIX D

Research Consultant Confidentiality Agreement

Project Title: Female Psychotherapists' Experiences of Client Sexual Advances

Principle Researcher: Marion Stewart

Research Supervisor: Dr. Derek Truscott

In my role as a research consultant or hired assistant, I, __________________ ______________________________, agree to respect the anonymity of the participants in this study by:

1. Keeping all of the research information shared with me confidential by not discussing or sharing the research information in any form or format (i.e., emails, discs, tapes, transcripts, etc.) with anyone other than Marion Stewart or Derek Truscott.

2. Keeping all research information in any form or format (i.e., emails, discs, tapes, transcripts, pictures etc.) secure while it is in my possession.

3. Returning all research information in any form or format (i.e., emails, discs, tapes, transcripts, pictures etc.) to the researcher, Marion Stewart when I have completed the research tasks.

4. Erasing or destroying all research information in any form or format regarding this research project that is not returnable to the researcher, Marion Stewart (i.e., email attachments or other information stored on computer hard drive).

____

Printed name   Signature   Date

____

Researcher as Witness   Signature   Date